L.A. Care
HEALTH PLAN

L.A. CARE HEALTH PLAN
CAL MEDICONNECT PROGRAM

PROVIDER MANUAL
2014

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1.0 L.A. CARE HEALTH PLAN

Dear Provider:

L.A. Care has information about many different topics that might be helpful to you on our website. It is a useful way to get information about L.A Care and its processes. Please visit our provider website at www.lacare.org for information about L.A. Care's:

- Quality Improvement Program
- Policy encouraging practitioners to freely communicate with patients about their treatment, regardless of benefit coverage limitations
- Requirement that practitioners and facilities cooperate with QI activities; provide access to their medical records, to the extent permitted by state and federal law; and maintain confidentiality of member information and records.
- Policy on notification of specialist termination
- Access standards
- Case Management services and how to refer patients
- Disease Management Program information and how to refer patients
- Coordination of Medicare and Medicaid benefits
- Care services to members with special needs.
- Clinical Practice Guidelines, including ADHD and Depression
- Medical record documentation standards; policies regarding confidentiality of medical records; policies for an organized medical record keeping system; standards for the availability of medical records at the practice site; and performance goals
- UM Medical Necessity Criteria including how to obtain or view a copy
- Policy prohibiting financial incentives for utilization management decision-makers
- Instructions on how to contact staff if you have questions about UM processes and the toll free number to call
- Instructions for triaging inbound calls specific to UM cases/issues
- Availability of, and the process for, contacting a peer reviewer to discuss UM decisions
- Policy on denial notices
- Policy regarding the appeals notification process
- Pharmaceutical procedures
- Policy regarding your rights during the credentialing/recredentialing process including to review information and correct erroneous information submitted to support your credentialing application, as well as obtain information about the status of your application; and how to exercise these rights
- Member's Rights and Responsibilities
- Web-based Provider and Hospital Directory

If you would like paper copies of any of the information available on the website, please contact us at **1-866-LACARE6 (1-866-522-2736)**

L.A. Care Health Plan

1.1 GENERAL INTRODUCTION

1.1.0 About the L.A. Care Provider Manual

In coordination with the Centers for Medicare and Medicaid Services (CMS), the Department Health Care Services (DHCS) has developed a new demonstration pilot that will provide comprehensive health services to individuals eligible for both Medicare and Medi-Cal ("Dual Eligibles" or "Duals"). The three-year pilot will test how aligning financial incentives can drive patient-centered care and rebalance the current health care system away from institutionalization and toward keeping patients at home. **Effective April 1, 2014, L.A. Care Health Plan's "Cal MediConnect" program began serving enrolled dual eligible members.**

The purpose of the L.A. Care Provider Manual is to furnish providers who participate in PPGs with information on critical processes for all L.A. Care direct lines of businesses. This version of the L.A. Care Health Plan Provider Manual has been created specifically for the care of L.A. Care's Cal MediConnect members. The manual is broken down by functional area and provides information and applicable requirements for both Medicare and Medi-Cal processes. Updates to the manual are made annually and are available online.

1.1.1 Rules of Participation

In order to ensure high quality, cost effective care to L.A. Care's underserved population, L.A. Care Cal MediConnect requires that all providers (medical, behavioral, pharmacy and LTSS) meet the following criteria to participate in the provider network:

- Meet all Credentialing standards outlined in section 7.0
- Meet all HIPAA requirements
- Have a signed contract with L.A. Care
- Be committed to working with a membership that is culturally diverse and be sensitive to cultural and language differences, and those members with disabilities

1.1.2 Responsibility of Participating Providers

L.A. Care Health Plan (L.A. Care) Cal MediConnect requires that its contracted medical groups, hospitals, ancillary providers and other Participating Physician Groups (PPGs) fulfill specified responsibilities. There is a segment entitled "Responsibility of Participating Providers" at the beginning of most sections of this manual that clarifies what functions, if any, are the responsibility of

L.A. Care's Cal MediConnect contracted providers. Please read each of these sections carefully in order to determine what functions are the responsibilities of L.A. Care, and which are the responsibility of PPGs, hospitals, ancillary providers, or other participating providers.

1.1.2 L.A. Care's Commitment to Provide Excellent Services

L.A. Care's overall goal is to develop policies, procedures, and guidelines for effective implementation of provider services in its direct product lines. To accomplish this goal, L.A. Care will work cooperatively with medical groups to ensure that providers have timely access to information and the appropriate resources to meet service requirements.

1.1.3 Traditional and Safety Net Providers

L.A. Care considers the following provider types as Traditional or Safety Net Providers: CHDP providers, Federally Qualified Health Centers, licensed community clinics and Disproportionate Share Hospitals. L.A. Care encourages PPGs to contract with these providers to the fullest extent possible.

1.2 L.A. CARE DEPARTMENTAL CONTACT LIST

L.A. Care Health Plan Cal MediConnect Program
1055 W. 7th Street
Los Angeles, CA 90017
(213) 694-1250

DEPARTMENT	NAME	EXTENSION
CAPITATION	Director	4236
Case Management	Case Management Nurse	5406
Claims	Director For all claims for which L.A. Care is responsible, please mail to: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081	4314
Regulatory Auditing & Compliance	Compliance Officer	4292
Cultural & Linguistic Services	Director	4559
Eligibility Verification	Member Eligibility Verification	888-839-9909
Encounter Data	Provider Information Line	866-LA-CARE6 or 1-866-522-2736
Health Promotion & Education	Director	4559
Long Term Services and Supports	Provider Line	855-427-1223 or 213-694-1250, ext. 5422 Fax: 213-438-4877
Marketing	Marketing Manager	4464

L.A. CARE DEPARTMENTAL CONTACT LIST (CONTINUED)

DEPARTMENT	NAME	EXTENSION
Member Services	General Information Line Director	888-839-9909 4250
Network Operations	Senior Director Provider Relations DIrector	5730 5316
Pharmacy	Senior Director	4251
Prior Authorizations/ **HOSPITAL ADMISSIONS**	L.A. Care Cal MediConnect UM Department must be notified within 24 hours or the next business day following the admission. To obtain an Authorization: CALL TOLL-FREE: 877-HF1-CARE (431-2273) FAX: 213-623-8669 WRITTEN REQUESTS: L.A. Care Health Plan 1055 West Seventh Street Los Angeles, CA 90017 Attn.: Authorization	
Provider Credentialing, Performance and Certification	Manager	4026
Provider Information/Data Issues	Provider Inquiry Line	866-LA-CARE6 or 866-522-2736
Provider Network Operations	Senior Director	5730
Provider Relations	Director	5316
Quality Management	Director	4207
Utilization Management	Director	4427
Utilization Management	Manager	4270
Outreach/Sales	Director	4575

1.3 GLOSSARY OF TERMS

ACRONYM OR WORD(s)	DEFINITION
Ancillary Service	The following services are considered ancillary: ambulance transportation; durable medical equipment (DME) including but not limited to apnea monitor, artificial limbs, and hearing aids; home health care; prosthetic and orthodontic devices; and skilled nursing facilities.
BOG	Board of Governors
Cal MediConnect	A three-year program designed to coordinate medical, mental and substance abuse care, long term care and home- and community-based services under one plan for members eligible for both Medicare and Medi-Cal. This product is regulated by both the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS.
CAP	Corrective Action Plans
CBAS	Community Based Adult Services
CCS	California Children's Services – This program provides health care services to children with certain physical limitations and diseases whose families cannot afford all or part of the care.
CHDP	Child Health & Disability Prevention
CMS	Centers for Medicare and Medicaid Services
CPO	Care Plan Options
DDS	Developmental Disability Services
SDHS	State Department of Health Services
DMHC	Department of Managed Health Care
DOFR	Division of Financial Responsibility
FSR	Facility Site Review
HEDIS	Health Plan Employer Data and Information Set
IBNR	Incurred But Not Reported

GLOSSARY OF TERMS (CONTINUED)

ACRONYM OR WORD(s)	DEFINITION
IHSS	In Home Supportive Services
IPA	Independent Practice Association – In the L.A. Care Healthy Families Program Provider Manual, IPA will be referred to Participating Physician Groups (PPGs).
L.A. Care	L.A. Care Health Plan (Local Initiative Health Authority for Los Angeles County)
LTC	Long Term Care
LTSS	Long Term Services and Supports (a.k.a. Managed Long Term Services and Supports)
Medi-Cal	The California Medical Assistance Program (Medi-Cal or MediCal) is the name of the California Medicaid welfare program serving low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. It is jointly administered by the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS), with many services implemented at the local level mainly by the Counties of California.
Medicare	A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MOU	Memorandum of Understanding
MA-PD	Medicare Advantage Prescription Drug
MLTSS	Managed Long Term Services and Supports (a.k.a. Long Term Services and Supports)
MNS	Medically Necessary Services – reasonable and necessary services rendered for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR§1395(y)
MSSP	Multipurpose Senior Services Program

ACRONYM OR WORD(s)	DEFINITIONS
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider – a physician who has a current, unrestricted license as a physician and/or surgeon in California, whose area of medical practice is one of the five categories designated as a PCP by the Department of Health Care Services (DHCS) and the Knox Keene Act. The five designated categories are general practitioner, internist, pediatrician, family practitioner and obstetrician/gynecologist (OB/GYN). **Note:** Specialists who also meet the requirements and are willing to assume the responsibilities of a PCP may also be designated as a PCP
PNRA	Provider Network Research & Analysis Unit
QIP	Quality Improvement Program
SED	Severely Emotionally Disturbed
SNF	Skilled Nursing Facility
SNP	Special Needs Plan

2.0 MEMBERSHIP AND MEMBERSHIP SERVICES

This section covers membership and member services for L.A. Care Health Plan Cal MediConnect members. Topics include eligibility, enrollment and disenrollment, primary care provider assignment, complaint resolution, and member rights and responsibilities.

2.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs) in L.A. Care Cal MediConnect are responsible for adhering to the member services provisions and guidelines specified in this section.

2.2 PROGRAM ELIGIBILITY

The following are eligible for L.A. Care Cal MediConnect:

- All full benefit Dual Eligible beneficiaries in L.A. County can enroll in L.A. Care's Cal MediConnect program. Full benefit is defined as Dual Eligible members who qualify for Medicare Parts A, B and D coverage and Medi-Cal coverage for Medicare Premiums, co-insurance, copayments and deductibles, as well as additional services, that are covered by Medi-Cal that Medicare does not cover (i.e. Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and other full benefit Dual Eligible beneficiaries)
- Beneficiaries over 21 years of age
- Dual-Eligible Special Needs Plan Enrollees

Failure to meet these requirements may result in termination of enrollment from L.A. Care Cal MediConnect after 180 days.

2.2.1 Conditions of Enrollment

All new enrollments will be confirmed with CMS. L.A. Care will enroll all Cal MediConnect members though the Medicare/Medi-Cal sales and enrollment process, and will comply with all of CMS' marketing, sales and enrollment process requirements. L.A. Care staff will provide each new enrollee with a Summary of Benefits, a Provider Directory, a Pharmacy Directory, a copy of the Pharmacy formulary and an effective date at the time of enrollment.

2.3 MEMBER ENROLLMENT ASSIGNMENT AND DISENROLLMENT

LA. Care has processes in place to ensure members are properly informed about enrollment rights and options, as well as to educate members about the plan benefits, rules and care plan elements with sufficient time to make informed choices.

L.A. Care uses multiple methods to meet the cultural and linguistic needs of members and to communicate with members in their own language, including translation of member informing documents into threshold languages, referral to physicians able to provide services in the member's preferred language, use of qualified bilingual staff, vendor contracts for telephonic and face-to-face interpreting services, including American Sign Language (ASL) at medical and non-medical points of contact, and use of the California Relay Service and Plan teletypewriter (TTY) system. L.A. Care's Member Services call center has the capability to communicate in over 100 languages.

L.A. Care maintains a member page on its website to house member documents and information. Members can access current provider directory information, summary of benefits, evidence of coverage and pharmacy benefit information as well as other helpful information and forms.

L.A. Care publishes accessibility levels for each contracted provider in the L.A. Care Provider Directory, and information is updated every three years. Provider Directories with updated information are sent to all new members upon enrollment with the "New Member Welcome Kit" and then annually thereafter based on member eligibility, so providers should notify us immediately of language and disability access levels.

2.3.1 Member Enrollment

2.3.1.1 L.A. Care will enroll all prospective enrollees into its Cal MediConnect program. Prospective enrollees will complete a CMS-approved L.A. Care enrollment form and the L.A. Care Enrollment Center will process all new enrollments with CMS. Enrollment into CMC is administered through DHCS through the State contracted enrollment vendor, MAXIMUS/Health Care Options (HCO). Prospective enrollees complete a CMS/DHCS approved enrollment form which is processed through HCO.

2.3.1.2 All dual eligibles have a Medicare Special Election Period, which allows them to enroll in and disenroll from a

Medicare-Advantage plan on a monthly basis. Dual eligibles may join a Medicare-Advantage plan outside of their Initial Election Period and Medicare's Annual Election Period.

2.3.1.3 All dual eligibles are required to enroll in a Managed Care Medi-Cal plan.

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2.3.2 Selection, Assignment, and Change of Primary Care Physician

2.3.2.1 Selection

2.3.2.1.1 At the time of enrollment, Cal MediConnect enrollees may select both a primary care physician and a PPG.

Enrollees may choose their current doctors or clinics if the doctors or clinics participate with L.A. Care's network. Enrollees may choose a new doctor from the panel of providers in L.A. Care's Provider Directory, which lists all Medical groups, PCPs, specialists and hospitals contracted with L.A. Care, and have helpful information about each doctor and clinic. Enrollees may choose a specialist as a PCP if they are listed as a PCP in the panel of providers.

Members may change their PCP at any time by calling Member Services. When a member chooses a PCP, the member also selects that PCP's Medical group so it is important to know with which set or group of providers, specialists and hospitals with whom the PCP is affiliated.

2.3.2.1.2 The enrollee's choice of primary care physician and PPG will be listed on the member's identification card. The identification card will be sent to the member within 10 days of enrollment confirmation from CMS.

2.3.2.1.3 The enrollee's PCP is responsible for coordinating, supervising and providing primary health care services to a Cal MediConnect enrollee, including but not limited to initiating specialty care referrals and maintaining continuity of care. Specialists, who also meet the

requirements for PCP participation and are willing to assume the responsibilities of a PCP, may also request designation as a PCP in the network (see Credentialing Addendum D).

2.3.2.2 Change of Participating Physician Group (PPG) and/or Primary Care Physician (PCP)

2.3.2.2.1 *Member-Initiated Change*

2.3.2.2.1. Members may change their PCP or PPG on a monthly basis. Members requesting to change to another PPG or PCP can do so by calling L.A. Care Health Plan at 1-888- 522-1298 (TTY/TDD) **1-888-212-4460**.

2.3.2.2.2 The change will occur on the 1st of the following month, provided the request is received by Member Services by the 20th of the month.

2.3.3 Notification of Enrollment

L.A. Care will mail the member a letter acknowledging receipt of the completed enrollment form within 10 days of receiving the completed enrollment election. L.A. Care will send a letter confirming the enrollment within 10 days of receiving confirmation from CMS on the transaction reply listing. L.A. Care will also send a Welcome Packet to the member's home address. The Welcome Packet includes a welcome letter, member identification card, Provider Directory, and the Cal MediConnect Evidence of Coverage/Member Handbook.

2.3.4 Disenrollment

2.3.4.1 Disenrollment refers to the termination of a member's enrollment with L.A. Care Health Plan. Disenrollment does not refer to a member transferring from one PCP or PPG to another.

2.3.4.2 Members may voluntarily disenroll from L.A. Care Health Plan's Cal MediConnect program at their discretion by contacting the Enrollment Contractor, however must remain in a Managed Care Medi-Cal plan. To voluntarily disenroll from L.A. Care's Cal MediConnect program, members may:

- Enroll in another Cal MediConnect Plan; or
- Elect to return to Medicare FFS, or
- Enroll in a Medicare Advantage Plan.
- If a member disenrolls from the Medicare portion of Cal MediConnect, the member may still be enrolled in L.A. Care for Medi-Cal only and will receive a Medi-Cal I.D. card. FFS Medicare services will be primary and services will be subject to L.A. Care Medi-Cal rules and processes, as described in the L.A. Care Medi-Cal manual.

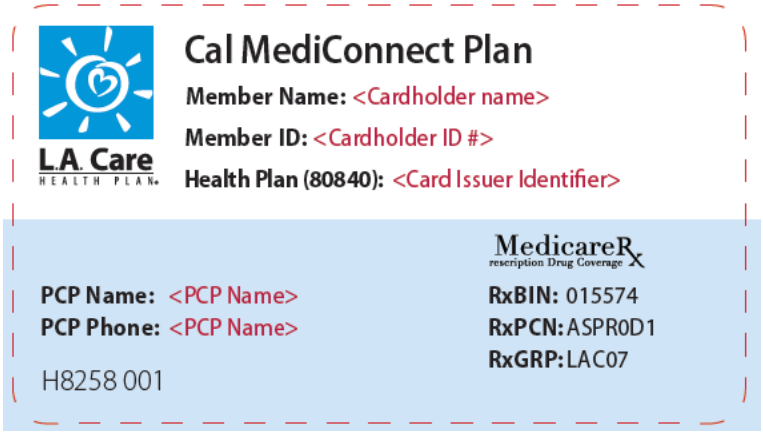
2.3.4.3 Members may be involuntarily disenrolled from L.A. Care's Cal Medi Connect program. A Member may be disenrolled from L.A. Care for the following reasons:

- Loss of Medicare Parts A and B
- Loss of Medi-Cal eligibility. L.A. Care Cal MediConnect provides up to 6 months to regain Medi-Cal eligibility before disenrolling.
- Moved out of Los Angeles County for more than 6 months.
- Knowingly falsifies or withholds information about other parties' reimbursement for their prescription drug coverage.
- Intentionally provides incorrect information on their enrollment application, affecting their eligibility to enroll in L.A. Care Cal MediConnect.
- Behave in a way that is disruptive, to the extent that continued enrollment seriously impairs our ability to arrange or provide medical care for them or for others who are members of L.A. Care Cal MediConnect. *This type of disenrollment requires CMS approval.*
- Allow someone else to use L.A. Care's Cal MediConnect membership card to receive medical care. CMS may refer the case to the Inspector General for further investigation if disenrolled for this reason.

2.4 MEMBER IDENTIFICATION CARD

The L.A. Care Cal MediConnect member identification card provides a member's program name, member ID number, language, pharmacy claims information, and PCP name, phone number and address.

Members who are enrolled in L.A. Care's Cal Medi Connect program for their Medicare and Medi-Cal benefits will be issued an ID card that has a Health Plan ID number. See the example below:



2.5 ELIGIBILITY VERIFICATION

A member's possession of an L.A. Care Cal MediConnect membership identification card does not guarantee current membership with L.A. Care Cal MediConnect or with the PPG identified by the card. Verification of an individual's membership and eligibility status is necessary to assure that payment is made to the PPG for the healthcare services being rendered by the provider to the member.

To verify member eligibility, providers should call L.A. Care's Provider Information line at 1-866-LACARE6 (1-866-522-2736) or check L.A. Care Connect on http://www.lacare.org.

2.6 EVIDENCE OF COVERAGE

An L.A. Care Cal MediConnect Evidence of Coverage (EOC)/Member Handbook is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and how to access such services. You can obtain a copy of the EOC by logging onto www.calmediconnectla.org , or by calling L.A. Care Health Plan's Provider Information Line at 1-866-LA-CARE6 (1-866-522-2736).

2.7 MEMBER'S RIGHTS AND RESPONSIBILITIES

L.A. Care Cal MediConnect members have specific rights and responsibilities that are fundamental to the provision and receipt of quality healthcare services. Member rights and responsibilities are described in

L.A. Care's Cal MediConnect Evidence of Coverage (EOC) Member Handbook and are listed below.

Member Rights

- **Your right to be treated with dignity, respect and fairness.** You have the right to be treated with dignity, respect, and fairness at all times. L.A. Care and its providers must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, national origin, medical condition, claims experience, receipt of health care, medical history, genetic information, or evidence of insurability. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you have a disability and need access to care and if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or (TTY) 1-800-537-7697, or your local Office for Civil Rights. We will provide reasonable accommodations to members who need it.

- **Your right to the privacy of your medical records and personal health information.** There are Federal and State laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in L.A. Care Cal MediConnect is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. L.A. Care will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations. The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your

personal information and medical records, please call Member Services.

- **Your right to see network providers, get covered services, and get your prescriptions filled within a reasonable period of time.** You will get most or all of your care from network providers, that is, from doctors and other health providers who are part of L.A. Care Cal MediConnect.

  You have the right to choose from an established panel of primary care providers (PCPs) from L.A. Care's network (we will tell you which doctors are accepting new patients).

  You have the right to go to a women's health specialist in L.A. Care's Cal MediConnect network (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.

  You have the right to timely access to your prescriptions at any network pharmacy.

- **Your right to know your treatment options and participate in decisions about your health care.** You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

  You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination.

- **You have the right to refuse treatment**. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication.

If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

- **Your right to use advance directives (such as a living will or a power of attorney).** You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

  If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare such as HICAP (Health Insurance Counseling and Advocacy Program). HICAP can be reached at 1-800-434-0222. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

  If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

  Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

Medical Board of California
Central Complaint Unit
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236

- **Your right to get information about L.A. Care Health Plan.** You have the right to get information from us about L.A. Care. This includes information about our financial condition, and how L.A. Care compares to other health plans. To get any of this information, call Member Services.

- **Your right to get information in other formats.** You have the right to get your questions answered. L.A. Care must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability.

- **Your right to get information about our network pharmacies and/or providers.** You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

- **Your right to get information about your prescription drugs, Part C medical care or services, and costs.** You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by L.A. Care Cal MediConnect. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. You also have the right to this explanation even if you obtain the prescription drug, or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to L.A. Care Cal MediConnect. Please review our formulary website or call Member Services for more information.

- **Your right to make complaints.** You have the right to make a complaint if you have concerns or problems related to your coverage or care. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against L.A. Care in the past. To get this information, call Member Services.

- **Members are free to exercise these rights without negative consequences.** They will be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Member Responsibilities

Your responsibilities as a member of L.A. Care Cal MediConnect include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. Call Member Services if you have questions.

- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides L.A. Care Cal MediConnect, it is important that you use your other coverage in combination with your coverage as a member of L.A. Care Cal MediConnect to pay your health care or prescription drug expenses. This is called “coordination of benefits” because it involves coordinating all of the health or drug benefits that are available to you.

- **You are required to tell L.A. Care Cal MediConnect if you have additional health insurance or drug coverage. Call Member Services.**

- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in L.A. Care Cal MediConnect and you must present your Plan membership card to the provider.

- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.

- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices.

- Paying your co-payment for your covered services. You must pay for services that aren’t covered.

- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of Los Angeles County you cannot remain a member of L.A. Care Cal MediConnect, but we can let you know if we have a Plan in that area.

- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please contact Member Services.

How members can get more information about their rights

If members have questions or concerns about their rights and protections, they may,

- Call L.A. Care's Member Services Department at 1-888- 522-1298 (TTY/TDD) **1-888-212-4460**.
- Get free help and information from their State Health Insurance Assistance Program (SHIP).
- Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048
- Cal MediConnect Ombudsman at **(855) 501-3077 (TTY 1-855-847-7914)**
- Medi-Cal Managed Care Ombudsman at 1-800-452-8609 or HMO Help Center at 1-888-466-2219.

2.8 NOTICE TO MEMBERS REGARDING CHANGE IN COVERED SERVICES

Members must be informed about any change in provision of services. L.A. Care Cal MediConnect must send written notification of any change to the member no less than sixty (60) days, or as soon as possible prior to the date of actual change. In case of an emergency, the notification period will be within fourteen (14) days prior to changes, or as soon as possible.

In some circumstances, when the event includes termination of a provider's contract, L.A. Care Cal MediConnect makes arrangements for members affected by the termination to continue care with their terminating provider until their treatment is completed. In order for L.A. Care Cal MediConnect to make these arrangements, the medical conditions must meet specific criteria; the provider must be willing to continue seeing the member and must be willing to accept L.A. Care's Cal MediConnect rate of reimbursement.

2.9 MEMBER GRIEVANCE PROCEDURE

A Grievance is defined as any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which L.A. Care Cal MediConnect or delegated entities provide health care services, regardless of whether any remedial action can be taken. This can include concerns about the operations of L.A.

Care Cal MediConnect or its providers such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, and the respect paid to members. An expedited grievance may also include a complaint that the health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

L.A. Care accepts any information or evidence concerning a grievance pertaining to the Cal MediConnect program either orally or in writing, for up to 60 days after the precipitating event.

L.A. Care acknowledges, investigates and resolves standard grievances within thirty (30) calendar days of the oral or written request. However, if information is missing or if it is in the best interest of the member, L.A. Care may extend the timeframe by an additional 14 days. L.A. Care responds to expedited grievances within 24 hours of the oral or written request. Expedited grievances include those cases where a member objects to: 1) L.A. Care's decision to extend the timeframe to make an organization determination or reconsideration; or 2) L.A. Care's refusal to grant a request for an expedited organization determination or reconsideration.

If a complaint is not resolved to the member's satisfaction, the member has the right to seek the opinion of the Quality Improvement Organization (QIO).

L.A. Care maintains a comprehensive complaint resolution system. L.A. Care and its PPGs work together to resolve member complaints. However, it is L.A. Care's responsibility to handle member complaints. PPGs are encouraged to attempt to address member questions or concerns before referring members to L.A. Care. All member complaints must be reported to L.A. Care's Member Services department. PPGs are required to respond to requests for information related to grievances within five (5) business days. If a PPG fails to provide the requested information, L.A. Care or the designated agent will be provided access to copy the appropriate medical records or other necessary information at the expense of the PPG.

L.A. Care tracks complaints by category and PPG. Grievance reports are reviewed and analyzed for appropriate corrective action plans.

Medicare and Medi-Cal have distinct appeals processes. Medicare benefits appeals follow the Medicare process, and Medi-Cal benefits follow the Medi-Cal process For benefits covered by both Medicare and

Medi-Cal, the member has the choice to follow the Member Appeal Procedure – Medicare (as described below) or the Member Appeal Procedure -- Medi-Cal (as described below). See the section on "Overlapping Benefits" below.

MEMBER APPEAL PROCEDURE -- MEDICARE

Organization Determination

An initial determination informing members of L.A. Care's decision to provide medical care, or pay for services already received.

Appeal Level 1: Appeal to L.A. Care

Standard Reconsideration of Organization Determination

Members may file reconsiderations of organization determinations for Medicare services with L.A. Care's Grievance and Appeals Unit. All reconsiderations must be filed within 60 days of notification of the organization determination decision. L.A. Care will resolve all reconsiderations regarding payment for services already received within 60 days. L.A. Care will resolve all standard reconsiderations regarding medical care within 30 days. However, if information is missing or if it is in the best interest of the member, L.A. Care may extend the timeframe by an additional 14 days. If L.A. Care decides in favor of the member with respect to payment reconsideration, L.A. Care must pay within 60 days of receiving the appeal. If L.A. Care decides in favor of the member with respect to a standard reconsideration of medical care, L.A Care must authorize or provide services within 30 days of receiving the appeal. If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the Independent Review Entity (IRE) within 30 days for cases involving medical care and within 60 days for cases involving payment decisions.

Expedited Reconsideration of an Organization Determination

L.A. Care will resolve all expedited reconsiderations within 72 hours, or sooner required based upon the health condition of the member. L.A. Care may extend the timeframe for an additional 14 days if information is missing or if it is in the best interest of the member. If L.A. Care decides in favor of the member, L.A. Care must authorize or provide care within 72 hours of receiving the expedited appeal. If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the Independent Review Entity (IRE) within 24 hours for review.

Appeal Level 2: Independent Review Entity (IRE)

At the second level, the appeal is reviewed by an outside, Independent Review Entity (IRE) that is contracted with CMS. If the IRE decides in favor of the

member with respect to payment of medical services already received, L.A. Care Cal MediConnect must pay within 30 days of receiving the decision. If the IRE decides in favor of the member with respect to a standard decision about medical care not yet received, L.A Care Cal MediConnect must authorize services within 72 hours or provide services within 14 days of receiving the decision. If the IRE upholds the Plan's determination, the member may request a Level 3 appeal, review by an Administrative Law Judge (ALJ).

Appeal Level 3: Administrative Law Judge (ALJ)

If the amount remaining in controversy meets the appropriate threshold requirement, any party to the reconsideration who is dissatisfied with the reconsideration determination has a right to a hearing before an ALJ. During the ALJ review, members may present evidence, review the record and be represented by counsel. The request must be filed within 60 calendar days of notification of the decision made by the IRE. The ALJ will make a decision as soon as possible. If the ALJ decides in favor of the member, L.A. Care Cal MediConnect must pay for, authorize, or provide the medical care or services within 60 days of receiving the decision. If the ALJ upholds the IRE's determination, the member may request a Level 4 appeal, review by the Medicare Appeals Council (MAC).

Level 4: Medicare Appeals Council (MAC)

Members must file with the MAC within 60 calendar days of the decision made by the ALJ. If the MAC reviews your case, (it does not review every case it receives) it will make a decision as soon as possible. If the MAC decides in favor of the member, L.A. Care Cal MediConnect must pay for, authorize, or provide the medical care or services within 60 days of receiving the decision. If the MAC upholds the ALJ's determination, or decides not to review the case, the member may request a Level 5, Federal Court.

Appeal Level 5: Federal Court

In order to request judicial review, the member must file a civil action in a United States district court within 60 calendar days after the date notified of the decision made by the MAC. However, the amount in controversy must meet the appropriate threshold. For 2012, the amount in controversy threshold is $1,350.00. If the threshold is met and a Federal Court Judge agrees to review the case, a decision will be made according to the rules established by the Federal judiciary.

When Members Disagree with Hospital Discharge

A Member remaining in the Hospital who wishes to appeal L.A. Care Cal MediConnect's discharge decision that Inpatient Services are no longer

necessary may request an immediate review with the Quality Improvement Organization (QIO). The Member will not incur any additional financial liability if:

- The Member remains in the Hospital as an Inpatient;
- The Member submits the request for immediate review to the QIO that has an agreement with the Hospital;
- The request is made either in writing, by telephone or fax; and
- The request is received by noon of the first working day after the Member receives written notice of the Plan's determination that the Hospital stay is no longer necessary.

Special Considerations Regarding Termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

Regarding Medicare Members, a termination of service means the discharge of a Member from Covered Services, or discontinuation of Covered Services, when the Member has been authorized by L.A. Care Cal MediConnect to receive an ongoing course of treatment from that Provider.

- The Member must contact the QIO, verbally or in writing, no later than noon of the day before the Covered Services are to end. At the same time the Physician Group will notify the Plan of the Notice of Medicare Non Coverage (NOMNC) issued to the Member. The Plan will track issuance and follow-up on all NOMNCs from delegated Physician Groups.
- If the Member disagrees with the NOMNC and requests an Appeal, the Plan will prepare the Detailed Explanation of Non-Coverage (DENC) for the Provider to issue to the Member. If the Member requests an Appeal with the QIO, the Plan must obtain the Member's medical records from the Provider and send:
- A copy of the DENC, along with the Member's medical records, to the QIO by close of business on the day of the QIO submitted to Plan appeal notification. The Plan may request that the records be sent directly to the QIO. The QIO must make a decision and
- Notify the Member and the Plan by close of business the following day.
- On the next business day, the Plan will notify the Physician Group of the fast-track Appeal request and the QIO's determination. If the QIO overturns the decision, the Physician Group shall continue authorization to the Group Provider, provide the Plan with proof of continued authorization and prepare and issue a new NOMNC notice when new discharge orders are written.
- If the Member fails to file a timely Appeal with the QIO, the Member may request an expedited Appeal from the Plan [42 CFR 422.624; 42 CFR 422.626]

MEMBER APPEAL PROCEDURE – MEDI-CAL

A member has the right to appeal directly to L.A. Care for all decisions to modify or deny a request for Medi-Cal services. A physician, acting as the member's representative, may also appeal a decision on behalf of the member.

- If the group's reconsideration process results in a denial, deferral, and/or modification with which the provider is still dissatisfied, the provider may request a formal appeal to L.A. Care for a higher level review.
- Members and providers may also appeal L.A. Care's decision to modify or deny a service request (this does not apply to the retrospective claims review/provider dispute resolution process). The appeal request is reviewed by a physician or physician consultant not involved in the prior determination.
- Member requested appeals may be initiated orally or in writing. Members (and Providers on behalf of Members) have the right to appeal an adverse utilization review determination.
- Members have the right to be represented by anyone they choose when they appeal an adverse determination, including an attorney, and have that representative act on their behalf at all levels of the appeal. They can name a relative, friend, advocate, doctor, or someone else to act for them. Others may also be authorized under State law to act for them.
- L.A. Care has a full and fair process for resolving member disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. The process for filing an appeal is made available to the member in writing through the member handbook (evidence of coverage), the L.A. Care Web site, and to the provider through the Provider Manual, the L.A. Care Web Site, and policies and procedures.
- Appeal Procedures provide for:

    - Allowance of least 180 days for Healthy Families/Healthy Kids members and at least 90 days for Medi-Cal members after notification of the denial for the member to file an appeal.
    - Acknowledgement of the receipt of the appeal within five (5) calendar days (Acknowledgement upon receipt by phone, if expedited).
    - Documentation of the substance of the appeal and any actions taken.
    - Full investigation of the substance of the appeal, including any aspects of clinical care involved.
    - The opportunity for the member to submit written comments, documents or other information relating to the appeal.
    - An authorized representative to act on behalf of the member.

- The appointment of a new person to review the appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
- The appointment of at least one person to review the appeal, who is a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment.
- Notification of the decision of the appeal to the member within 30 calendar days of receipt of the request, or 72 hours if expedited.
- Providing to the member upon request, access to and copies of all documents relevant to the member's appeal.
- Notification to the member about further appeal rights.
- Members who have disagreement with the appeal decision, and wish to appeal further, have the right to contact and file a grievance with the Department of Managed Health Care (DMHC), or to request an Independent Medical Review (IMR).

Standard Review

- Upon receipt of a standard appeal, the UM Specialist will immediately investigate and inform the Chief Medical Officer/physician designee.
- An acknowledgment letter will be sent to the member or provider acting on behalf of the member within five (5) business days. The letter will include information regarding the appeals process.
- The physician reviewer will review the standard appeal and determine if he/she is qualified to make a determination on the clinical issues presented in the case.
- If the physician reviewer determines he/she is qualified, he/she will make a resolution/disposition determination.
- If the physician reviewer determines he/she is not qualified, he/she will consult with another qualified professional prior to making a determination.
- The physician reviewer may also contact the provider requesting services to further discuss the member’s clinical condition.
- A determination will be made within thirty (30) calendar days from receipt of the appeal and information necessary to make a determination.
- Written notification of determination will be sent within two (2) business days of the determination. The notification will include:

    - Final determination
    - A statement setting forth the specific medical and scientific reasons for the determination, and a description of alternative treatments, supplies, and/or services as

appropriate
    - Reasons other than medical necessity (e.g., non-covered benefits, etc.) will include the statement of benefit structure
    - Instructions for appealing further to the Department of Managed Health Care (DMHC) will include DMHC's address and toll-free telephone number, as applicable
    - The phone number and extension of L.A. Care's physician reviewer

Expedited Review

- A member or provider may request an expedited reconsideration of any decision to deny or modify a requested service if waiting thirty (30) calendar days for a standard appeal determination may be detrimental to the enrollee's life or health, including but not limited to, severe pain, potential loss of life, limb or major bodily function. In the case of an expedited appeal, the decision to approve, modify, or deny requests by a provider prior to, or concurrent with, the provision of healthcare services to members, will be made in a timely manner that is appropriate for the nature of the member's condition and not to exceed 72 hours after the plan's receipt of the information.
- Upon receipt of an expedited request, the UM specialist will immediately investigate and inform the physician reviewer.
- The physician reviewer will review the expedited appeal request and determine if he/she is qualified to make a determination on the clinical issues of the case.
- If the physician reviewer determines he/she is not qualified, he/she will consult with another qualified professional prior to making a determination.
- A determination will be made within the established timeframe from receipt of the appeal and necessary information.
- Written appeal acknowledgement/determination notification will be sent to the member and provider within 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the appeal determination. The notification will include:

    - The final determination
    - A statement setting forth the specific medical and scientific reasons for the determination, and a description of alternative treatments, supplies, and/or services as appropriate
    - Reasons other than medical necessity (e.g., non-covered benefits etc.) will include the statement of benefit structure
    - Instructions for appealing further to the Department of Managed Health Care (DMHC), to include DMHC's address and toll free telephone number, as applicable

- The phone number and extension of the L.A. Care physician reviewer

Determinations that cannot be completed within the thirty (30) calendar days for standard appeals, or within 72 hours for expedited appeals, must be forwarded to DMHC for final resolution.

State Fair Hearings - Additional Requirements Specific to the Management of Medi-Cal Member Appeals

Medi-Cal Members or their representative may contact the State Department of Social Services to request a State Fair Hearing or an Expedited State Fair Hearing at any time during the appeal process up to ninety (90) days from receipt of the denial/modification letter.

Medi-Cal Members also may contact the Office of the Ombudsman to request assistance with their appeal.

Independent Medical review (IMR)

A member may request an Independent Medical Review (IMR) through the Department of Managed Health Care (DMHC) to obtain an impartial review of a denial decision concerning:

- The medical necessity of a proposed treatment.
- Experimental or investigational therapies for a life-threatening or seriously debilitating disease or condition.
- Claims for out-of-plan emergency or urgent medical services.

The application and process for seeking an IMR is always included with the appeal response notification letter resulting from upholding a denial or modification of a request for service.

MEMBER APPEAL PROCEDURE – OVERLAPPING BENEFITS

For benefits covered by both Medicare and Medi-Cal, the member has the choice to follow the Member Appeal Procedure – Medicare (as described above) or the Member Appeal Procedure -- Medi-Cal (as described above).

If the member chooses the Medi-Cal procedure, the final determination possible is that made in a State Fair Hearing, as described above.

If the member chooses the Medicare procedure, and wished to appeal the decisions of the Independent Review Entity (Maximus), the members or their representative may contact the State Department of Social Services to request a State Fair Hearing or an Expedited State Fair Hearing

3.0 ACCESS TO CARE

This section summarizes the access to care requirements for L.A. Care Participating Physician Groups (PPGs) for all of L.A. Care Health Plan's direct product lines, including Cal MediConnect.

3.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

All PPGs are responsible for fulfilling the access standards below. L.A. Care monitors the ability of its members to access these services according to the specified "L.A. Care Access Standard."

L.A. Care will disseminate age and gender specific preventive care guidelines on an annual basis.

3.2 L.A. CARE/PARTICIPATING PHYSICIAN GROUP ACCESS REQUIREMENTS

Service	L.A. Care Access Standard
Availability of ancillary services	Available within 10 miles from the primary care physician
Availability of hospitals	Travel time and distance standards of 10 miles travel distance or 30 minutes travel time from their residence or workplace
Availability of primary care physician – distance requirements (PCP Geo Access reports)	Travel time and distance standards of from 5 to 10 miles travel distance or 30 minutes travel time from their residence or workplace
Primary Care Physician Minimum Site Hour Requirement	PCP must be physically on site eight (8) hours per week per site with a maximum of four (4) sites Each site must be available a minimum of sixteen (16) hours per week to see L.A. Care members
Availability of specialty care	Travel time and distance standards of 15 miles travel distance. Some specialties require 20 minutes travel time and a distance of 10 miles, while others may be 30 minutes and 10 miles.
Member requested primary care physician changes	Members can request a PCP change monthly. L.A. Care will process the member requested PCP change
Maximum member ratio	PCP to member ratio (1:2000) Provider to Extender Ratio • Nurse Practitioner – 1:4

Service	L.A. Care Access Standard
	• Physician Assistant – 1:2 L.A. Care allows a provider an additional 1000 members per extender up to a maximum of 5000 members per PCCP
Routine specialty referral authorization	Within 10 working days

3.3 PRIMARY CARE AND SPECIALIST PHYSICIAN ACCESS REQUIREMENTS

Service	L.A. Care Access Standard
Appointment making systems	An efficient and effective written or computerized appointment making system, which includes following up on broken appointments
Appointments for routine primary care Services for a member who is symptomatic but does not require immediate diagnosis and/or treatment	10 calendar days maximum
Appointments for routine prenatal care	Within two weeks from request
Appointments for routine preventive care	Physical exam/preventive services – 30 calendar days maximum for appointment
Appointments for urgent care	Within 48 hours
Routine specialty referral appointment	Within 10 working days
Availability of interpreter service	L.A. Care provides 24 hours/7 days a week interpretive services
Availability of primary care physician – time requirements	24 hours/7 days a week
Preventive Exams A periodic health evaluation for a member with no acute medical problem, including: Initial Health Assessments and Behavioral Risk Assessments	Within 90 calendar days of enrollment EPSDT/CHDP or preventive health examination within four weeks from request
AAP periodic screenings	As prescribed by AAP Periodicity guidelines
Emergency appointment: Services for a potentially life	Immediate, 24 hours a day/7 days a week

threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health	
Non-emergent telephone appointment responsiveness	30 minutes
Office waiting time: The time a member with a scheduled medical appointment is waiting to see a doctor once in the office	5 - 45 minutes
Telephone waiting time: The maximum length of time for office staff to answer the phone	30 seconds
Call Return Time (After Hours): The maximum length for PCP or on-call provider to return a call	30 minutes
Services for members with disabilities	Compliance with all provisions of the Americans with Disabilities Act: • Clearly marked (blue) curb or sign designating at least one designated parking space near accessible primary entrance • A wheelchair accessible bathroom or alternative access which is equipped with handrails in the bathroom • Wheelchair accessible hand washing facilities or reasonable alternative • A wheelchair access ramp • Pedestrian ramps have a level landing at the top and bottom of the ramp. • Exit doorway openings allow for clear passage of a person in a wheelchair • A water fountain or alternative provisions • Accessible passenger elevator, or reasonable alternative for multi-level floor accommodation • Clear floor space for wheelchair in waiting

	area and exam room

3.4 PHARMACY SERVICE ACCESS REQUIREMENTS

Service	L.A. Care Access Standard
Denied or modified prescription	L.A. Care's Clinical Pharmacist, Pharmacy Director or Medical Director makes a determination on denied or modified prescriptions within 24 hours for expedited request and 72 hours for standard request
Drug prior authorization request	24 hours for expedited request and 72 hours for standard request
Availability of counseling in the members language	Availability of verbal counseling in appropriate threshold language
Emergency pharmacy services	30 day supply for continuity of care until determination of request can be done

3.5 MONITORING

The PCP is responsible for responding to any access deficiencies identified by review methods, examples of which include:

- Facility Site Review (FSR)
- Exception reports generated from member grievances
- Medical records review
- Random surveys sent to members
- Feedback from PCP regarding other network services (i.e., pharmacies, vision care, hospitals, laboratories, etc.)
- Access to care studies
- Provider office surveys or visits

4.0 SCOPE OF BENEFITS

This section summarizes the scope of benefits for direct product lines under L.A. Care.

4.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

L.A. Care is contracted with various provider organizations for the provision of health benefits. Under the terms of provider agreements with L.A. Care, certain Participating Physician Groups (PPGs) and hospitals have agreed to assume the financial responsibility of providing specified health benefits. To determine which health benefits a PPG and hospital may be delegated and therefore financially responsible for providing services, please refer to the Division of Financial Responsibility (DOFR) of the entity's agreement with L.A. Care. Each agreement summarizes which health benefits a PPG or hospital is financially responsible for providing.

4.2 HEALTH BENEFITS – MEDI-CAL

Covered services, including services for the detection of symptomatic diseases, as defined by Title 22, Section 51301 through Section 51365 of the California Code of Regulations, should be provided with no co-payment. A listing of these benefits and services may be found in the Medi-Cal Managed Care Evidence of Coverage or L.A. Care UM Policies. The benefits and service requirements are also available online at www.ccr.oal.ca.gov.org**.**

4.3 HEALTH BENEFITS – MEDICARE ADVANTAGE HMO

With the exception of certain Part D covered drugs, there will be ***no cost sharing*** for any of Medicare Advantage HMO plan benefits. A list of current benefits can be found on the L.A. Care Medicare web site pages in the Summary of Benefits or Evidence of coverage.

Benefits	Covered	Member Cost
Doctor Visits	**Yes**	**$0**
Inpatient Hospital Services (90 days per benefit period)	**Yes**	**$0**
Inpatient Behavioral Health (up to 190 lifetime days)	**Yes**	**$0**
Skilled Nursing facility (100 days per benefit period)	**Yes**	**$0**
Home Health Care	**Yes**	**$0**

Hospice (care must be provided by Medicare certified hospice; FFS Medicare pays)	**Yes**	**$0**
Podiatry Services	**Yes**	**$0**
Outpatient Behavioral Health	**Yes**	**$0**
Outpatient Substance Abuse	**Yes**	**$0**
Outpatient Surgery	**Yes**	**$0**
DME and Prosthetic Devices	**Yes**	**$0**
Medical Supplies	**Yes**	**$0**
Emergency Care	**Yes**	**$0**
Hearing Services (diagnostic hearing exam)	**Yes**	**$0**
Out of Area (see World- wide emergency care)	**Yes**	**$0**
Supplemental Benefits		
World-wide Emergency Care (covered outside the U.S. with a $10,000 annual limit)	**Yes**	**$0**
Non Emergency Transportation (up to 28 one-way trips annually)	**Yes**	**$0**
Vision Services (annual exam and glasses - $100 annual limit on eyewear)	**Yes**	**$0**
Preventive Dental Services (limitations apply – see dental benefit booklet)	**Yes**	**$0**
In-house Assessment (annual)	**Yes**	**$0**

Benefits

How to Access Behavioral Health Services:

L.A. Care Cal MediConnect has partnered with Beacon Health Strategies, a, managed behavioral health care company, to provide behavioral health services to L.A. Care Cal MediConnect members. Both members and providers can call **Beacon** Provider Relations at 855-856-0577 to coordinate access to care or they can call L.A. Care's Member Services or the Provider Inquiry Line.

Supplemental Benefits

How to access Dental Services:

Dental services can be access directly through an in-network provider. There is no prior authorization required for preventive services. Comprehensive dental services are also available and copayments will vary for these services. Both members and providers can call **Liberty Dental Plan** at **1-888-700-5243** to refer members for dental care.

How to access Non Emergency Transportation:

Transportation services can be accessed by contacting LogistiCare. LogistiCare is a Transportation Management Organization that has been contracted by L.A. Care to arrange non-emergency medical transportation services. LogistiCare's contract with L.A. Care covers Los Angeles County only and accepts requests 24 hours a day, seven days a week. It is recommended to contact LogistiCare at least 48 hours prior to the member's appointment.

Services can be requested by calling **Logisticare** at **866-529-2141** and selecting one of the following transportation options:

Press 1 for Ambulatory/Wheelchair Reservations
Press 2 for Ambulatory/Wheelchair "Where is my ride?" (Scheduling a Return Ride)
Press 3 for Gurney/Ambulance
Press 8 for Information in Spanish or dial 866-529-2142

How to access Vision Care:

Contact **VSP** Member Services at **(800) 877-7195** or **(800) 428-4833** for the hearing impaired, or visit their website at www.vsp.com to locate a participating provider.

Annual In-house Assessment:

L.A. Care's Member Services will initiate the outreach to members to conduct assessment. If member has not been contacted or has had an In-house assessment within six (6) months of their enrollment with L.A. Care, please provide the **(888) 4LA-CARE or (888) 452-2273** to the members for them to call at their convenience to set up an appointment.

Medicare Part D 2014 Coverage

L.A. Care Health Plan Medicare Advantage-HMO members *pay nothing* for generic drugs up to the initial coverage limit of $2,830. Before a member's total yearly drug costs reach the $2,830 Initial Coverage Limit, members pay $0 for generic drugs and $3.30 for brand name drugs. Members typically pay $1.10 co-pay per prescription for generic drugs and $3.30 for brand name drugs during the coverage gap (between $2,830 and $4,550). Once a member reaches $4,550 in yearly out-of- pocket drug costs, they pay $0 for covered drugs. Copayments may vary depending on the member's low-income subsidy level.

What drugs are covered by this Plan?

L.A. Care Health Plan has a formulary that lists all drugs covered. Drugs on the formulary will generally be covered as long as the drug is medically necessary, are covered by Part D, the prescription is filled at a network pharmacy or through our network mail order pharmacy service. Certain prescription drugs have additional requirements for coverage or limits on our coverage. The formulary is updated monthly and the current formulary list can be found on the L.A. Care Cal MediConnect web site pages.

How do members get their prescription filled?

Members must obtain their prescriptions from a network pharmacy or through the network mail order pharmacy service. A Pharmacy Directory will be provided in the new enrollment packet.

What is the mail order pharmacy service?

Members can obtain their prescriptions for medications taken on a regular basis, for a chronic or long-term medical condition through the network mail order pharmacy service. Orders must be for at least a 90-day supply, and no more than a 90-day supply of the drug. Mail orders will take approximately three (3) days to process.

It is not required to use the mail order service to get an extended supply. Network pharmacies can also provide extended supplies. All drugs listed on our formulary are available through the mail order pharmacy service.

For further details regarding Part D Coverage please call our Pharmacy Department at (888) 4LA-CARE

4.4 MECHANISMS TO CONTROL UTILIZATION OF SERVICES

L.A. Care uses the traditional managed care model of assigning members to a PCP of their choice to coordinate the entire range of services. PCPs are responsible to directly provide the primary care services and refer members to specialty care through L.A. Care's authorization process. The PCP is seen as the point of entry for all specialized care. For services that do not require a prior authorization, member have a "self-direct option," allowing the members or caregivers to directly refer to the service or LTSS (Long-Term Services and Supports program, such as mental health or substance abuse providers).

L.A. Care expects to use subcontracted health plans LTSS activities, which means they have capacity and experience to coordinate all services for their members, including physical health, mental health and social service needs. Subcontracted plans may sub-delegate LTSS care coordination activities to

qualified vendors. LTSS care coordination will not be delegated to a Provider Group.

L.A. Care has experience with a broad range of LTSS providers, including contracting and coordinating care with skilled nursing facilities; working with Intermediate Care Facilities (ICFs) and Institutes for Mental Disease (IMDs) when members transition in or out of those facilities; contracting with MSSP providers for a variety of services including care coordination; collaborating with the Personal Assistance Services Council (PASC) on several initiatives and projects, including the joint offering of health education training workshops for IHSS providers and consumers at the L.A. Care Family Resource Center; funding and jointly offering "Living Well With a Disability" workshops with Independent Living Centers (ILCs) around L.A. County; training staff at all six ILCs on how to navigate managed care; strong collaboration with all seven L.A. County Regional Centers, including developing models of care and coordination of services for members with intellectual and developmental disabilities and training their staff on navigating managed care The coordination of LTSS services will be provided through a cross-functional multi-disciplinary approach including staff with LTSS expertise. Among many functions, the LTSS unit will monitor the progress of members in institutional settings, communicating closely with the member, staff at the facilities, and coordinating transitions out of facilities with family and friends, PCPs, home health and home care agencies and others as needed. The LTSS unit will also coordinate physician support, deploying contracted physicians and physician extenders to bring primary care to members in long term facilities. The LTSS unit will include UM and care management nurses, health navigators, and authorization technicians to facilitate access to Medically necessary DME, and will be supported by physicians, behavioral health specialists, health education staff and pharmacists as needed.

Model of Care Overview

L.A. Care will provide Dual Eligible members with the full, seamless, person-centered continuum of medical care and social supports and services needed to maintain good health and remain in the community with quality of life—through risk stratification and assessment processes, care management capacity, outreach and enrollment strategies for hard-to-reach populations, a large and diverse network of public and private providers, and health information technologies. Throughout this demonstration project, the Cal MediConnect program will build on our extensive Medi-Cal and Medicare networks and local stakeholder relationships to coordinate and streamline the full range of primary, acute, behavioral and long term services and supports.

The Cal MediConnect "Model of Care" demonstrates various methodologies to coordinate and provide services and care to members who are frail, disabled, have multiple chronic illnesses and require end of life care. The Model of Care aims to delay institutional placement and manage the complex chronic health conditions of Dually Eligible beneficiaries. The Cal MediConnect model provides

a comprehensive approach to health care delivery in a delegated network to members in danger of premature institutionalization, via the following:

- **Network** --To ensure an adequate network of primary and specialty care practitioners, L.A. Care's Provider Network Operations has established quantifiable standards for both geographic distribution and ratio of providers to members of Primary Care Physicians and high volume specialists. L.A. Care endorses and promotes comprehensive and consistent standards for **accessibility** to, and **availability** of, health care services for all members. L.A Care will measure compliance with these standards and implement interventions to improve access to, and availability of, health care services as appropriate.
- **Behavioral Health** – Cal MediConnect delegates Behavioral Health services to a Managed Behavioral Health Organization (MBHO)., and collaborates with behavioral health practitioners using information collected to improve coordination between medical and behavioral care. L.A. Care has established quantifiable standards to align with federal, state and accreditation requirements for measuring emergent, urgent, and routine appointment access to behavioral health services.
- **Health Risk Assessment** – Cal MediConnect contacts members via initial outreach calls and while performing the health risk assessments that ensure assessment and referral to the appropriate health plan program and access to plan benefits that are structured at maintaining independence in the community. This includes referrals to various social service programs, such as LTSS, MSSP, and CBAS services.
- **Cultural and Linguistic Services** – The comprehensive program ensures medically necessary covered services are available and accessible to members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- **Integrated Benefits Sets** – Cal MediConnect's member access to care is improved by providing specialized care through combining the benefits available through Medicare and Medi-Cal. The ability to integrate benefit sets and provide enhanced or supplemental benefits improves the coordination of health care services.
- **Appropriate Utilization, Coordination and Transition of Care** – Appropriate utilization of services is assured by monitoring and measuring hospital-based care goals such as reducing inappropriate/preventable or avoidable admissions, emergency room utilization, and premature institutionalization. Every member will be offered a seamless, person-centered plan of care that integrates physical health, behavioral health and LTSS. The immediate goal is for every member to have a Care Manager as a clearly identified point of contact for all coordination of care. Cal MediConnect has alternative service providers and facilities necessary to support care transitions of members.

- **Preventive Benefits** – Cal MediConnect promotes the appropriate use of preventive benefits to provide early disease detection and intervene in the disease process to avoid complications.
- **Improved Outcomes** -- L.A. Care adopts evidence-based clinical practice guidelines promulgated by recognized sources (e.g., leading academic and national clinical organizations including the California Guidelines for Alzheimer's disease Management) for selected conditions identified as relevant to its membership. To understand and implement programs that are impactful to members and their perception of their health, L.A. Care annually assesses member satisfaction as well as their perception of their health via the Quality of Life Survey Questions.

Utilization Management

L.A. Care may create mechanisms to help contain costs for providing health care benefits to members. Such mechanisms may include, but are not limited to:

- Requiring prior authorizations for benefits
- Providing benefits in alternative settings
- Providing benefits by using alternative methods

4.5 PHARMACY BENEFITS – MEDI-CAL

Prescription Drugs

Medically necessary drugs not covered under Medicare Part D, when prescribed by a participating licensed practitioner acting within the scope of his or her licensure, and drugs are listed on L.A. Care's Drug Formulary, and filled at a participating pharmacy. There are five (5) categories of drugs that will be covered under Medi-Cal:

- Cough/cold medications
- Over-the-counter medications (except for insulin & syringes which are covered by Medicare Part D)
- Prescription vitamins and minerals

4.6 EXCLUDED PHARMACY BENEFITS – MEDI-CAL

- Experimental or investigational drugs, unless accepted for use by the standards of the medical community.
- Drugs or medications for cosmetic purposes.
- Medicines not requiring a written prescription order (except insulin and diabetes monitoring supplies, spacer devices, and peak flow meters).
- Dietary supplements, appetite suppressants or any other diet drugs or medications (except when medically necessary for treatment of morbid obesity).

- Any benefits in excess of limits specified previously.
- Services, supplies, items, procedures or equipment, which are not medically necessary as determined by L.A. Care, unless otherwise specified.

4.7 NON-FORMULARY DRUGS PRIOR-AUTHORIZATION REQUIRED – MEDI-CAL

Drugs not included in L.A. Care's Drug Formulary and deemed medically necessary may be provided subject to Prior Authorization. Provider questions concerning non-formulary drug coverage and Prior Authorization requirements may be directed to the MedImpact, L.A. Care's pharmacy benefit manager, at 1-800-788-2949. L.A. Care's Director of Pharmacy will review all requests not meeting prior approval criteria. Denials may be appealed through the L.A. Care Grievance and Appeals process.

4.8 PHARMACY BENEFITS – MEDICARE ADVANTAGE

Please see Chapter 16 of this manual for a description of Part D prescription drug coverage for L.A. Care Health Plan's Medicare Advantage-HMO.

5.0 UTILIZATION MANAGEMENT

This section summarizes L.A. Care Health Plan's (L.A. Care) Cal MediConnect Utilization Management (UM) Processes for direct contract Participating Physician Groups (PPGs). UM functions/ activities vary depending on specific contractual agreements with each contracted PPG, provider, and hospital. Please check your contract Division of Financial Responsibility (DOFR), or contact L.A. Care's Provider Information Line at 1-866-LACARE6 or Utilization Management at 1-877- 431-2273.

L.A. Care Cal MediConnect performs UM activities which are consistent with State and Federal regulations, State contracts and other L.A. Care Health Plan policies, procedures and performance standards as set forth in L.A. Care's UM Program Description Document.

Regarding performance standards, L.A. Care adopts evidence-based clinical practice guidelines promulgated by recognized sources for selected conditions identified as relevant to its membership for the provision of non-preventive health, acute and chronic medical conditions, and for preventive and non-preventive behavioral health services. Clinical Practice Guidelines are presented for review and approval to the Physician Quality Committee (PQC), are reviewed at least every two (2) years and updated as needed. Clinical practice guidelines are disseminated to practitioners via the L.A. Care website and on a regular basis via Physician Quality Improvement Liaison Nurse (PQIL) site visits. Practitioners are also informed through a practitioner newsletter when clinical practice guidelines or updates are available. Compliance with these guidelines is measured by several departments, such as QI, UM, FSR and Health Education. Annually, the QI Department measures compliance with utilization of clinical practice guidelines. Performance is measured by HEDIS rates and a medical record review.

L.A. Care Cal MediConnect is staffed with professional registered nurses and paraprofessionals who are available to assist the PPG and their providers with UM activities. These activities include but are not limited to:

- Benefit interpretation
- Referral management, outpatient and in-patient
- Coordination of care and services for linked programs (CCS, DDS, Behavioral Health, etc.)
- Coordination of End Stage Renal/Chronic Kidney Disease benefit
- Coordination of services that require disenrollment (e.g. transplants, Long Term Care, Waiver Programs)
- Complex care management and care coordination
- Education of PPG/providers on policies, procedures and legislative updates

5.1 GOAL AND OBJECTIVES

Goal

The goal of L.A. Care's Cal MediConnect Utilization Management Program (UM) is to ensure and facilitate the provision of appropriate medical and behavioral health care and services to L.A. Care Cal MediConnect members. The program is designed to monitor, evaluate and support activities that continually improve access to and quality of medical care provided to L.A. Care Cal MediConnect members.

Objectives

The Utilization Management Program's objectives are designed to provide mechanisms that assure the delivery of quality health care services and to optimize opportunities for process improvement through:

- Managing, evaluating, and monitoring the provision of healthcare services rendered to L.A. Care Cal MediConnect members for the enhancement of, and access to, appropriate services.
- Facilitating communication and develop partnerships between Participating Provider Groups/Providers (PPGs/Providers), members, and L.A. Care Cal MediConnect.
- Developing and implementing programs to encourage preventive health behaviors, which can ultimately improve quality outcomes.
- Monitoring PPGs/Providers provision of health assessments and basic medical case management to all members.
- Assisting PPGs/Providers in providing ongoing medical care for members with chronic or catastrophic illness.
- Developing and maintaining effective relationships with linked and carved-out service providers available to L.A. Care Cal MediConnect members through County, State, Federal, and other community based programs to ensure optimal care coordination and service delivery.
- Facilitating and ensure continuity of care for L.A. Care Cal MediConnect members within and outside of L.A. Care Health Plan's network.
- Integrating quality and utilization management activities.
- Ensuring a process for UM that is effective and coordinated through Committees, work groups and task forces with the involvement and cooperation of experts in all fields of medicine, management, patient advocacy and other relevant fields.
- Providing leadership to PPGs/Providers through the development of and/or recommendations for program and process changes/ improvements that result from data collection and analysis of utilization activities.
- Ensuring that UM decisions are made independent of financial incentives or obligations.

5.2 SCOPE OF SERVICE

The scope of L.A. Care's Cal MediConnect Utilization Management Program includes all aspects of health care services delivered at all levels of care to L.A. Care Cal MediConnect members. L.A. Care Cal MediConnect offers a comprehensive health care delivery system along the continuum of care, including urgent and emergency services, ambulatory care, preventive services, hospital care, ancillary services, behavioral health (mental health and addiction medicine), home health care, hospice, rehabilitation services, skilled nursing services, and care delivered through selected waiver programs, and through linked and carved out services.

L.A. Care Cal MediConnect administers the delivery of health care services to its members through different contractual agreements.

L.A. Care Cal MediConnect Programs are administered through different contractual arrangements with medical groups and Independent Provider Associations (IPAs) or collectively called Participating Provider Groups (PPGs), which may include delegation of some or all UM functions.

L.A. Care and L.A. Care's PPGs shall provide or arrange for all medically necessary covered services for members.

If medically necessary services are not available within the L.A. Care network, PPG contracted network contracts are initiated on an individual basis to ensure availability of medically necessary care and services in accordance with benefit agreements.

At a minimum the UM program includes the following:

- Assures that services which are medically necessary are delivered at the appropriate level of care, including inpatient, outpatient, and the emergency room.
- Assures that authorized services are consistent with the benefits provided by the Cal MediConnect program.
- Provides a comprehensive analysis of care by identifying under- and over-utilization patterns by physician and within the program.
- Reviews care and identifies trends that positively and negatively impact the quality of care provided to the members.
- Defines, monitors, and trends medical practice patterns impacting members' care.
- Ensures that appropriate medical review guidelines are available and used by UM personnel.
- Identifies, develops, revises, and implements appropriate policies, procedures, processes, and mechanisms for UM that can be used to

evaluate medical necessity for requested services on a timely and regular basis.

- Instructs all institutions, physicians, and other health care clinicians regarding the criteria used, the information sources employed, and the methods utilized in the approval and review processes.
- Provides the health plan network with information related to effective mandated information system and communications for the monitoring, management, and planning of medical services.
- Ensures that network institutions, physicians, and other health care clinicians provide services unless otherwise mandated by regulatory standards.
- Determines if illness or injury are covered under other programs including third-party payers, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP) or Behavioral Health Services.
- Ensures that guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate.
- Facilitates consistent practice patterns among institutions, physicians, and other health care clinicians with L.A. Care Cal MediConnect program by offering feedback to the PPGs/Providers to assist in optimizing appropriate medical practice patterns.
- Provides case management services to ensure cost effective ongoing care at the appropriate level.
- Utilizes information in member and physician satisfaction surveys to develop quality improvement activities as appropriate.
- Conducts inter-rater reliability of physician and non-physician reviewers to assess determinations made as part of the UM process.
- Provides required reports.
- Ensures coordination and continuity of care for members receiving linked and carved out services.

5.3 AUTHORIZATION REVIEW PROCESS

Treatment Authorization Review (TAR) Processes

Request for services are reviewed in accordance with approved guidelines and criteria as adopted by L.A. Care's Cal MediConnect Utilization Management Program, Utilization and Quality Management Committees. Decisions are made according to medical necessity criteria and the member's benefit structure. There are eight (8) components of the Utilization Management Referral (Treatment Authorization Request – TAR) review process.

- Prior Authorization/Pre-Service Review
- Concurrent Review

- Retrospective/Post-service Review
- Emergent/Urgent Review
- Expedited Review
- Second Opinion Review
- External Independent Review/Independent Medical Review
- Reconsideration Review

Authorization considerations for Services covered under Medi-Cal

Because L.A. Care Cal MediConnect members have full Medi-Cal coverage, the request for service authorizations also considers services that are not covered under Medicare. Following services not covered under Medicare would be covered under Medi-Cal:

- **Monthly plan premium** is $0 since members are covered by Medi-Cal
- **The Part B premium** is $ 96.40, however Cal MediConnect members will pay $0, since the premium is paid by Medi-Cal on the member's behalf
- **Inpatient Hospitalization**: $0 for unlimited number of days for inpatient coverage in the hospital as long as the member's stay is medically necessary and authorized.
- **Long Term care (Skilled Nursing Facility):** Medi-Cal covers additional days beyond the Medicare limit if extra days are authorized and medically necessary
- **Vision Care:** Member pays $0 for glasses or contact lenses every two years if medically necessary. In addition, member pays $0 for an office visit every other year, unless there is a medical need for additional visits.
- **Hearing Aids:** Members pay $0 for hearing aids that are provided by an in-network specialist.
- **Acupuncture:** Members pay $0 for acupuncture services from the Medi-Cal fee-for-service program.
- **Podiatry:** Member pays $0 for up to 12 additional routine/maintenance visits per year (24 total per year, including nail trimmings, cutting and removal of calluses, etc).
- **Incontinence Supplies:** Member pays $0 for medically necessary incontinence supplies.
- **Dental Services:** Member pays $0 for dental services from Denti-Cal.
- **Excluded Medicare Part D Drugs:** member pays $0 for certain excluded drugs covered by Medi-Cal, including prescribed over-the-counter drugs. Please refer to the Pharmacy section in this manual for details

5.4 STANDARD UTLIZATION MANAGEMENT CRITERIA

Established criteria are required for approving, modifying, deferring, or denying requested services. L.A. Care utilizes evaluation criteria and standards to approve, modify, defer, or deny services. UM Criteria are:

- systematically developed, objective and quantifiable statements used to assess the appropriateness of specific health care decision, services, and outcomes.
- developed with involvement from actively practicing health care providers
- consistent with sound clinical principles and processes
- evaluated and updated if necessary, at least annually

L.A. Care utilizes the Utilization Management Committee to involve providers in the development and or adoption of specific criteria used by L.A. Care and its delegated providers. The UM Committee is responsible for overall direction and development of strategies to manage the UM Program. The UM Committee assesses the utilization of medical services, reviews and makes recommendations regarding utilization management or case management. The Committee also reviews and makes recommendations regarding UM delegated oversight activities. The Committee is responsible for the review, revision and approval of all UM policies and procedures, UM program evaluation, UM program description and the UM Program Work Plan

Clinical criteria are used to determine medical necessity in the referral management (Treatment Authorization Request – TAR) review process to ensure consistency of authorization and review decisions by UM staff. Consistency of application of criteria is checked at all levels of delegation via the annual audit.

Criteria to determine appropriateness of medical services utilized by PPGs/Providers and their networks shall be consistent with those utilized by L.A. Care Cal MediConnect. PPGs/Providers may develop additional clinical criteria for use within their system, but they must be reviewed and approved by L.A. Care Cal MediConnect prior to their implementation. All approved criteria must be transmitted and utilized throughout PPGs/Providers and provider networks, and shall be made available by the PPGs/Providers to providers, members and the public upon request. The potential criteria sources include but are not limited to:

- Center for Medicare and Medicaid Services National Coverage Determinations
- InterQual
- MCG Healthcare Management Guidelines
- Apollo Criteria
- Other L.A. Care Health Plan approved criteria

L.A. Care Cal MediConnect draws from and follows the recommendations of a number of nationally recognized sources in the development of medical policy and criteria related to preventive care, admissions, outpatient surgeries and diagnostic and therapeutic services. Examples of these organizations include:

- Centers for Disease Control
- American College of Obstetrics and Gynecology
- Diagnostic and Treatment Technology Assessment (DATTA)
- Food and Drug Administration (FDA)

For provider or member appeals resulting from a denial of services using consensus based criteria, L.A. Care will review the request for services based on available evidence based criteria or guidelines.

When appropriate, L.A. Care's Cal MediConnect CMO may assemble a panel of independent experts to assist in medical necessity determinations. At the L.A. Care Cal MediConnect level, adverse decisions may be appealed to the L.A. Care Cal MediConnect CMO or designee. Additional appeals may be pursued in accordance with CMS requirements and L.A. Care Cal MediConnect policy, if disagreements with L.A. Care Cal MediConnect Peer Review/Grievance Committee decisions occur.

Members, providers and the public may obtain UM criteria or UM Policies and Procedures used by L.A. Care Cal MediConnect in referral management determinations by calling the UM Department at (877) 421-2273. UM staff shall relay the request to the UM Director (or designee) for response. All requests for UM criteria are logged in the UM Criteria tracking log and are processed upon request in accordance with state requirements.

5.5 ACCESS TO CARE CRITERIA

L.A. Care and PPGs utilization management policies and review criteria are available for disclosure to L.A. Care Cal MediConnect, Providers, members, and the public upon request in accordance with established regulatory and contractual requirements and L.A. Care Health Plan requirements.

5.6 EMERGENCY HEALTH CARE SERVICES

L.A. Care Cal MediConnect and its PPGs ensure that emergency health care services are available and accessible within the service area 24 hours a day, seven days a week, and shall provide 24 hours access for members and providers to obtain timely authorization for medically necessary care.

For circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be

discharged safely; a licensed physician and surgeon shall be available for consultation and for resolving disputed requests for post-stabilization care.

5.7 REFERRAL MANAGEMENT PROCESS

L.A. Care Cal MediConnect may delegate referral management to the PPGs. While PPGs have some degree of latitude in establishing review processes, they must contain the following provisions according to their delegation agreement, which are established in L.A. Care's Cal MediConnect policies and procedures:

- Appropriately licensed health professionals conduct the supervision of all review decisions and processes.
- No other individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for reason of medical necessity or benefit limitations.
- Review decisions are supervised by qualified medical professionals and all denials/modifications will be reviewed by a qualified Physician.
- Physician consultants from the appropriate specialty areas of medicine and surgery who are certified by the applicable American Board of Medical Specialties shall be utilized as necessary. A list of these physician consultants (reviewers) shall be available to the PPGs and L.A. Care Cal MediConnect.
- There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, updated regularly, and consistently applied.
- Reasons for decisions are clearly documented.
- There is a well-publicized appeals procedure for both providers and members.
- Decisions are made in a timely manner.
- UM decisions are made independent of financial incentives or obligations.
- Records, including any CMS Member Notices and Medi-Cal Notice of Actions, shall meet the mandated retention requirements. The retention requirements for Medicare records are 10 years.

5.8 SEPARATION OF MEDICAL DECISIONS AND FINANCIAL CONCERNS

Under Federal Code of Regulations and California Health and Safety Code 1367(g), medical decisions regarding the nature and level of care to be provided to an enrollee, including the decision of who will render the service, must be

made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization Management decisions are therefore made by medical personnel and are based solely on medical necessity. Practitioners may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. L.A. Care requires that each PPG and hospitals UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions.

5.8.1 Over/Under Utilization Monitoring/ Detection/ Correction

L.A. Care maintains processes and mechanisms to monitor, detect, and correct over/under utilization of Cal MediConnect services to ensure appropriate access, quality, and level and appropriateness of care are provided to its members.

L.A. Care facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under and over-utilization of services. L.A. Care will monitor and analyze relevant data and take action to correct any patterns of potential or actual inappropriate under- or over-utilization. Monitors include systematic mechanisms which apply to the overall provider network, individual practice sites, and individual practitioners used by L.A. Care to:

- measure and analyze utilization patterns by product line
- identify and correct any instances of improper utilization

Over/Under Utilization Monitoring/Detection/Correction mechanisms/processes include, but are not limited to:

- monitoring inappropriate emergency room usage for routine primary and specialty care
- review of services for appropriateness and effectiveness of cost effective patient care for detecting/correcting over- and under-utilization
- review for inappropriate utilization and/or care provided in an inappropriate setting(s) that may also be indicative of barriers to accessibility for routine health care services

L.A. Care's UM Committee performs the following over/under utilization monitoring/detection mechanisms at a minimum:

- **Medi-Cal: L.A. Care Medi-Cal National Medicaid HEDIS Measurement:** L.A. Care applies the national Medicaid HEDIS results for the 25th and 75th percentiles to monitor Medi-Cal Plan Partners for measurement of over- and under- utilization in the following areas:

- Hospital Length of Stay
- Hospital Bed Days per 1000 Member Months
- Hospital Discharges
- Ambulatory Office Visits
- Emergency Room Visits

- **L.A. Care Medi-Cal HEDIS Preventive Services Performance Reports:** L. A. Care Health Plan applies the minimum performance level to the measurement of preventive services performance. L.A. Care Health Plan identifies and measures each Plan Partner's performance as follows.
  - Well-Child Visits 0-15 Months
  - Adolescent Well-Care Visits
  - Childhood Immunizations Combination 1
  - Childhood Immunizations Combination 2
  - Timeliness of Prenatal Visits
  - Postpartum Care
  - Chlamydia Screening in Women 16-20 Years
  - Chlamydia Screening in Women 21-25 Years
  - Use of Appropriate Medications for People with Asthma
  - Breast Cancer Screening
  - Cervical Cancer Screening

- **Medi-Cal Provider Feed Back Reports:** L.A. Care Health Plan tracks a majority of the Preventive Services (Well Child and Adolescent Visits, Chlamydia, Breast, and Cervical Screening) on a quarterly basis through the L.A. Care Health Plan's Health Outcomes and Analysis (HO&A) Department.

- **Preventable Hospitalizations**
  - **IHAs:** Measurement of new members receiving Initial Health Assessment (IHA) within required timeframes.

Medicare: The UM department conducts a quantitative analysis against the established thresholds. Examples of comparable data include but are not limited to the following:

- Quality Compass- Provides comparative data by region on all HEDIS use of service measures and individual CAHPS questions
- MCG Guidelines–Provides comparative utilization data related to guidelines.
- Regional Data Sources such as CCHRI- Provides regional data, thresholds and benchmarks.
- National HEDIS benchmarks.: The proposed Clinical Improvement measures are pending final approval but are anticipated to include the CMS HEDIS measures along with additional measures, but are not limited to:

- Plan All Cause Readmission (PCR)
- Medication Reconciliation Post Discharge (MRP)
- Use of High Risk Medication in the Elderly (DAE)
- Annual Monitoring of Persistent Medications (MPM)
- Care for Older Adults (COA)
- Identification of Alcohol and other Drug Services (IAD)
- Antidepressant Medication Management (AMM)
- Follow-up After Hospitalization for Mental Illness (FUH)
- Mental Health Utilization (MPT)
- Behavioral Outcome Measures
- Medicare Health Outcomes Survey (HOS)
    - Fall Risk Management (FRM)
    - Physician Activity in Older Adults (PAO)
    - Management of Urinary Incontinence in Older Adults (MUI)
- LTSS/HCBS/Behavioral Health Outcomes
    - Reduce Member Grievances
    - Improve Member Satisfaction
    - Reduce Incidence of Decubitus Ulcer development
    - Reduce Incidence of Dehydration
    - Reduce Incidence of Falls
    - Reduce Incidence of preventable infections
    - Reduce Rate of institutionalization
    - Increase the number of members receiving coordinated care
    - Increase referrals made to HCBS
    - Antidepressant Medical Management (AMM) – HEDIS measure

Emergency room encounter data received from each delegated entity is analyzed. Trends in emergency room department utilization by Sub-Plan, PPG, provider or member may indicate access, education or under-utilization issues at any of these levels while indicating over-utilization at the emergency room level.

Hospitalization admit and re-admit data will be studied by utilizing encounter data and analyzing reports at L.A. Care level that indicate a trend of re-admit for same/similar diagnosis. If a pattern is found at any level, the possibility of under-utilization of inpatient services or outpatient support services may exist and warrant further investigation.

Encounter data will be run periodically against a “patterns of care” program to analyze encounter patterns by diagnosis or procedure (i.e., OB pre- and perinatal services or CHDP services) against the standards in the patterns systems. Under-utilization, over-utilization or non-submission of encounter data may be reason for widely aberrant patterns.

Review of disenrollment (voluntary and involuntary), out of plan service or grievance trends which may indicate access or quality issues will be conducted quarterly and the results reviewed by the CMO and UM and QI directors reported with recommendations to the QOC Committee. The results or action plans recommended by the QOC committee are sent to the sub-committees of the Board of Governors of L.A. Care and also shared with delegates

After analysis of the above data (which includes reviews by UM, QI, Health Outcomes and Analysis, Provider Relations, and the CMO), the CMO may direct the following activities (list not all inclusive):

- L.A. Care goals shall be to meet or exceed Cal Medi-Connect performance measures
- Discuss plans for improvement if needed
- Report results from the UM Committee to the QOC Committee for identification of performance improvement follow-up activities when needed based on results of the data analysis, discussion and plans for improvement as needed.

Requirements for Delegated Entities Over/Under Utilization Monitoring/ Detection Systems

L.A. Care's and delegated providers' descriptions of over/under utilization monitoring/detection systems must include monitoring inappropriate emergency room usage for routine primary and specialty care and the review of services for appropriateness and effectiveness of cost effective patient care for detecting/correcting over- and under-utilization.

L.A. Care's Cal MediConnect UM Committee performs the following over/under utilization monitoring/detection mechanisms at a minimum:

Use of Services

- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Non-Acute Care
- Behavioral Health Utilization - Inpatient Discharges and Average Length of Stay Behavioral Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
- Identification of Alcohol and Other Drug Services
- Outpatient Drug Utilization (for those with a drug benefit)

Ambulatory and Hospitalization Services

L.A. Care monitors potential over-under utilization of services by reviewing ambulatory and hospital data. This data includes PPG encounter data and L.A. Care claims data. The reports include:

- Outpatient Services
  - Primary Care
  - Specialty Care
  - Ancillary Services
- Emergency Room utilization
- Hospital Services
  - Bed Days
  - Average Length of Stay
  - Hospital Readmissions

- **Emergency Room Reports -** This data will be compiled into a monthly and rolling report for analysis by the UM Committee. Trends in Emergency Room Department utilization may indicate access, education or under-utilization issues at any of these levels while indicating over-utilization at the Emergency Room level.

- Hospitalization Admit and Re-admit data will be studied by utilizing encounter data and analyzing reports at L.A. Care Cal MediConnect level that indicate a trend of admission and re-admission for same/similar diagnosis. If a pattern is found at any level, the possibility of under-utilization of inpatient services or outpatient support services may exist and warrant further investigation.

  Encounter data will be run periodically against a “patterns of care” program to analyze encounter patterns by diagnosis or procedure against the standards in the patterns systems. Under-utilization, over-utilization or non-submission of encounter data may be reason for widely aberrant patterns.

  Review of disenrollment (voluntary and involuntary), out of plan service or grievance trends which may indicate access or quality issues will be conducted quarterly. The results will be reviewed by the UM and QA/QI directors reported with recommendations to the appropriate Quality Committees

  Recommendations from the various Quality Committees will be conveyed to the PPGs via the Provider Network Operations assigned staff or Joint Operation Meetings.

5.9 DELEGATION OF UTILIZATION MANAGEMENT

L.A. Care Cal MediConnect program has a formal process by which Utilization Management functions (which includes Case Management activities) are delegated to the PPGs. Policies and Procedures and the delegation agreement describe (in detail) delegation standards, initial delegation requirements, and ongoing monitoring and reporting requirements.

If a federal or state law does not allow the organization to fulfill NCQA requirements, NCQA holds the organization harmless for all affected scoring elements. In other words, NCQA may score an element NA or give the organization credit, if appropriate, when there is a direct conflict between an NCQA requirement and a federal or state law. The organization must present NCQA with documentation identifying the regulation and the conflict and alert the ASC prior to the survey start date (submission date).

L.A. Care Cal MediConnect program requires that delegated PPGs have a Utilization Management Program in place to monitor and evaluate the care and services provided to its members. PPGs UM program will be consistent with L.A. Care's Cal MediConnect UM program and meet State and Federal requirements and regulations. L.A. Care Cal MediConnect will monitor the infrastructure and activities of the PPGs and the oversight of their respective networks to assure compliance with contractual and regulatory requirements. PPGs are required to submit to L.A. Care Cal MediConnect:

- An annual Utilization Management Program document and program evaluation,
- Monthly encounter data,
- Oversight reports as defined in the delegation agreement
- Referral management activity and supplemental reports as defined in the delegation agreements.

PPGs/Providers must have systems in place which address the mandatory requirements to coordinate care between managed care plans and identified linked and carved-out programs as defined by the contract.

De-Delegation of UM Activities

L.A. Care Cal MediConnect may require or impose corrective action, including revocation of delegated status, if the PPG does not comply with the delegated Utilization Management requirements. If L.A. Care Cal MediConnect withholds or withdraws delegated status for Utilization Management from a PPG, L.A. Care's Cal MediConnect Utilization Management department shall assume the level of UM activity appropriate to the non-delegated PPG. L.A. Care Cal MediConnect reserves the right to continue to delegate Utilization Management

to the PPGs if they meet L.A. Care's Cal MediConnect standards for delegation. L.A. Care's Cal MediConnect Utilization Management department will provide consultation to the PPG and may actively participate with the PPG to assist the PPG to come into compliance with a UM delegated function prior to L.A. Care's Cal MediConnect revocation of a UM delegated status.

5.10 STANDARDS FOR DELEGATION OF UM FUNCTIONS

L.A. Care Cal MediConnect shall retain the ultimate responsibility for ensuring that PPGs utilize and maintain an effective Utilization Management Program.

The following required guidelines provide high level descriptions of required Utilization Management processes and functions to be delegated to the PPGs through L.A. Care's Cal MediConnect policies and procedures:

- The delegated PPGs must have a written utilization management program/plan in place. The program must have documented goals and objectives and describe the organizational structure and staffing for performing the program functions.

- The delegated PPG must have UM operations that meet all contractual, regulatory, and L.A. Care Cal MediConnect regulatory requirements, including but not limited to meeting all timeliness and corresponding standards.

- The UM program must identify and correct areas of over-utilization and under-utilization of services.

- The delegated PPGs must have an established utilization management committee which meets at least quarterly to review utilization issues and determine improvement plans where indicated. L.A. Care Cal MediConnect representatives may attend the committee meeting, upon advance request.

- The minutes of the utilization management committee must be made available upon request to L.A. Care Cal MediConnect.

- L.A. Care Cal MediConnect Utilization Management staff must be permitted reasonable access to the PPGs utilization management files, minutes and records of the UM Committee meetings, for the purpose of auditing utilization management activities.

- PPGs and providers within their networks will have processes in place to take appropriate action in areas where problems are identified and provide feedback to L.A. Care Cal MediConnect regarding the conclusions, recommendations, actions and follow-up. Serious quality issues, limitation of providers' practice, suspension or sanction activity will be reported to L.A. Care Cal MediConnect immediately.

- PPGs will have policies and procedures to ensure separation of clinical decision making from financial incentives.

- UM data must be sent to L.A. Care Cal MediConnect in a timely manner and in an appropriate format as requested by L.A. Care's Cal MediConnect UM and Information Services departments for trending and reporting in compliance with State and Federal regulatory requirements.

5.11 DELEGATION MONITORING AND OVERSIGHT

L.A. Care Cal MediConnect is responsible for evaluating PPGs' ability to perform the delegated activities including an initial review to assure that the PPG has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. Delegation monitoring shall be performed to ensure PPGs meet standards set forth by the L.A. Care Cal MediConnect and regulatory body requirements. This includes the continuous monitoring, evaluation and approval of the delegated functions.

L.A. Care Cal MediConnect will monitor and oversee the delegated UM activities of the PPGs and their networks to ensure ongoing compliance with State, Federal, and L.A. Care Cal MediConnect requirements. UM data submitted to L.A. Care Cal MediConnect by PPGs will be analyzed and areas for improvement identified and managed through the Corrective Action Plan (CAP) process with the PPG/Provider or through the Quality Improvement Process, as appropriate, in accordance with L.A. Care's Cal MediConnect organizational sanction policies. L.A. Care Cal MediConnect will perform different types of audits and oversight activities of PPGs as appropriate. The UM data and oversight activities will include, but not be limited to the following:

UM Reports

PPGs are required to submit to L.A. Care Cal MediConnect on a monthly basis via mail, electronic mail or fax:

- Oversight reports include referral management activity and supplement reports as defined in the delegation agreement including but not limited to:
    - Quarterly PPG Reporting of Medicare Organizational Determinations (Fully Favorable, Partially Favorable, and Adverse) on the ICE Medicare Part C Report Template PPG Reporting of Medicare Organization Determinations or L.A. Care approved template
    - ICE Provider Group reporting template or L.A. Care
    - Care Transitions Reports
    - Continuity of Care
    - Case Management
    - Medi-Cal Linked and Care Out Services (Dual Eligibles)

- L.A. Care Cal MediConnect contracted/delegated medical groups (PPGs) are provided with required templates for quarterly reporting for Medicare Organization Determinations:

    - For Medicare Part C Reporting – L.A. Care Cal MediConnect utilizes the ICE format with instructions/templates. (Attachment A)
    - For Medicare logs of organization determinations –L.A. Care Cal MediConnect utilizes the CMS required format with instructions/templates. (Attachment B)

- PPGs are required to submit the reports to L.A. Care's Cal MediConnect Medical Management Department on a quarterly basis:

    - Reports are required to be submitted by the 45th day following the close of the quarter.
    - Fax or email to L.A. Care's Cal MediConnect UM Delegation Oversight Coordinator by Right Fax 213-438-5710
    - Organization Determination reports data based on the required reporting periods of
        - 1/1 through 3/31 (1st Q) – Due May 15th
        - 4/1 through 6/30 2nd Q) – Due Aug 15th
        - 7/1 through 9/30 (3rd Q) – Due Nov 15th

General Directions for reporting CMS Part C Initial Determinations to L.A. Care Cal MediConnect:

- Reports may be submitted using the ICE quarterly report format (Attachment A).

- **NOTE: PPG's must submit a log of the actual data elements used to identify the Initial Determinations.**
- **This log must contain the following elements:**
  - **PPG name,**
  - **Member ID (usually the HIC #),**
  - **unique case # (usually the Referral number),**
  - **resolved date (by MM/DD/YYYY),**
  - **Type of IO (Initial Organization - IO,**
  - **Decision ID (1=Fully Favorable, 2=Partially Favorable, 3=Adverse).**
- **A sample log may be found at the end of this section (Attachment B)**
  - Exclude dismissals, withdrawals or Quality Improvement Organization reviews of request for continued Medicare-covered services (e.g. SNF).
  - Includes only organizational determinations that are filed directly the delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity).
  - Includes all methods by which organization determination requests are received (e.g., auth request form, by telephone, letter, fax, in-person).
  - Includes all organization determinations regardless of who filed the request.

Quarterly report Log of all Medicare Organization Determinations

In addition to L.A. Care's Cal MediConnect requirement for the standard Quarterly submission of the Medicare Advantage Part C Reporting for CMS, L.A. Care Cal MediConnect will now also require an additional Quarterly report Log of all Medicare Organization Determinations. Therefore, starting 4th Quarter 2011, we expect to receive two reports regarding Medicare.

Please note that because this new log is an Excel file, it must be submitted as an Excel file through Secure E-mail or to the L.A. Care FTP site so that it can be sorted by L.A. Care and / or CMS (Do not submit by FAX or Right Fax). Please send report to EMetivier@LACare.org only by secure e-mail or to the L.A. Care FTP site with an email to EMetivier@LACare.org advising of placement on the L.A. Care FTP Site.

***For Partially Favorable or Adverse (**Modification or Denial) determinations, the Notice of Action letters (CMS/DHCS/L.A. Care) and medical records utilized

in the determination must be sent to the L.A. Care Cal MediConnect UM Department on the date of the denial.

The submitted reports, combined with information obtained via site visits and audits, will be used to accomplish the UM oversight functions required by regulation and/or contract requirement.

Medicare Part C Reports from PPGs will be included in the total report that L.A. Care sends to CMS on a quarterly basis. The PPG logs of Initial Determinations on L.A. Care's excel format will be sent to CMS when requested.

L.A. Care Cal MediConnect will analyze the reports and present the results to the PPGs at the Utilization Management Committee meeting. The goal of performing plan and group specific analysis is to monitor utilization activities, member access to care, and to validate and compare to community norms/ benchmarks. Any variance(s) will be reviewed and discussed at the Utilization Management Committee meetings, and periodically at the Quality of Care Committee. All the information obtained in these reports will be shared with the PPGs/ Providers for UM and QI purposes.

Oversight Audits

As part of L.A. Care's Compliance Plan, L.A. Care's Compliance Officer has established a Medicare Auditing and Monitoring policy and procedure ("Policy") which requires ongoing auditing and monitoring of delegated entities to ensure compliance with Medicare rules and responsibilities. This Policy will be adapted and extended to ensure compliance with all Coordinated Care Initiative rules and responsibilities. The Policy identifies key components of the auditing and monitoring process including, but not limited to, PNO, QI, Medical management, financial compliance and credentialing.

Oversight for L.A. Care's Cal MediConnect directly contracted PPGs are performed as prescribed in the UM Oversight Plan as approved by the UM Committee. Wherever possible these audits may be done in conjunction with other L.A. Care Cal MediConnect departments to improve efficiencies and decrease duplication. The primary objective of the oversight audit is to ensure compliance with L.A. Care's Cal MediConnect Utilization Management Department policies and procedures, standards of care, Local, State, and National regulatory requirements, and provisions of the purchaser contracts (e.g. DHCS, CMS, MRMIB). The oversight audit consists of document review and staff interviews to verify that policies/procedures/processes have been implemented and are being applied and complied with. This may include, but not be limited to, audits of case files and medical records. The oversight audits are conducted to ensure compliance with the following requirements:

- Annual approved Utilization Management Program, Work Plan, and Evaluation

- UM Policies/Procedures/Processes
- UM Care Coordination for in and out of network referrals/hospitals
- UM Care Coordination for Linked and Carved Out Services
- Initial Health Assessments for Medi-Cal
- Medicare standards

As part of L.A. Care's oversight process, L.A. Care performs due-diligence reviews prior to provider contracting and an annual on-site audit of delegated provider groups to ensure compliance with federal, state and NCQA requirements related to the delivery of quality healthcare services. Specifically, administrative and clinical oversight responsibilities are assigned to multidisciplinary group of health plan professionals representing the following administrative and clinical areas

- Credentialing
- Financial Compliance
- Pharmacy
- Regulatory Affairs & Compliance
- Medical Management (UM)
- Quality Management
- Provider Network Operations

The scope of L.A. Care's administrative and clinical audits are comprehensive and based on federal, state, accreditation and contractual requirements. L.A. Care uses an audit tool for each specific audit area that is designed to assess for compliance and delegation capacity. The audit tools are updated on an annual basis to capture new regulatory and contractual requirements. The audit tools for each specific audit area capture, in part, audit elements for audit area.:

Supplemental File Review Audits

Previously termed focused audits and supplemental audit topics may be identified by the Utilization Management Committee, CMO, Medical Director, and/or as a mid-year assessment of new legislative implementation requirements or indicated as a consequence of findings from internal (e.g., performed by L.A. Care Cal MediConnect) or external (e.g. State or Federal) oversight/audit activity. The purpose of a supplemental audit is to capture more specific/detailed information that may not be captured through Encounter Data, Supplemental Reports or the annual oversight audit. The goal of the supplemental audit is to ensure compliance with L.A. Care's Cal MediConnect Utilization Management department policies and procedures, standards of care, regulatory requirements, and provisions of purchaser's contracts with a specific issue. The supplemental audit may consist of document review, file review and/or medical record review and staff interviews. Supplemental audits may be used to capture more specific

or detailed information and/or to follow-up on identified deficiencies or areas of concern.

A sampling methodology, used to select member records, ensures a representative sample from the delegated entity for the supplemental audit.
Supplemental audit tools are scored according to the methodology approved by the UM Committee

The supplemental audit may address any Utilization Management and coordination of care category as identified by L.A. Care Cal MediConnect in our purchasers' contract.

Continuous Monitoring Activities

Continuous Monitoring Activities are used to further supplement the basic oversight activities of annual/focused audits and supplemental report submission review in order to provide more comprehensive and timely oversight in selected areas where episodic audits/review have not been adequate in ensuring compliance with regulations. A sampling methodology appropriate to each continuous monitoring activity is defined to ensure representative sampling, and approved by the UM Committee. Examples of continuous monitoring may include, but are not limited to:

- Referral Management Review, including denials and denial notifications
- Care Coordination for Linked and Carved Out Services

Decisions by the Plan or delegated PPG are tracked for any trends and appropriate actions taken as necessary.

The L.A. Care Cal MediConnect UM Department reviews denials issued and submitted by the delegated Physician Groups. Delegated PPGs are required to submit all denial letters with any supporting documentation current to the denial or on a weekly basis to the Program.

Plan and PPG denial letters are evaluated for compliance in the following areas:

1. Timeliness of the decision-making and notification process
2. Physician involvement in the decision making
3. Clear and concise denial reason
4. Appropriate information available for decision-making
5. Documentation of criteria for medical necessity denials or benefit reference
6. Appeal rights and process
7. Appropriate template

If deficiencies are found in the initial review, the Program or delegated PPGs are notified of the areas of deficiencies for immediate correction. Continued non-

compliance issues are reported to the Delegation Oversight Committee for recommendations.

Delegated Physician Group letters are also audited during the annual oversight audits.

Corrective action plans are required for those PPGs with less than 90% compliance.

- PPGs with deficiencies or corrective action plans will be monitored according to L.A. Care Cal MediConnect policy.

- If a PPG remains non-compliant, the findings will be reported to the Delegation Oversight Committee for a decision regarding continued delegation.

The Program will provide delegated PPGs with the approved CMS/SDHS or L.A. Care Cal MediConnect letter templates that need to be used, at least once every year or more often as the need arises. This is to ensure that the PPG are using standard regulatory approved language.

5.12 RESPONSIBILITY OF PARTICIPATING PROVIDER GROUPS

5.12.1 PPGs are responsible for primary (basic) medical case management, coordinating health care services, and referral management of services for which the PPG has financial responsibility, for members enrolled with their primary care physicians.

5.12.2 The PPG also has responsibility for notification to and obtaining prior-authorization from L.A. Care's Cal MediConnect UM department for services which L.A. Care Cal MediConnect has sole financial responsibility.

PPGs that do not obtain prior authorization for services that are the responsibility of L.A Care Cal MediConnect and not defined as eligible under the Risk Pool arrangement are subject to assume the financial risk for said service. Please refer to the contract DOFR and or the mutually agreed upon Delegation Agreement.

5.12.3 The PPG agrees and is required to:

5.12.3.1 Make available to L.A. Care Cal MediConnect any requested data, documents and reports

5.12.3.2 Allow site visits, periodic attendance at UM meetings, evaluation and audits by L.A. Care Cal MediConnect or other agencies authorized by L.A. Care Cal MediConnect to conduct evaluations.

5.12.3.3 Have representation and involvement in activities scheduled to enhance and/or improve the quality of health care services provided to our members.

5.12.4 Continuing Coverage of Services for Cal MediConnect Enrollees and Newly enrolled members:

PPGs are responsible for the initial review of continuity of care (CoC) for new enrollees or for members assigned to a terminated provider. PPGs must assess the enrollees request or assess the UM referral management system to identify Members currently schedule with or who may have open authorizations with a terminated provider. L.A. Care is not required to provide continuity of care for services not covered by Medi-Cal or Medicare.

When a newly enrolled member joins a L.A. Care contracted PPG or a PPG's physician and/or specialist leaves the Plan either voluntarily or involuntarily Members assigned to them may require continuity of care services. To be eligible for "Continuity of Care" (COC) services the member must request the service. Requests can be made by phone, in writing or by fax.

New Enrollees may request to receive continuity of care by a non-participating provider, if at the time of the Members enrollment the Member was receiving services from that provider.

For newly enrolled Cal MediConnect members, L.A. Care assures continuity of care for medical, psychosocial, mental and behavioral, and long-term services and supports (LTSS), upon new enrollment. L.A. Care must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for:

- A period, up to six months, for primary and specialty Medicare services, if all of the following criteria are met:
    - The enrollee demonstrates an existing relationship with the provider, prior to enrollment;
    - The provider is willing to accept payment from the MMP based on the current Medicare fee schedule; **and**
    - The MMP would not otherwise exclude the provider from their provider network due to documented quality of care concerns.

- A period, up to 12 months, for Medi-Cal services covered under this Demonstration other than in-home supportive services (IHSS), if all of the following criteria are met:

    - The enrollee demonstrates an existing relationship with the provider, prior to enrollment;
    - The provider is willing to accept payment from the MMP based on the MMP's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and
    - For Long Term Care Facilities, pursuant to the Cal MediConnect contract §§ 2.8.4.1.1.2. and 2.8.4.1.2.2., for services provided under the Cal MediConnect continuity of care requirements, L.A. Care and it's delegates shall pay out-of-network providers at rates not less than the current Medicare fee schedule for Medicare nursing facility services and not less than the applicable Medi-Cal FFS rate for Medi-Cal nursing facility services.

L.A. Care and its delegates must determine the provider meets applicable professional standards and would not otherwise exclude the provider from its provider network due to documented quality of care concerns.

For Cal MediConnect members, L.A. Care will provide enrollees that use the transition benefit with appropriate assistance and information necessary to enable them to understand the transition. This includes contacting those enrollees to ensure they have the necessary information to enable them to switch to a formulary product or as an alternative pursue necessary prior authorizations or formulary exceptions.

Continuing medical services for Cal MediConnect members who request continued access, and the provider agrees and has been treating the member for:

- Acute condition - For the duration of the condition.
- Serious chronic (long term) condition – For a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider.
- Pregnancy – includes the rest of the pregnancy and immediate postpartum care.
- Terminal illnesses/conditions - For the length of the illness.
- Children from birth to age 36 months – For up to 12 months.
- Surgery or other procedure that has been authorized by the plan as part of a documented course of treatment.

Timeframe for processing CoC request

Decisions concerning a member's request for the continuation of covered services shall be rendered consistent with the timeframes appropriate for the nature of the member's medical condition.

- Urgent or expedited within 15 business days (review and notification)
- Routine request within 30 calendar days;
- Concurrent review pertaining to care underway 1 business day
- The Non-participating Provider and the Member will be notified of the decision:
    - The provider, verbally and or in writing, within 24 hours of the determination
    - The member, verbally and or in writing, within 48 hours of the determination

Continuity of Care Process

Members may initiate requests for continuity of care. When this occurs, L.A. Care must begin to process the request within five working days after receipt of the request. The continuity of care request begins when L.A. Care or its delegate determines there is a pre-existing relationship and has entered into an agreement with the provider.

L.A. Care or it's delegate may determine an existing relationship through use of the data provided by CMS or DHCS, such as FFS utilization data from Medicare or Medi-Cal. A Member or his/her provider may also provide information that demonstrates a pre-existing relationship with the provider. A Member may not attest to a pre-existing relationship unless L.A. Care or its delegate makes this option available.

Following the identification of a pre-existing relationship, L.A. Care or its delegate must determine if the provider is an in-network provider, If the provider is not an in-network provider, L.A. care or its delegate must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

Continuity of care request must be completed within 30 calendar days from the receipt or within 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs. A continuity of care request is considered completed when:

- The member is informed of his or her right of continued access, or if L.A. Care or its delegate and the out-of-network FFS provider are unable to agree to a rate,
- L.A. Care or it's delegate has documented if the provider has any quality of care issues/concerns,
- L.A. care or its delegate has made a good faith effort to contact the provider and the provider is no-responsive for 30 calendar days

If L.A. Care or its delegates are unable to reach an agreement because they cannot agree to a rate or have documented quality of care issues with the provider, L.A. Care or its delegates will offer the member an in-network alternative. If the member does not make a choice, the member will be assigned to an in-network provider. Members maintain the right to pursue an appeal through the Medicare and Medi-Cal processes.

If the provider meets all of the necessary requirements in including entering into a contract, letter of agreement, single case agreement, or other form of relationship with L.A. Care or it's delegate, Members must to allowed access to that provide for the length of the continuity of care period unless the provider is only willing to work with L.A. Care for a shorter timeframe. In this case, L.A. Care will allow the member to have access to the provider for a shorter period of time.

At any time, members may change their provider regales of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, L.A. Care or its delegate must work with the provider to establish a care plan for the member.

L.A. Care requires a nonparticipating provider whose services are continued for a newly covered enrollee to:

- Agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
- If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.
- Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered will be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider.

- Neither L.A. Care or its delegated provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates

Members are responsible for any amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the L.A. Care or its delegated provider group.

Continuity of care Provider Referrals outside of the network

An approved out of network provider must work with L.A. Care and its contracted network and cannot refer the member to another out-of-network provider without authorization from L.A. Care or its delegates. In such cases, L.A. Care or its delegates may make the referral if medically necessary and there is not an available and appropriate provider within the network.

Continuity of Care – Durable Medical Equipment

For DME, L.A. Care must provide continuity of care for services, but is not obligated to use providers that are determined to have a pre-existing relationship, for the applicable six or twelve months.

Continuity of Care with Terminating Providers

L.A. Care requires the terminated provider whose services are continued beyond the contract termination date to:

- Agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
- If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, L.A. Care is not required to continue the provider's services beyond the contract termination date.
- Unless otherwise agreed by the terminated provider and L.A. Care or by the individual provider and the provider group, the services rendered will be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider.
- Neither L.A. Care nor its delegated provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates.

Letters of Agreement

PPGs will are responsible for negotiating any Letter of Agreements/Intent (LOA/LOI) to validate contract terms as well as ensuring if necessary, a quality assessment is performed validating there is no quality of care issue with the provider, i.e. 805 Reports, Office of Inspector General Reports, Hot Sheet etc.

PPGs are responsible for ensuring care coordination Member's requesting continuity of care to ensure care needs are met and the member is safely transitioned to a network provider upon the completion of the identified and approved treatment plan. In instances where there if a facility component to the continuity of care requests, PPGs are responsible for notification to L.A. Care UM Department to ensure the appropriate facility authorizations and necessary LOA/LOI are in place.

Existing continuity of care provisions under California Law

California law provides additional protections of which Cal MediConnect members also have rights and protections.

L.A. Care must allow Cal MediConnect members to continue use of any single-source drug that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by L.A. Care, until the prescribed therapy is no longer prescribed by the contracting physician.

Acute Condition (for example, pneumonia)	As long as the condition lasts
Serious Chronic Condition (for example, severe diabetes or heart disease)	No more than 12 months. Usually until you complete a period of treatment and your doctor can safely transfer your care to another doctor
Pregnancy	During Pregnancy and immediately after the delivery (the post-partum period)
Terminal Illness	As long as the person lives
Care of a Child 0- 36 months	For up to 12 months
An already scheduled surgery or other procedure (for example, knee surgery or colonoscopy)	The surgery or procedure must be scheduled to happen within 180 days of your doctor or hospital leaving your health plan

Additional requirements pertaining to continuity of care are defined in the Health and Safety Code and require health plans to, at the request of the member or

provider, provide for the completion of covered services by a terminated provider or non-participating provider.

These are: Mental Health Acute Condition - 90 days or though the acute period of illness

5.13 SERVICES REQUIRING PRIOR AUTHORIZATION

The delegation of certain UM activities affords flexibility for PPGs to establish internal prior authorization requirements. These requirements must be reviewed and approved by L.A. Care Cal MediConnect through the delegation process.

There are services for which the PPG must submit a request/referral to L.A. Care Cal MediConnect for prior authorization, or notification concurrently with or retrospective of the services for authorization by L.A. Care Cal MediConnect. All authorization requests submitted to L.A. Care Cal MediConnect will be responded to within the defined timeframes as identified in the most recent product specific version of the applicable "Decision Making Timeliness Matrix" (Attachment included)

Unless defined in the most recent L.A. Care Cal MediConnect PPG Auto Approval Listing, the services listed below, and any future updates dependent on delegation and DOFR, must first be authorized by L.A. Care's Cal MediConnect UM department:

- Durable Medical Equipment (DME)
- Home Health Services
- Hospital admission (non-emergent/urgent)
- Skilled Nursing Facility admissions, skilled and long term care
- Medical Supplies not provided in physicians' offices
- Most elective surgical and invasive diagnostic procedures (inpatient or outpatient facility component)
- Orthotics & Prosthetics
- Physical/Occupational & Speech therapies (see DOFR)
- Rehabilitation services
- Transplant evaluation
- Self-injectibles

Referrals may be submitted on paper, by phone, or electronically. All requests must be submitted on a L.A. Care Cal MediConnect Referral Form and include the following information:

- Requesting provider
- Patient's name, date of birth, address, phone number, and social security number
- Confirmation of current L.A. Care Cal MediConnect eligibility

- Patient's diagnosis and medical history supportive to the service requested
- Supportive medical records needed to make a determination
- Appropriate coding (using current CPT4, ICD9, and/or HCPCS codes), identification of services requested
- Identification of requested provider of service, including name, type of provider, location and provider's phone number

5.14 ORGANIZATIONAL DETERMINATIONS - DEFERRAL, MODIFICATION, AND/OR DENIAL DETERMINATIONS AND NOTIFICATION REQUIREMENTS

Referral Status and Timelines

L.A. Care's Cal MediConnect Utilization Management Department reviews referral/authorization requests and makes organization determinations based on medical necessity through the application of approved clinical criteria and assessment of the individual needs of the member. Regarding timeliness of decisions, L.A, Care's practice is to make a decision in a time frame that is the most generous to the member.

Organization Determinations means any determination (whether adverse, fully favorable or partially favorable) made by L.A. Care Cal MediConnect for any of the following:

- Requests for service
- Discontinuation of service that the enrollee believes should be continued because they believe the service to be medically necessary.
- Refusal to pay for services in whole or part, including the type or level of services that enrollee believes should be furnished by the Cal MediConnect contracted plan Medicare Advantage organization.
- Payment for any health services furnished by a provider other than the Cal MediConnect contracted plan that the enrollee believes are covered under Medicare or if not covered by Medicare, should have been furnished or arranged for by the Cal MediConnect contracted plan.
- Payment for temporarily out of area renal dialysis services, emergency services, post stabilization care, or urgently needed services.
- Failure of L.A. Care Cal MediConnect to approve, furnish, arrange, or provide the enrollee of timely notice of an adverse determination, such that a delay may adversely affect the health of the enrollee.

Routine (non expedited or standard) Organization Determinations are made using appropriate clinical and CMS coverage guidelines and the member is

notified within 14 calendar days of receipt of the request, per Medicare timeliness standards.

Expedited Determination for urgent requests**:** To request an expedited determination, an enrollee or a physician must submit an oral or written request directly to L.A. Care Cal MediConnect or the delegated PPG. Urgent requests for services are referred to the PPG or L.A. Care depending upon the entity responsible for reviewing the referral request. Urgent referral requests are submitted when services are required to prevent serious deterioration of health following the onset of an unforeseen condition or injury. Urgent referral requests made to L.A. Care Cal MediConnect will be reviewed by an L.A. Care Cal MediConnect UM Specialist to assess whether the care requested meets the definition for urgent processing**.** If request is approved for urgent processing, L.A. Care Cal MediConnect or the delegated PPG makes its determination and notifies the enrollee and the physician involved of its decision (whether adverse or fully favorable , partially favorable or adverse) as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

Based on CMS standards, referrals that do not meet the criteria for urgent processing will be reviewed by L.A. Care's Cal MediConnect Medical Director. If the service requested does not meet the criteria for an urgent request, the referral request will be converted to a routine request for processing within the routine timeframe which is 14 calendar days from the date and time of the request. Members may file an expedited grievance if they do not agree with L.A. Care Cal MediConnect's decision.

If the referral request does not meet criteria for medical necessity or covered benefit, these requests are subject to a modification or denial by L.A. Care's Cal MediConnect Medical Director. PPGs will be notified by L.A. Care's Cal MediConnect UM staff member prior to the change in referral status. Appropriate communications are sent to the member and provider. If the services are denied, the denial notice must be the appropriate CMS approved denial letter (Notice for Denial of Medical Coverage, NDMC) and must include the reason for the denial, the criteria used, and include Medicare appeal rights.

A physician will make all determinations of deferment, modification or denial of requests for services.

Extensions: L.A. Care Cal MediConnect or delegated PPGs may extend the routine request or 72 hour deadline (expedited or urgent request) by up to 14 calendar days if the enrollee requests the extension or if L.A. Care Cal MediConnect or the PPG justifies a need for additional information and how the delay is in the interest of the enrollee (for example, receipt of additional information from non-contracted providers may change L.A. Care Cal MediConnect's decision to deny). When the organization extends the deadline, it

notifies the member in writing of the reasons for the delay and informs the member of the right to file a grievance if he or she disagrees with the organization's decision to grant an extension. The member is given prompt oral notice of the extension (as expeditiously as the member's health condition requires but no later than upon expiration of the extension) and a written notification follows within 3 calendar days. The letter confirms the oral notification. ***(See: Attachment A - ICE Medicare Timeliness Standards)***

Only a qualified physician can make a determination to deny or modify a request based on medical necessity. Denials and modifications of requested services may be issued with an alternative care option when appropriate.

A request for authorization that results in a modification, reduction, or denial of Covered Services based on medical necessity or Benefit coverage shall be reviewed by the L.A. Care Cal MediConnect or PPG Medical Director or designated Physician reviewer. The Plan or PPG should clearly document and communicate the reasons for each denial. The intent is for Providers and Members to receive sufficient information to render an informed decision whether or not to appeal the modification or denial of coverage. This policy covers both non-behavioral and behavioral healthcare.

L.A. Care Cal MediConnect and delegated PPGs shall comply with the standards for timeliness in decision making and notification of UM denial or modification decisions per specifications of the UM Timeliness Guidelines required by CMS or DHCS. Notifications may be given orally, electronically, or written as specified in regulatory guidelines. L.A. Care Cal MediConnect will notify Physician Groups of any changes in these standards as required.

If a request is denied or modified, the Plan or the delegated PPG shall utilize either the:

- CMS mandated Notice of Denial of Medical Coverage (NDMC) and the supplemental CMS Region IX approved template letters for Medicare Members.

- DHCS Notice of Action (Only for those services not covered by CMS but covered by DHCS),

Denials include modifications or delays in the Covered Service requested.

A denial letter is issued based on standard criteria (medical or Benefits) and must include the following:

a) A description of the Covered Service being denied, modified or deferred
b) Clear and concise explanation of the reason(s) for the decision. This should be presented in a clear, understandable language.

c) A description of the criteria, guidelines, protocol, or benefit provision used to make the decision.
d) Notification that a Member can obtain a copy of the criteria, guideline, protocol, or actual Benefit provision on which the denial decision was based, upon request.
e) An alternate treatment plan will be identified when medically indicated.
f) A description of Appeal and or reconsideration rights, including the right to submit written comments, documents, or other information relevant to the Appeal.
g) An explanation of the Appeal process, including the right to Member representation and time frames for deciding Appeals.
h) A description of the Expedited Appeal process if a denial is an urgent pre-service or urgent concurrent denial.
i) Name and phone number of the Physician reviewer involved in the initial determination.
j) A Member's right to select an authorized third party, such as legal counsel, relative, friend or any other person as a representative.

UM REFERRAL PEER REVIEW DISCUSSION – PPG or L.A. Care Cal MediConnect are required to provide access to the Medical Director or physician reviewers responsible for the UM determination .

PEER REVIEW DISCUSSIONS

A provider requesting a second review of a referral request for authorization may write or call the Medical Director/ designated peer reviewer and provide additional information for further discussion. This process, or reconsideration, usually occurs prior to the issuance of the denial notification to the member under the following terms:

- Reconsideration must occur within one (1) business day from the receipt of the provider telephone call or written request.
- If the Medical Director or designated peer reviewer reverses the original determination based on additional information given by the provider, the case will be closed.
- If reconsideration does not resolve a difference of opinion, the provider may then submit a request for review through the expedited or standard appeal process to L.A. Care Cal MediConnect.
- If the group's reconsideration process results in a denial, deferral, and/or modification with which the provider is still dissatisfied, the provider may request a formal appeal to L.A. Care Cal MediConnect for a higher level review.

NOTIFICATIONS

The PPG or L.A. Care Cal MediConnect will send written notification of prior-authorization request denial, deferral, and/or modification to the member or

member's representative, member's PCP, and/or attending physicians and L.A. Care Cal MediConnect, according to the provisions below:

- All denials and modifications of service requests, including denials for non-covered benefits, must be communicated to the provider and member in writing within the required timeframes and utilize the appropriate CMS template notices The communication must contain the following:

    - Specific reason(s) for the decision
    - Medical or other criteria used in making the decision
    - All appeal options and processes including necessary instructions and applications (e.g. Independent Medical Review, routine and expedited appeal processes, etc.)
    - Name and contact information of the physician reviewer making the determination
    - Written notification will also include information describing the grievance processes for CMS or Department of Health Services

Timelines for Decision Making

SEE ATTACHED PRODUCT SPECIFIC DECISION-MAKING MATRICES (Attachment C)

Self-Referral Services Certain services are available without referral or authorization. These include:

- **Routine women's health care**, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from a plan provider.
- **Flu shots** and **pneumonia vaccines**, as long as they are furnished by a plan provider.
- **Emergency services**, whether provided in or out-of-network
- Urgently needed care received from non-plan providers when the member is temporarily outside the Plan's service area. Also, urgently needed care that the member gets from non-plan providers when they are in the service area but, because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services received when the member is temporarily outside the Plan's service area.

5.15 AFTER HOURS UM ACCESS

L.A. Care Cal MediConnect and its delegated entities shall provide 24 hours/7 days/week telephone access to utilization management professionals and ensure that multilingual capability is available at the 24-hour number:

Multi-lingual capability is provided by L.A. Care Cal MediConnect through a telephonic interpretation services contracted vendor.

A physician or contracting physician shall be available 24 hours a day to: authorize medically necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary:

- response to request is required within 30 minutes or the service is deemed approved in accordance with Title 22, CCR, Section 53855 (a), or any future amendments
- authorize non-urgent care following an exam in the emergency room
- response to request is required within 30 minutes or the service is deemed approved in accordance with Department of Health Services (DHCS) contractual requirements
- respond to expedited requests for**:**
    - appeals of denial of services
    - quality of care grievances

L.A. Care's Cal MediConnect UM physician and staff are available after hours (24 hours, 7 days/week) for provider and access to care determinations. If you have a question regarding UM referrals for urgent services provided after normal business hours, please contact:

L.A. Care Health Plan
Attn: UM Department
1055 West Seventh Street, 10th Floor
Los Angeles, CA 90017

(877) 431-2273

Fax: (213) 438-5777

5.16 EXCEPTIONS FROM PRIOR AUTHORIZATIONS

5.16.1 In developing prior-authorization requirements, certain parameters and any future updates must be followed by the Delegated Entity. These parameters include exceptions from prior-authorization or services for which prior authorization is disallowed. The services include the following:

- Emergency services (medical screening and stabilization).
- Preventative health services for all ages including immunizations
    - flu and pneumococcal vaccinations and screening mammograms.
- Services identified in the most current version of the L.A. Care Cal MediConnect "Direct Referrals List"

5.17 Hospital Inpatient Care

Unless noted in the PPGs delegation agreement, Cal MediConnect is responsible for hospital inpatient concurrent review. Cal MediConnect UM staff or case manager will collaborate with the attending Physician (Hospitalist), Hospital case manager and Physician Group Case Manager for continuing Inpatient Services and discharge planning.

The attending PPG is responsible for the professional component of inpatient care and shall perform rounds on all Members who are Inpatients, as will, when appropriate, the Member's PCP, if the attending Physician is a Specialist Physician. The PPG shall monitor continuing care, collaborate with the Plan when continued Inpatient Services are required and initiate discharge planning and follow-up services, when indicated.

Hospital inpatient care may be pre-planned, pre-authorized, urgent or emergency admissions. The PCP is responsible for obtaining required pre-authorizations for inpatient care from the PPG. The PCP must notify the PPG of an emergency admission. Unless delegated for concurrent review, t**he PPG must notify L.A. Care Cal MediConnect of *all* inpatient admissions**. L.A. Care Cal MediConnect maintains a list of contracted hospitals and ancillary services. If you do not have a PPG copy, please contact your L.A. Care Cal MediConnect Provide Network Operations representative.

Emergent inpatient admissions – for PPGs that are managing an inpatient admission and do not coordinate within one (1) business day of the admission, **the hospital facility charges may be subject to capitation adjustment as defined in the terms of the PPG contract at the discretion of L.A. Care.**

Elective inpatient admissions – for PPGs that do not obtain prior authorization for the admission by L.A. Care Cal MediConnect, **the hospital facility charges are subject to capitation adjustment as defined by the terms of the PPG contract at the discretion of L.A. Care.**

While a member is hospitalized, the PPG/PCP must:

- Coordinate, with the assistance of UM staff, care for members admitted to out of network facilities for emergency care or other

reasons. After determination of the appropriateness of an emergency admission and a transfer assessment is made, the member will either be transferred to a network facility or care will be continuously monitored at the initial facility of admission until discharge or a transfer is appropriate.

- Respond to the concurrent review process, including level of care, length of stay, and medical necessary elements when he/she acts as the attending physician or works in conjunction with the attending physician for a hospital stay.
- Assist with the discharge planning by ordering and requesting authorization for appropriate elements of discharge.

Emergency Notification of Admission

All elective and emergency inpatient admissions must be brought to the attention of L.A. Care's Cal MediConnect UM department **within 24 hours of the admission**. These notifications may occur by calling in or faxing the patient's admission face sheet to the following:

L.A. Care Cal MediConnect Utilization Management Department

1-877-431-2273
OP Fax: 213-438-5777
IP FAX: 877-314-4957
Medi-Cal SPD FAX: 213-438-6100

Emergent inpatient admissions – for PPGs that are managing an inpatient admission and do not coordinate within 1 business day of the admission, the hospital facility charges may be subject to capitation adjustment as defined in the terms of the PPG contract.

Transfers from Non-Participating Providers
In cases where a Member requires Emergency Services at a Hospital or facility other than a Plan contracted Hospital, Physician Group and Group Providers shall make best efforts to transfer such Members to a Plan-designated Hospital as soon as medically appropriate (i.e., following stabilization of the Member). Group Providers shall coordinate and accept transfer of care from Non-Participating Providers when and as medically appropriate, whether the Member's Emergency or post-Emergency Services has been rendered Out-of-Area or In-Area. Physician Group shall consult with the Plan regarding arrangements for Member transfers. If a Member is Out-of-Area and, in the opinion of Physician Group's designated Physician and/or Plan's Medical Director, said Member requires continued Physician Services upon transfer, and Physician Group's designated Physician and other Group Physicians do not accept transfer of the Member for such Covered Services, Physician Group shall bear the costs of Physician Services rendered from the date Member is deemed transferable. In the event disputes arise between Physician Group and Plan

relating to the Plan Medical Director's decision regarding a Member's transferability, Physician Group may appeal such decision to Plan's UMC.

Inpatient Concurrent Review

Cal MediConnect Inpatient concurrent review is usually a coordinated effort between L.A. Care and the PPG. Once notified, L.A. Care's Cal MediConnect UM staff will perform telephone reviews with the hospital staff:

- Inpatient concurrent review will begin within one (1) day of notification of the admission and include an assessment of the appropriateness of the level of acute care by using accepted criteria.
- Concurrent review will be conducted on or before the dates assigned at the end of the initial review and each subsequent review. Concurrent review includes an evaluation of the following:

    - Appropriateness of acute admission
    - Plan of treatment
    - Level of care
    - Intensity of services/treatment
    - Severity of illness
    - Quality of care
    - Discharge planning

- These reviews will be conducted utilizing accepted guidelines for acute levels of care, such as intensity of service and severity of illness criteria, MCG Care Guidelines, or other guidelines and criteria developed and/or approved by L.A. Care Cal MediConnect.

- Concurrent quality issues noted during utilization review will be documented and reported to the PPG, L.A. Care's Cal MediConnect UM Medical Director and Quality Improvement department. When appropriate, quality issues will be discussed with the attending physician by the UM medical staff for appropriate intervention. Depending on the urgency or gravity of the situation, discussion of the issues may also be necessary with Senior Executive Administration.
- Utilization review concurrent focus will be proactive, and UM/Case Management levels of focus will be employed as appropriate.

- L.A. Care's Cal MediConnect UM staff will begin discharge planning within 24 hours of notification of admission and facilitate the involvement of a multidisciplinary team of physicians, nursing, social work, and others, as appropriate.

- Patient and family intervention will occur, as appropriate, throughout the stay to assure discharge plans are in place and appropriate for each

member. Discharge plans will consider the disease process, treatment requirements, the family situation, and available benefits and community resources.

- Average length-of-stay guidelines will be used for discharge planning purposes. Discharge screens, lower level of care guidelines, or clinical decision made by the physician are to be used for the final discharge date plan.

- Questionable continued stay plans are to be discussed with the attending physician and then reviewed by L.A. Care's Cal MediConnect physician reviewer for further discussion with the attending physician.

Discharge Planning/ Transition of Care

L.A. Care UM staff or delegates will begin discharge planning within 24 hours of notification of admission and will facilitate the involvement of a multidisciplinary team of providers, care coordinators, and others as appropriate. Patient and family engagement will occur as appropriate, throughout the stay to assure appropriate discharge plans are in place.

Discharge plans will be based on member clinical condition, treatment requirements, the family situation, available benefits and community resources. The discharge plan will be consistent with the member's existing care plan and will be added to the ICP. PPG Medical Directors should contact the attending physicians for a peer to peer review of the cases which fall out of standard care guidelines. In cases where the PPG and the attending physician do not agree on the continued plan of care, the PPG Medical Director may consult with L.A. Care's Medical Director for assistance.

PPGs must maintain a process to manage discharges through a Transition of Care (TOC) program. The TOC program should evaluate members at the time of the admission to identify members at "high risk" for an adverse transition. PPGs may utilize a screener to identify the most appropriate interventions for the program. If the PPG does not have a program, they should contact L.A. Care to discuss alternative options for meeting the responsibility. At risk members may be identified by the following:

- Re-admission within 30 days of discharge
- Chronic behavioral health conditions
- Members in complex case management/high care coordination
- Admissions with a projected long length of stay (greater than 10 days)
- Complex medical diagnosis/conditions
- Complex social conditions (homelessness, lack of family support)
- History of inappropriate utilization of care setting (i.e., frequent

ER visits)

The minimum requirements of a TOC program include, but are not limited to:

- Robust communication process for Stakeholders including the member, care team and provider
- Timely care management process
- Ability to perform medication reconciliation
- Ability to facilitate access to needed care
- Ability to perform in-home evaluations, as needed
- Ability to coordinate home and community based services and community resources
- Ability to meet reporting and monitoring requirements timely

PPGs may utilize a screener to identify the most appropriate interventions for the program. If the PPG does not have a program, they should contact L.A. Care to discuss alternative options for meeting the responsibility.

PPGs will be assessed to ensure the TOC program meets the minimum requirements. The policy of L.A. Care is that all PPGs have a TOC which supports appropriate coordination of care in a member-center manner that is cost effective.

Discharge Planning/LTSS

L.A. Care provides a reassessment of members' eligibility for accessing long term services and supports at the time of discharge planning. Members admitted to the hospital will have inpatient care management and discharge planning targeted at identifying and supporting member preferences.

For members transitioning to home, the Care Managers will assess refer to the LTSS team for the need of additional social services to successfully transition to home. The process includes a comprehensive assessment or reassessment to identify supportive services targeted at maintaining the member's safety in the home setting.

Measuring the Effectiveness of the Transition of Care program

The effectiveness of the interventions will be measured by reviewing hospital utilization and all cause readmission rates per 1000 on a quarterly basis. In addition, a random sampling of files will be audited to assess processes are in place to ensure:

- Sharing of the care plan between settings within 24 hours of discharge to the facility, Primary Care Provider or health care professional

- Member and/or Member's family is coached on the transition to the next level of care
- Follow up visit with health care professional within 30 calendar days of discharge

Notification of Hospital Discharge Rights to Members

L.A. Care's Cal MediConnect members receive the "Important Message (IM) from Medicare" from affiliated hospitals upon admission. The message explains the member's rights including the right to appeal to the Quality Improvement Organization (QIO) if they believe they should not be discharged. Medicare enrollees who are hospital inpatients have a statutory right to appeal to the Quality Improvement Organization which is the Health Services Advisory Group, Inc. (HSAG) in California for an immediate review when a hospital and a Medicare health plan, with physician concurrence, determine that inpatient care is no longer necessary.

- **Hospitals must issue** the IM within 2 calendar days of admission and must obtain the signature of the enrollee or his or her representative and provide a copy at that time.

- The message is a statutorily required notice that explains the enrollee's rights as a hospital patient, including discharge appeal rights.

- Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but **not less than 2 calendar days** before discharge.

- Enrollees who are being transferred from one inpatient hospital setting to another inpatient hospital setting do not need to be provided with the follow up copy of the notice prior to leaving the original hospital, since this is considered to be the same level of care. Enrollees always have the right to refuse care and may contact Health services Advisory Group [HSAG]

The Quality Improvement Organization {QIO} appointed by CMS for California) if they have a quality of care issue. The receiving hospital must deliver the Important Message from Medicare again according to the procedures in this rule.

A "follow up" copy of the signed IM must be delivered to the enrollee prior to discharge using the following guidelines:

- **Delivery Timeframe:** Hospitals must deliver the follow up copy as far in advance of discharge as possible, but **not less** than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely within 1- 2 calendar days, hospitals should make arrangements to deliver the follow up copy of the notice, so that the enrollee has a meaningful opportunity to act on it. However, when discharge cannot be predicted in advance, the follow up copy may be delivered as late

as the day of discharge, if necessary. If the follow-up copy of the notice must be delivered on the day of discharge, hospitals must give enrollees who need it at least 4 hours to consider their right to request a QIO review.

- L.A. Care's Cal MediConnect members have a right to request an immediate review by the QIO when L.A. Care Cal MediConnect and the hospital (acting directly or through its utilization review committee), with physician concurrence, determine that inpatient care is no longer necessary.

- **Members Submitting a Request:** An L.A. Care Cal MediConnect member who chooses to exercise the right to an immediate review must submit a request to QIO (HSAG in California) as indicated on the IM notice. In order to be considered timely, **the request must be made no later than midnight of the day of *discharge***, may be in writing or by telephone, and must be requested before the enrollee leaves the hospital. The member, upon request by HSAG, should be available to discuss the case. The member may, but is not required to, submit written evidence to be considered by HSAG.

- **Timely Requests:** When the member makes a timely request for a QIO review – that is, requests a review no later than midnight of the day of discharge – the member is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the member receives notification of the determination from HSAG. Liability for further inpatient hospital services depends on HSAG decision as follows:

Unfavorable determination: If QIO notifies the member that they did not agree with the member, liability for continued services begins at noon of the day after QIO notifies the enrollee that HSAG agreed with the hospital's discharge determination, or as otherwise determined by HSAG.

Fully and/or Partially Favorable determination: If QIO notifies the enrollee that they agreed with the member, the member is not financially responsible for continued care (other than applicable coinsurance and deductibles) until L.A. Care Cal MediConnect and hospital once again determine that the member no longer requires inpatient care, secure the concurrence of the physician responsible for the enrollee's care, and the hospital notifies the member with a follow up copy of the IM.

L.A. Care Cal MediConnect **or its Delegates to Provide the Detailed Notice of Discharge:** When QIO notifies L.A. Care Cal MediConnect that a member has requested an immediate review, the plan must, directly or by delegation, deliver a

Detailed Notice of Discharge (the Detailed Notice) to the member with a copy to HSAG as soon as possible but not later than noon of the day after HSAG's notification. L.A. Care Cal MediConnect is responsible for ensuring proper execution and delivery of the Detailed Notice, regardless of whether it has delegated that responsibility to its providers. **If a member requests more detailed information prior to requesting a review**, plans may, directly or by delegation, deliver the detailed notice in advance of the member requesting a review.

Use of Standardized Notice: L.A. Care Cal MediConnect uses the standardized form {(CMS-10066). This notice is also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Plans may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice. The Detailed Notice must be the standardized notice provided by CMS and contain the following:

- A detailed explanation of why services are either no longer reasonable and necessary, or are otherwise no longer covered.
- A description of any applicable Medicare coverage rule, instruction, or other policy, including information about how the enrollee may obtain a copy of the policy.
- Any applicable Medicare health plan policy, contract provision, or rationale on which the discharge determination was based.
- 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 enrollee's case.
- Any other information required by CMS.

Providing Information to QIO: Upon notification by QIO of the member's request for an immediate review, L.A. Care Cal MediConnect and hospital must supply all information that QIO needs to make its determination, including copies of both the IM and the Detailed Notices, as soon as possible, but **no later than noon of the day after QIO notifies the L.A. Care** Cal MediConnect **and /or hospital of the request**. In response to a request from L.A. Care Cal MediConnect, the hospital must supply all information that QIO needs to make its determination, including copies of both the IM and the Detailed Notices (if applicable) as soon as possible, but no later than close of business of the day the plan notifies the hospital of the request for information. At the discretion of QIO, L.A. Care Cal MediConnect and the hospital may make the information available by telephone or in writing. A written record of any information not transmitted in writing should be sent as soon as possible.

Coverage during QIO's expedited review: L.A. Care Cal MediConnect is financially responsible for coverage of services during QIO's review as provided

for in these rules, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

Reconsiderations

An enrollee who is dissatisfied with QIO's determination can request a reconsideration from QIO in accordance with CMS regulation 42 § 422.626(f).

- **Submitting a Request**: If QIO upholds L.A. Care's Cal MediConnect discharge decision in whole or in part, the enrollee may request, no later than 60 days after notification, that QIO has upheld the decision that QIO reconsider its original decision.

- **Note:** If the enrollee is no longer an inpatient in the hospital and is dissatisfied with QIO's determination, the enrollee may appeal directly to an **Administrative Law Judge** (**ALJ), the Medicare Advisory Council (MAC), or a federal court.**

5.18 Standard Reconsideration of Organization Determination (Appeals)

Any party who is dissatisfied with an L.A. Care Cal MediConnect or delegate Medicare organizational determination (adverse, fully favorable or partially favorable) or a Medi-Cal UM decision (denial or modification) or with one that has been reopened and revised may request reconsideration (Medicare) or an appeal (Medi-Cal) of the determination in accordance with the procedures as outlined in CMS regulations 42CFR422.582, concerning a request for reconsideration, or 42CFR422.584, concerning certain expedited reconsiderations or California DMHC regulation / DHCS requirements.

Members have the right to appeal decisions regarding their health care if that they do not agree with:

- Payment for emergency services, post-stabilization care, or urgently needed services
- Renal dialysis services out-of-area
- Payment for any other health services furnished by a Non-Contracting Physician Group or facility the enrollee believes are covered under Medicare or Medi-Cal, or should have been arranged for, furnished, or reimbursed by L.A. Care Cal MediConnect
- Services not received, but which the enrollee feels L.A. Care Cal MediConnect is responsible to pay for or arrange
- Discontinuation of services that the enrollee believes are still medically necessary covered services

L.A. Care Cal MediConnect members will file reconsiderations of organization determinations with L.A. Care's Grievance and Appeals Unit. All reconsiderations must be filed within 60 calendar days of notification of the organization determination decision. If the request for reconsideration is filed beyond the sixty calendar (60) days from the date of the notice of the organization determination, a party to the organization re-determination request may file a request for ***good cause*** extension with L.A. Care Cal MediConnect.

L.A. Care Cal MediConnect designates someone other than the person involved in making the initial organization determination when reviewing a reconsideration. If the original denial was based on a lack of medical necessity, then the reconsideration is performed by a physician with expertise in the field of medicine that is appropriate for the services at issue. In cases involving emergency services, L.A. Care Cal MediConnect applies the prudent layperson standard when making the reconsideration determination.

Request for Payment reconsiderations: L.A. Care will resolve all reconsiderations regarding payment for services already received within 60 calendar days from the date of the request for reconsideration.

Request for Service Reconsiderations: L.A. Care Cal MediConnect will resolve all standard reconsiderations regarding medical care within 30 calendar days. However, if information is missing or if it is in the best interest of the member, L.A. Care Cal MediConnect may extend the timeframe by an additional 14 calendar days.

Favorable and/or Partially Favorable decision for member, payment request: If L.A. Care decides in favor of the member **with respect to payment** reconsideration, LA. Care Cal MediConnect must pay within 60 calendar days of receiving the appeal.

Unfavorable decision for member, payment request: If L.A. Care Cal MediConnect upholds an adverse payment determination; it will automatically forward the case to the independent review entity (Maximus) within 60 calendar days for cases involving payment decisions.

Favorable and/or Partially Favorable decision for member, service request: If L.A. Care Cal MediConnect decides in favor of the member with respect to a standard **reconsideration of medical care or service**, LA. Care Cal MediConnect must authorize or provide services within 30 calendar days of receiving the appeal.

Unfavorable decision for member service request: If L.A. Care Cal MediConnect upholds an adverse determination, L.A. Care Cal MediConnect

will automatically forward the case to the independent review entity (Maximus) within 30 calendar days for cases involving medical care

Reversal of L.A. Care's Cal MediConnect **Decision by IRE (Maximus):** If, on reconsideration of a request for service, L.A. Care's Cal MediConnect determination is reversed in whole or in part by the independent review entity contracted by CMS, L.A. Care Cal MediConnect will **authorize the service under dispute within 72 hours from the date it receives notice reversing the determination**, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but **no later than fourteen (14) calendar days from that date**. L.A. Care's Cal MediConnect Medical Management Department will inform the independent review entity contracted by CMS that the organization has effectuated the decision.

- **If decision is upheld by the IRE, then** the enrollee may appeal directly to an **Administrative Law Judge** (**ALJ), the Medicare Advisory Council (MAC), a federal court, or to an authority designated in the Member Appeal Procedure -- Medi-Cal described previously.**

Expedited Reconsideration of an Organization Determination:

L.A. Care Cal MediConnect will resolve all expedited reconsiderations within 72 hours, or sooner based upon the health condition of the member. LA. Care Cal MediConnect may extend the timeframe for an additional 14 days if information is missing or if it is in the best interest of the member. If L.A. Care Cal MediConnect decides in favor of the member, L.A. Care Cal MediConnect must authorize or provide care within 72 hours of receiving the expedited appeal. If L.A. Care Cal MediConnect upholds an adverse determination, L.A. Care Cal MediConnect will automatically forward the case to the independent review entity within 24 hours for review.

Expedited Grievance:

A member may file an expedited grievance under the following circumstances:

- L.A. Care Cal MediConnect or the delegated PPG extends the time frame to make an organization determination or reconsideration; or

- A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration;

L.A. Care Cal MediConnect or the delegated PPG must respond within 24 hours to an enrollee's expedited grievance. L.A. Care Cal MediConnect or the delegated PPG communicates with the member about the right to file an expedited grievance using a CMS model notice.

5.19 Special Considerations Regarding Termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

A termination of service is the discharge of a Member from Covered Services, or discontinuation of Covered Services, when the Member has been authorized by L.A. Care Cal MediConnect to receive an ongoing course of treatment from that Provider. For purposes of this Section, "Member" will also encompass "or Member's representative," as applicable.

1) The "Notice of Medicare Non-Coverage" (NOMNC) will be issued by L.A. Care Cal MediConnect or it Delegates when:
   a) A Member is being discharged from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services;
   b) The Plan has made a determination that Covered Services are no longer covered or necessary. With respect to the exhaustion of Medicare Benefits (100 days for SNF), per CMS directive, the Notice of Denial of Medical Coverage (NDMC) should be used to convey this information, rather than the NOMNC. The QIO does not normally conduct Appeal reviews related to the exhaustion of Benefits, therefore, these Appeals will be handled by the Plan; or
   c) A determination that such Covered Services are no longer Medically Necessary.

Delivery of Notice: In accordance with Medicare Valid Delivery requirements, the Plan, in collaboration with the Provider, issues the NOMNC that notifies the Member of the termination of Covered Services or discharge, no later than **two calendar days or at the next to last visit**, if the span of time between service visits exceeds two days, before the proposed end of Covered Services. If the Member disagrees with the termination of services/discharge,

1) The Member must contact the QIO, verbally or in writing, no later than noon of the day before the Covered Services are to end. At the same time the Provider entity or delegated PPG will notify L.A. Care Cal MediConnect of the NOMNC issued to the Member. L.A. Care Cal MediConnect will track issuance and follow-up all NOMNC's from delegated PPGs or Provider entities.

2) If the Member disagrees with the NOMNC and requests an Appeal, L.A. Care Cal MediConnect will prepare the Detailed Explanation of Non-Coverage

(DENC) for the Provider to issue to the Member. If the Member requests an Appeal with the QIO, L.A. Care Cal MediConnect will process as follows:

a) Plan must obtain the Member's medical records from the Provider and send a copy of the DENC, along with the Member's medical records, to the QIO by close of business on the day of the QIO submitted to Plan appeal notification. The Plan may request that the records be sent directly to the QIO.
b) The QIO must make a decision and notify the Member and the Plan by close of business the following day. On the next business day, the Plan will notify the delegated PPG of the fast-track Appeal request and the QIO's determination. If the QIO overturns the decision then the PPG or L.A. Care Cal MediConnect shall continue authorization to the Group Provider. The delegated PPG must provide the Plan with proof of continued authorization and prepare and issue a new NOMNC notice when new discharge orders are written. If the Member fails to file a timely Appeal with the QIO, the Member may request an expedited Appeal from the Plan based on CMS regulation [42 CFR 422.624; 42 CFR 422.626]

5.20 Second Opinion Process

The second opinion program provides members and providers with the ability to validate the need for specific procedures. The use of screening criteria will be employed in addition to securing a second physician consult, when necessary. Second opinions will be rendered by an appropriately qualified health care professional identified as a primary care physician or a specialist who is acting within his or her scope of practice, and who possesses clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Second opinion request will be processed in accordance with the state regulatory requirements at no cost to the member.

5.21 STANDING REFERRALS

A standing referral is a referral made by the PCP for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis. A member may request a standing referral to a specialist through his/her PCP or through a participating specialist.

L.A. Care Cal MediConnect maintains a referral management process and also delegates the referral management process to delegated entities.

Delegated entities shall maintain policies and procedures for the referral management that include review of standing referrals for members who require specialty care or treatment for a medical condition or disease that is life threatening, degenerative, or disabling.

Authorization and Referral Processes

- Authorization determinations for specialty referral/services shall be processed in accordance with L.A. Care Cal MediConnect's and/or its delegated entities policies and procedures for referral management and within required time frames for standing referrals as described in this procedure.
- Services shall be authorized as medically necessary for proposed treatment identified as part of the member's care treatment plan utilizing established criteria and consistent with benefit coverage.
- Once a determination is made, the referral shall be made to the Specialist within four (4) business days of the date the proposed treatment plan, if any, is submitted to the physician reviewer.
- The duration of a standing referral authorization shall not exceed one year at a time, but may be renewed for periods up to one year if medically appropriate.

Credentialing Requirements

The specialist provider/special care center shall be recredentialed by and contracted with L.A. Care Cal MediConnect or its delegated entities' network to provide the needed services or:

- If standing referrals are made to providers who are not contracted with L.A. Care Cal MediConnect or it delegated entities' network, L.A. Care Cal MediConnect and/or its delegated entities shall make arrangements with that provider for credentialing prior to service, appropriate care coordination, and timely and appropriate reimbursement.
- In approving a standing referral in-network or out-of-network, L.A. Care Cal MediConnect and PPGs delegated for UM will take into account the ability of the member to travel to the provider.
- Delegated entities can request assistance from L.A. Care Cal MediConnect for locating a specialist (See Specialty Care Liaison Program Procedure).

HIV/AIDS Referrals

When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, L.A. Care Cal MediConnect and/or its delegated entities shall refer the member to an HIV/AIDS specialist.

- When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the member's health care who is infected with HIV, L.A. Care Cal MediConnect and/or its delegated entities shall refer the member to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician if:
  - the nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
  - the nurse practitioner or physician meets the qualifications specified in the state regulations; and
  - the nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient

Care Coordination:

The PCP shall retain responsibility for basic case management/coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the delegated entities contract with L.A. Care Cal MediConnect.

Requests for standing referrals will be processed in accordance with the state regulatory requirements.

5.22 INITIAL and PERIODIC HEALTH ASSESSMENTS (IHA)

Delegated providers shall have processes in place to ensure the provision of an IHA (complete history and physical examination) to each **new** Cal MediConnect member within the first six months of the effective date of enrollment. This is a one -time preventive physician exam. The one-time exam includes a thorough review of:

- Health issues
- Health education
- Preventive services

L.A. Care Cal MediConnect shall provide lists of new member Enrollees to the delegated PPGs/PCPs on a monthly basis. L.A. Care Cal MediConnect and its Delegated providers shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented.

- Documented attempts that demonstrate unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.
- For follow-up on missed and broken appointment documentation requirements see *Section: Coordination of Medically Necessary Services*

L.A. Care Cal MediConnect and its delegated PPGs are responsible for maintaining and disseminating to its Provider Network, protocols and High Risk Categories by age groupings based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) and Center for Medicare and Medicaid Services (CMS) for use in determining the provision of clinical preventive services.

Delegated providers shall ensure that the performance of the initial complete history and physician exam for adults includes, but is not limited to:

- Blood pressure.
- Height and weight.
- Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
- Clinical breast examination for women over 40;
- Screening mammogram for women age 40 and over, baseline mammograms for women between ages 35-39
- Pap smear (or arrangements made for performance) on all women determined to be sexually active or be at high risk for vaginal or cervical cancer,
- Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for Chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
- A series of 3 Human Papillomavirus (HPV) shots for all adolescent girls, preferably at age 11-12 years, to prevent cervical cancer and genital warts. The vaccine is also recommended for girls and women 13-26 years of age who did not receive it when they were younger.
- Screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
- Colon cancer screening for members over 50 years of age (fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy or barium enema); there is no minimal age for a screening colonoscopy
- Prostate Cancer Screening for men over 50 years
- Bone Mass Measurements for members at risk for osteoporosis
- Diabetes screening
- Glaucoma screening for members at high risk for glaucoma

Cal MediConnect members are eligible to receive via direct access (self-referral) flu and pneumococcal vaccinations at no cost to the member. Female members also have the option of obtaining direct access to a women's health specialist for women's routine and preventive health services.

The IHA must include documentation that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures that they may take to promote their own health

High risk individuals are defined as individuals whose family history and/or life-style indicates a high tendency towards disease, or who belong to a group (socioeconomic, cultural, or otherwise) which exhibits a higher tendency toward a disease.

Each provider, supplier and practitioner furnishing services to members shall maintain an enrollee health record in accordance with L.A. Care Cal MediConnect policy and applicable Medicare and Medi-Cal standards, taking into account professional standards. These standards should ensure the appropriate and confidential exchange of information among provider network components.

Adult Preventive Services

Delegated Providers shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members.

Delegated Providers shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, health adult Members {age twenty-one (21) and older}.

As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services.

In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall b provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

Delegated Providers shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the finding or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. Delegated Providers shall ensure that these services are initiated as soon as possible but no later than 60 days following discovery of a problem requiring follow up

Immunizations for Adults

Delegated Providers are responsible for ensuring all adults are fully immunized and shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

In addition, Delegated providers shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the finding of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

5.23 COMPREHENSIVE HEALTH RISK ASSESSMENT

Comprehensive Health Risk Assessments

The HRA is an essential component of the care management process.. L.A. Care will maintain an assessment process to:

- Assess each new enrollee's risk level and needs based on an interactive process such as telephonic, web-based or in-person communication with the member
- Address the care needs and coordinate the Medicare and Medical benefits across all settings
- Review historical Medicare and Medicaid utilization data
- Follow timeframes for reassessment

The HRA is a standardized self-reported screening tool conducted with each member upon enrollment. The HRA is administered by non-clinical staff members, who conduct telephone interviews with members or caregivers and make follow-up phone calls, when needed, to clarify any questions from previous calls. When staff are unable to reach a member, a written form is mailed with a self-addressed stamped envelope for completion by the member. A follow up call is made to the member to confirm receipt of the mailing.

L.A. Care will incorporate the following four steps to identify members' needs during the Health Risk Assessment and care planning process:

- **Step One: Stratify**. Members are identified and referred for care management interventions by utilization data, self-referral, referral by a provider, caregiver, disease management program, etc. Predictive modeling programs are being utilized to stratify and prioritize members for care management interventions. These programs use an algorithm to examine ER and hospital utilization, pharmacy utilization, and diagnosis codes to determine who is at greatest immediate risk. The effectiveness of these processes is dependent upon the receipt of complete and accurate claims records as early as possible, preferably prior to enrollment.

  On a monthly basis, L.A. Care uses claims to stratify members into risk categories and prioritize those who may need intervention and support soonest. The 12 months of paid fee for- service claims (both Medi-Cal and Medicare) will be incorporated into the predictive modeling process to stratify members into risk categories and prioritize those most vulnerable during the transition.

Health Risk Assessments are administered within 90 days of enrollment for the Special Needs Population (SNP). For Cal MediConnect members, the HRA is administered within 45 days for those initially stratified as high risk and within 90 days for those initially stratified as low. Initial stratification is based on claims and encounter data received from DHCS and CMS.

- **Step Two: Assessments and Care Planning.** Care Managers use the HRA information begin the comprehensive assessment phase process in the care planning process. The Care Manager shares the assessment information and initial care planning with the Interdisciplinary Care Team (ICT) to further develop the members' Interdisciplinary Care Plan (ICP).The HRA will be integrated into the care management process and will be performed in the most appropriate setting and format. For example, an assessment might be completed at the member's home, in a provider's office, at a CBAS site, or telephonically, whichever will produce the highest quality, most effective result. The tool will draw on national, standardized assessment tools and best practices for determining risk levels. Some members are assessed frequently through various County agency program such DPSS for IHSS hours annually, by CBAS provider sites, by MSSP providers, by physicians, by social workers at other agencies providing care and service. The multiple tools used are often duplicative and beneficiaries are subjected to repetitive and time consuming processes. L.A. Care is collaborating with L.A. County agencies to standardize the assessment tools and centralize the information in a secured shared repository to streamline the process overall.

  Care Managers develop the initial person-centered plan of care from information provided by the member and/or the member's family member, caregiver or representative through the HRA, quality of life assessment and follow-up telephone calls. Assessments may be completed in multiple visits with the factors of care management criteria addressed. Components of the assessment may be completed by other members of the care team and with the assistance of the member's family member or caregiver. Home visits may be conducted as needed to reach isolated members and assess social and environmental needs. Visits may also be made to the homes of persons who live in group homes, supported apartments, assisted living and other residential settings, to get a thorough assessment of the supports provided in those settings, and to meet staff who are important to members.

  Care Plans are self-directed and developed in collaboration with an ICT, providers and designated providers as deemed appropriate by the identified needs or members request. The care plan includes a schedule for follow-up that includes, but is not limited to, counseling, disease management referrals, education and self-management support. Follow-up activities include specific dates on which the care managers will follow up with the member. The care plan includes an assessment of the member's progress toward overcoming barriers to care and meeting goals. The care management and coordination

process includes reassessing and adjusting the care plan and its goals as needed. The care plan is updated whenever there is a change in the member's major goals, level of health, formal or informal supports, or major life change, such as the death of a spouse or caregiver.

- **Step Three: Connect.** Care Managers are responsible for referring and connecting members to the intervention and supports that match their identified needs. For LTSS, this will often involve making referrals to County offices. L.A. Care is collaborating with various County agencies to develop communication protocols to ensure that referrals are streamlined to avoid overwhelming county capacity, and to receive information back from the County for purposes of monitoring the plan of care.

- **Step Four: Re-assess.** Re-assessment will be conducted periodically, based on needs and risk profile, but at least annually or when an event such as a fall or hospital admission warrants a re-assessment. Assessment tools and processes will be reviewed periodically to ensure they are responsive to changes in the health care and social service landscape, and that they incorporate new evidence-based guidelines.

L.A. Care supports self-direction of LTSS when a member wishes to self-direct and can meet the responsibilities associated with self-direction. When certain LTSS needs are identified, including the need for personal care and homemaker services, development of the person-centered plan of care will include discussion of self-directed service options, including the IHSS program. When applicable, self-directed services will be included in the plan of care.

The HRA tool is automatically scored and a preliminary risk assessment profile is generated based on the responses. Based upon the HRA score, members are assigned to L.A. Care's Cal MediConnect appropriate care management program. Through this process, members are prioritized for additional assessments by a Care Manager or contracted assessment entity as needed.

The Care Manager is responsible for the initial review and analysis of the HRA prior to communication with the member and the member's caregiver. Caregivers may be designated to communicate with the Care Managers and ICT on behalf of members. Staff will obtain consent from the member to communicate protective health information to caregivers by legal documentation or by completing a L.A. Care Authorization Representation form. The Authorization Representation form will be kept on record in the member's secured information system. The initial comprehensive HRA is completed within the first 90 days of enrollment and an annual reassessment of the HRA is completed within 12 months of the last HRA or more frequently based on the needs of the member or change in member's health status.

HRA screening questions are included to assess members for substance abuse issues or conditions. The responses to the questions trigger staff responsible for

care planning to further screen and provide members with health education information or information on self-referral program and services specific to their needs. The HRA identifies Medical, psychosocial, functional needs and cognitive needs, documents Medical and mental health history, etc. The health risk assessment screens for:

1. Health status, chronic health conditions/health care needs
2. Clinical history
3. Mental health and cognitive status activities of daily living (ADLs)/Instrumental activities of daily living (IADLs)Depression
4. Medication review
5. Cultural and linguistic needs, preferences or limitations
6. Evaluate visual and health needs, preferences or limitations
7. Quality of Life
8. Life planning activities
9. Caregiver support
10. Available benefits
11. Continuity of care needs
12. Fall prevention
13. Long Term Services and Supports, including HCBS

Communicating the Health Risk Assessment & Stratification Results to the ICT, Provider, & Member

Results of the HRA are shared with the various stakeholders. The HRA and stratification results are stored securely on the L.A. Care Information System. Prior to the ICT discussion, the Care Manager will identify members due for a ICT planning discussion. During each discussion the HRA results are viewed by the team electronically via secured access which is password protected. Members of the ICT participating in the planning discussion but who do not have direct access to the secured information , such as the member or caregiver, will receive a hardcopy document prior to the meeting via a encrypted electronic notification or certified mailing of the health risk assessment and proposed care plan prior to the meeting.

To summarize, the care planning/care coordination process uses a person-centered approach by including:

- Health care needs assessment and quality of life assessment that include information received from the member or the member's representatives;
- Individualized goals set with input from the member, care manager, participating physician(s), ICT, and family, friends or caregivers, as appropriate;
- Assessment of the care setting (including home) appropriate to goals, and the education and training, and community supports required to achieve the desired level of functioning/independence;

- Home visits to fully assess the member's social and environmental needs;
- Educational and other supports necessary to reach self-management goals;
- The broad range of services and supports needed to keep people out of institutional settings whenever possible, including rehabilitation, home health, home care, DME, nutritional support, psychosocial support, financial support, legal interventions and other supports; and
- Problem identification that is specific to the member's individual needs, preferences and circumstances.

5.24 COORDINATION OF MEDICALLY NECESSARY SERVICES

The PCP is responsible for providing members with routine medical care and serve as the medical case manager within each managed care system. Referrals are made when services are medically necessary, outside the PCP's scope of practice, or when members are unresponsive to treatments, develop complications, or specialty services are needed. The PCP is responsible for making referrals and coordinating all medically necessary services required by the member. Pertinent summaries of the member's record should be transferred to the specialist by the PCP. Authorization flow charts are provided at the end of this section.

In the event that a member requests a change of provider, L.A. Care Cal MediConnect collaborates with the member to find a provider in the network who meets the needs of the member, such as language preferences and proximity to the member's home, etc. With the member's permission, the member's individualized Care Plan is shared with the new PCP by L.A. Care's case manager. The care plan will include a member's medical, psychosocial and medication information.

Outpatient Referral

If the PCP determines that a member requires specialty services or examinations outside of the standard primary care, the provider must request for these services to be performed by appropriate contracted providers. The provider must ensure the following steps in coordinating such referrals:

1. Submit a referral request to the PPG or the designated hospital physician to obtain authorization for those services.

2. The PPG will process the request, or contact the L.A. Care Cal MediConnect UM department to obtain authorization for the facility component of services needed, as appropriate.

3. After obtaining the authorization(s), PCP will refer the member to the appropriate specialist or facility. The PCP, office staff, or member may arrange the referral appointment.

    - Note the referral in the member's medical record and attach any authorization paperwork.

    - Discuss the case with the member and the referral provider.

    - Receive reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider, or facility the member was referred to.)

    - Discuss the results of the referral and any plan for further treatment, if needed, and care coordination with the member.

      Specialty referrals that require prior authorization must be tracked by the PCP's office and authorizing PPG for follow-up through a tickler file, log or computerized tracking system. The log or tracking mechanism should note, at a minimum, the following for each referral:
        - Member name and identification number
        - Diagnosis
        - Date of authorization request
        - Date of authorization
        - Date of appointment
        - Date consult report received

Missed or Broken Appointments

Appointments may be missed due to member cancellation or no show. Providers are required to attempt to contact the member a minimum of three times when an appointment is missed or broken. Attempts to contact must include:

- **First Attempt** – phone call to member (or written letter if no telephone). If member does not respond, then;
- **Second Attempt** – phone call to member (or written letter if no telephone). If member does not respond then;
- **Third Attempt** – written letter

Pregnant member with two or more missed/broken appointments must be referred to the L.A. Care Cal MediConnect UM Care Manager for follow-up after the broken appointment procedure is completed without response from the members.

Documentation must be noted in the member's medical record regarding any missed or broken appointments, reschedule dates, and attempts to contact.

Missed and Broken Procedure or Laboratory Test

Appointments for procedures or tests may be missed or broken. The provider must contact the member by phone or letter to reschedule. Documentation must be noted in the medical record regarding any missed or broken procedure or tests, reschedule dates, and any attempts to contact the member.

Receipt of Specialist's Report

The PCP must ensure timely receipt of the specialist's report (e.g., use of tickler file). Specialists are required to submit a written report to the referring physician. This written report must include the specialist's findings, recommended treatment, results of any studies, test and procedures and recommendations for continued care.

Reports for specialty consultations or procedures should be in the member's chart within a given timeframe, usually two (2) weeks. For urgent and emergent cases, the specialist should initiate a telephone report to the PCP as soon as possible, and a written report should be received within two (2) weeks.

If the PCP has not received the specialist's report within the determined timeframe, the PCP should contact the specialist to obtain the report.

Unusual Specialty Services

L.A. Care Cal MediConnect and its delegated PPGs/PCP must arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within network, when determined Medically Necessary.

Services Received in an Alternative Care Setting

The PCP should receive a report with findings, recommended treatment and results of the treatment for services performed outside of the PCPs office. The provider must also receive emergency department reports and hospital discharge summaries and other information documenting services provided.

Home health care agencies submit treatment plans to the PCP after an authorized evaluation visit and every 30 days afterward for review of continued home care and authorization.

The PCP should also receive reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action**.**

5.25 CARE TRANSITIONS

L.A. Care's Cal MediConnect Medical Management Department and its delegate is responsible for management of the process for care transitions and makes a special effort to coordinate care when members move from one care setting to another, such as when they are discharged from a hospital.

Transitions are the movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of exacerbation of a chronic condition or moving from a hospital to a rehab facility after surgery.

Managing Transitions: L.A. Care's Cal MediConnect Care Managers facilitate safe transitions by either conducting or assigning providers the following tasks and monitoring system performance:

- For planned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting, identifying that a planned transition is going to happen

- For planned and unplanned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting, sharing the sending setting's care plan with the receiving setting within one business day of notification of the transition

- For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process

- For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about changes to the member's health status and plan of care

- For planned and unplanned transitions from any setting to any other setting, providing each member who experiences a transition with a consistent person or unit within L.A. Care's Cal MediConnect Medical Management department who is responsible for supporting the member through transitions between any points in the system

- For planned and unplanned transitions from any setting to any other setting, notifying the patient's usual practitioner of the transition

- For all transitions, L.A. Care Cal MediConnect Medical Management Department shall conduct an analysis of L.A. Care's Cal MediConnect aggregate performance on the above aspects of managing transitions at least annually

Coordinating Services for members at high risk for transition

L.A. Care Cal MediConnect handles coordination of care through either the Case Management or UM staff. To streamline the transition of case management activities, particularly around behavioral health, Cal MediConnect has hand-off processes for delegated and contracted agencies. When a member issues is identified (either medical or behavioral), clinical case managers determine if the member already has an established case manager with a contracted provider, or in the community and collaborates to get the member needed care. If the issue is urgent and a case manager cannot be identified in a reasonable time to prevent jeopardizing member safety, the Cal MediConnect case managers will address the member needs until a hand-off is appropriate.

L.A. Care Cal MediConnect works with members (or their responsible parties) and with their primary care physicians or providers to stabilize the member's conditions and to manage care in the least restrictive setting. Examples of coordinating care include:

- Contacting at risk member or responsible party, determining whether home health care would prevent a hospital admission and ordering the service as necessary.
- Contacting the member's treating physician to alert him/her about the potential for adverse drug events based on pharmacy claims review.
- Intervening to help member receive the necessary monitoring for blood-thinning medications as an example.

Educating members or responsible parties about transitions and how to prevent unplanned transitions:

As part of the identifying and coordinating care to prevent potential problems, L.A. Care's Cal MediConnect UM/Case Management staff educates at risk members or responsible parties about how to maintain health and remain in the least restrictive setting. L.A. Care Cal MediConnect contacts all members at least annually regardless of whether or not they are at risk, with information about potential problems and how to avoid them.

5.26 CERVICAL CANCER SCREENING

L.A. Care Cal MediConnect and/or its delegated providers shall have procedures to provide for Cervical Cancer Screening, a covered preventive health benefit for L.A. Care Cal MediConnect members.

The coverage for an annual Cervical Cancer Screening test shall include the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the Federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration, upon the referral of the member's health care provider (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care

to the member and operating within the scope of practice otherwise permitted for the licensee).

L.A. Care Cal MediConnect and/or its delegated entities shall ensure that routine referral processes are followed when the member, in addition to the conventional Pap test, requests a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

5.27 CARE MANAGEMENT

L.A. Care Cal MediConnect ***does not delegate complex case management to the PPGs.***

Case Management means a collaborative process of managing the provision of health care to enrollees with selected conditions, (e.g., chronic, catastrophic, high cost cases, etc.). The goal is to coordinate the care to promote both quality and continuity of care.

Case management is divided into three components:

- Basic medical case management,
- Complex Care Management
- Targeted Case Management

In day-to-day operations, these three components work closely together to provide members with continuous, coordinated, quality healthcare. L.A. Care Cal MediConnect recognizes the importance of continuous and coordinated health care as a key element to achieving high quality, cost effective care.

Basic Medical Case Management Services means services provided by a Primary Care Provider to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for L.A. Care Cal MediConnect enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

The Primary Care Physician (PCP) has the principal role as the basic Medical Case Manager for his/her assigned members. The PCP conducts the Initial Health Assessment, provides all basic medical care/case management to assigned members, and coordinates referrals to specialists, ancillary services and linked services as needed.

L.A. Care Cal MediConnect also recognizes that some members have complex needs that require more than usual coordination of services and therefore provides the targeted or complex nursing case management in assistance to the

PCP's basic care/case management. Members with more complex needs are actively enrolled into the care management program.

L.A. Care's Care Management Program uses an interdisciplinary collaborative team approach comprised of contracted and employed staff who are responsible for providing patient care management and education through professionally knowledgeable, licensed, and when applicable, credentialed professionals in collaboration with the PCP and community and state specific resources. Participants of the ICT are selected based on the needs of the populations, such as clinicians with experience in managing the geriatric population as well as managing chronic health conditions, support administrative roles serving vulnerable disadvantaged populations, licensed behavioral health practitioners and staff with expertise in Medicare and Medicaid operations. To support the specific care coordination needs of member receiving behavioral health or accessing services through an LTSS program, ICTs specific to those programs will be developed and staffed using a multidisciplinary approach described above. The Care Manager or assigned team member communicates with providers to share pertinent member health and health status information.

L.A. Care's Cal MediConnect Care Management Program includes four levels:

- Basic Care Management
- Complex Care Management
- Targeted Care Management
- Care Coordination

Basic Care Management

The Primary Care Physician (PCP) is responsible for Basic Care Management for his/her assigned members. The PCP is responsible for ensuring that members receive an initial screening and health assessment, which initiates Basic Medical Care Management

The PCP is required to conduct the initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and carved out services, as needed, based on the member's individual treatment plan.

Follow up calls are made within five calendar days by a member of the care management team (i.e. Care Manager, Social Worker, Care Coordinator or Transition of Care Nurse) to ensure members have been linked to the appropriate service and service provider. Identified services and member health care outcomes are shared with the ICT team and the PCP during the ICT planning discussion. Any changes to the care plan are communicated to the ICT and PCP either in writing or telephonically. Members are in also informed and encouraged to discuss the changes with the PCP during the next scheduled visit.

For services or care needs triaged as urgent or emergent c (i.e. home safety assessments, medication reconciliation, home oxygen requirements, continuity of care with out-of-network providers, etc) but are identified prior to or after the formalized ICT discussions, the Care Manager will coordinate services directly with the PCP or the L.A. Care Medical Director within one business day of identification. Outcomes of the identified services are incorporated into the member's care plan

Complex Care Management

Complex Care Management is provided for members with extensive utilization of medical services or those having chronic or immediate medical needs requiring more management than is normally provided through the Basic Care Management. Complex Care Management is a collaborative process between the Primary Care Provider and a RN Care Manager who provides assistance in planning, coordinating, and monitoring options and services to meet the Member's health care needs.

The program incorporates the dynamic processes of individualized screening, assessment, problem identification, care planning, intervention, monitoring and evaluation. The Care Management Program uses an interdisciplinary collaborative team approach comprised of patient care management and education through experienced licensed professionals in collaboration with the Primary Care Physician and community and state specific resources. The team consists of Medical Directors, Registered Nurse Care Managers, Nurse Practitioners, Clinical Pharmacists, social workers and non-clinical support staff Coordinators.

The team works closely with contracted practitioners and agencies in the identification, assessment and implementation of appropriate health care management interventions for eligible children and adults with special health care needs, including the provision of care coordination for specialty and state waiver programs.

L.A. Care's Cal MediConnect Care Management team is responsible for working collaboratively with all members of the health care team including the PCP, hospital discharge planners, specialty practitioners, ancillary practitioners, community and state resource staff. The Care Managers, in concert with the health care team, focus on coordinating care and services for members whose needs include preventive services, ongoing medical care, rehabilitation services, home health and hospice care, and/or require extensive coordination of services related to linked and carved out services or the coordination and/or transfer of care when "carved-out" services are denied.

Care Managers assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs of these members across the continuum. The essential functions of the Care Manager include:

- Assessment
- Care Planning
- Interventions
- Coordination and Implementation
- Monitoring/Evaluation
- Facilitation
- Advocacy

Through interaction with members, significant others and health care providers, the care manager collects and analyzes data about the actual and potential care needs for the purpose of developing individualized care plans.

Care Management, Care Coordination, Individualized Care Planning and Interdisciplinary Care Team

PPG's Responsibilities

Health Risk Assessments (HRAs and the Preliminary Care Plans and a HRA Summary Report can be accessed via L.A. Care's Provider Portal . The completed initial and annual HRAs and Preliminary Care Plans for all risk levels (High, Moderate, and Low) are made available to the PPGs and PCPs on the Provider Portal on a weekly basis. The PPG is responsible to download the HRAs and Preliminary Care Plans for the Moderate and Low Risk level members, assign PPG Care Management staff to review the HRA data, assimilate additional data (ex. Claims, authorization activity) and outreach to the member to formulate a clinical, member-centric Individualized Care Plan (ICP). The ICP (See ICP section below) becomes the basis for further care management/care coordination activity at the PPG level.

The PPG is responsible to a process to share the documents with the contracted PCPs. The PCPs are responsible to review the HRA's, Preliminary Care Plan, sign the documents in acknowledgement of receipt/review and address key findings from the documents during member visits. The PPGs have the oversight responsibility of their contracted providers to ensure that the data provided has been reviewed and incorporated into the member's record.

If an initial or annual HRA has not been completed by the member, the PPG case management staff and PCP staff is responsible to encourage the member to complete the HRA and/or facilitate a warm transfer to the HRA vendor (**1-855-810-9724**) for completion.

Individualized Care Plan:

The PPG is responsible to use the initial and annual HRA information for Moderate and Low Risk members to further develop a clinical Individualized Care Plan and case management/care coordination follow-up plan. The care plan must include measurable goals and the timeframe for follow up with the member. The member and/or caregiver must be included in the development of the care planning activities and include the member's agreement with the care plan whenever possible. If the member and/or caregiver refuse to participate in the care planning process, documentation of the efforts to include the member and the member response must be reflected in the member record. The PPG is responsible to provide the member with a copy of the ICP per the members' preference (written, verbal) and document this activity in the member record.

The PPG case management staff is responsible to assess for the need for Interdisciplinary Care Team (ICT) members' inclusion in the development of the ICP, including L.A. Care's Care Management staff when appropriate (See ICT section below). Documentation in the PPG member care plan and record at the PPG level will demonstrate the ICT members' attendance and input into the plan of care.

The PPG is responsible to educate their contracted PCPs on the requirement to include ICT members in the Moderate and Low Risk member care planning process. Documentation of the ICT will be reflected in the PCP care plan (ex. Communication and plan with specialist).

The PPG is responsible to review the HRA, preliminary ICP and create an ICP using the information received in the documents for the Low Risk members. The PPG is responsible to ensure that the PCP reviews the HRA and ICP results, signs the documents and incorporates the documents in the member record.

The PPG is responsible to submit the PPG Care Plan for the Low and Moderate Risk members upon request and complete the Model of Care Reporting Tool and submit to L.A. Care on a monthly basis.

Timing of the ICP

The ICP will be reviewed and revised (at a minimum):

- At least annually
- Upon notification of change in member status

The ICP is reviewed during ICT meetings and in accordance with scheduled follow-up on member goals.

Update frequency may change in response to routine and non-routine reviews and revisions, including required updates when members are not meeting their ICP goals. The ICP should be developed within **30 days** of HRA

Developing Care Plan Goals

Prioritized goals consider the member/caregiver goals, preferences and desired level of involvement in the ICP. Goals should be "SMART" - **S**pecific, **M**easureable, **A**ctionable, **R**ealistic, **T**ime-bound. A full description of developing SMART goals is provided in L.A. Care policy UM 158 Complex Case Management.
Care Plans must document the identification and management of barriers to member goals:

- Understanding the member's condition and treatment
- Desire to participate in the case management plan
- Belief that their participating will improve their health
- Financial or transportation limitation that may hinder participating in care
- Mental and physical capacity

Care plans must also contain an assessment of goals and progress (documented as ongoing process). In addition to the member's self-reported outcomes and health data to assess if member goals are being met. This includes but is not limited to:

- Utilization data
- Preventive health outcomes
- HRAs (annual)
- Pharmacy data

Interdisciplinary Care Team:

The PPG is responsible to arrange an ICT meeting/discussion for all initial and annual HRA-defined Moderate Risk and Low Risk members and include vital members who will contribute the plan of care. The ICT meeting may be conducted in a formal meeting forum or in ad hoc forum (ex. Call to specialist to discuss plan), but must be documented in the member record as an "ICT meeting" and include the name and professional discipline/s invited to participate and the recommendations of the ICT members (example below). The ICT member recommendations are incorporated into the member ICP.

The PPG is responsible to conduct additional ICT meetings according to member change in health status, which may necessitate a re-stratification of risk level (ex.

change from Moderate to High risk). The PPG will include L.A. Care Health Plan Care Management staff in ICT meetings whenever necessary (ex. potential change in risk status or guidance in available Health Plan benefits).

The member's ICT should be comprised of appropriate staff to meet the needs identified during the care plan discussions. Composition of ICT based on identified needs (e.g., PCP, Specialist, PPG CM, and Social Worker). Member or Members designated representative should be invited to participate in the ICT as feasible. ICT lead team members are responsible for documenting the operation detail and communication (meeting dates-phone call and follow up).

ICT activities/outcome should be shared documentation (dissemination of ICT reports to all stakeholders).
At a minimum the ICT meeting minutes require:

- the date of meeting
- names and roles of attendees
- fact that Member or representative was invited
- topics discussed
- any revision to the care plan
- The documentation of care plan revision may be at a high level (e.g., "revised priority of goals", or "added goal for weight management"). The actual changes will be documented in the Care Plan.

How an ICT is assembled

ICT documentation can occur in several ways:

- **Informal:** Involving the Care Manager, member and single discipline (ex. PCP, Registered Dietician, Social Worker)
- **Formal:** Structured large meeting format with multiple disciplines prepared to contribute

Whether it is informal or formal, it is essential to document "ICT Convened". This documentation is based on the documented need for ICT (e.g. Review HRA results, multiple issues need coordination)
The Lead ICT member identifies members who need to participate (e.g. PCP, PPG CM) and is responsible for setting up meeting date, time, mode (ex. conference call) as well as sending invitations to all including member

EXAMPLE ICT DOCUMENTATION:

ICT convened for Mr. Smith on 3/23/14 at 1500.
ICT focus: Review Moderate Risk HRA/Preliminary Care Plan Results

1) Needs assistance with shopping
2) Needs food resources
3) Has 3 chronic conditions
4) Takes 5 or more medications daily ICT Members Include:

PPG CM_____-Lead/attended
L.A. Care CM_____-attended
Mr. Smith-declined invite to PCP_____-attended
L.A. Care LTSS staff _____-attended

Plan: L.A. Care LTSS staff will assist member with IHSS process and food resources. PPG CM will assist with referral to available disease management programs and provide medication reconciliation. PPG CM will call member to update on ICT plan, update care plan with follow up schedule and offer care plan to be mailed.

Care Coordination

L.A. Care's Cal MediConnect Care Management Program is a member advocacy program designed and administered to assure that the member's healthcare services are coordinated with a focus on continuity, quality and efficiency in order to produce optimal outcomes.

Care coordination by Care Managers or designated staff (i.e. UM Specialist, Care Coordinators) is provided for members needing assistance in coordinating their health care services. This service includes members who may have opted out of complex care management but have continuing coordination of health care needs.

These include, but are not limited to, members assigned to or receiving:

- Out of Area/Network services
- Hospital discharge follow up calls
- Non-emergency medical transportation

Identifying Members for Care Management

Although all members are actively enrolled in the care management program, the program also uses multiple data sources to identify members that are eligible for the program but no yet referred.

These include, but are not limited to, the following:

- Claims and Encounter Data

- Hospital Discharge Data
- Pharmacy Data, if applicable
- Data collected through the UM management process, if applicable
- Data supplied by purchasers, if applicable (such as claims data supplied by DHCS)
- Data supplied by members or caregivers (such as Initial health Risk Assessment)
- Data supplied by practitioners

Access to Complex Care Management

L.A. Care Health Plan retains the responsibility for case management and **does not** delegate complex case management to the PPGs.

The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The program incorporates the dynamic processes of individualized screening, assessment, problem identification, care planning, intervention, monitoring and evaluation. The Care Management Program uses an interdisciplinary collaborative team approach comprised of patient care management and education through experienced licensed professionals in collaboration with the Primary Care Physician and community and state specific resources. The team may be comprise of Medical Directors, RN Care Managers, Clinical Pharmacists, social workers and non-clinical support staff Coordinators, Primary or Specialty Care Providers and Behavioral Health Specialists.

The team works closely with contracted practitioners and agencies in the identification, assessment and implementation of appropriate health care management interventions for eligible children and adults with special health care needs, including the provision of care coordination for specialty and state waiver programs.

Complex Care Management is provided for members with extensive utilization of medical services or those having chronic or immediate medical needs requiring more management than is normally provided through the Basic Care Management. Complex Care Management is a collaborative process between the member, Primary Care Provider, an RN Care Manager and Interdisciplinary Care Team (ICT) who provides assistance in planning, coordinating, and monitoring options and services to meet the Member's health care needs.

L.A. Care's Care Management team is responsible for working collaboratively with all members of the health care team including the PCP, hospital discharge planners, specialty practitioners, ancillary providers, community and state resource staff. The Care Managers, in concert with the health care team, focus on coordinating care and services for members whose needs include preventive services, ongoing medical care, rehabilitation services, home health and hospice care, and/or require extensive coordination of services related to linked and carved out services or the coordination and/or transfer of care when "carved-out" services are denied.
Care Managers assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs of these members across the continuum. The essential functions of the Care Manager include:

- Assessment
- Care Planning
- Interventions
- Coordination and Implementation
- Monitoring/Evaluation
- Facilitation
- Advocacy

L.A. Care's Care Managers provide the care management activities for the complex and High Risk members which includes reviewing HRA results, completing the ICP with the member and ICT and organizing and leading the ICT. Communication with the PPG and PCP is an important component in the collaborative process and interdisciplinary approach.

Referrals to Complex Case Management

Members may be referred for complex case management by:

- Disease Management (DM) program referrals. Referrals are received from the DM program upon identification of complex needs according to specified CCM program criteria.
- Discharge planner referrals. Referrals to the CCM program may be made during the discharge planning process when real or potential complex needs are identified. These referrals may be made by hospital discharge planners or Social Workers involved in the discharge planning process.
- L.A. Care UM (UM Staff) referrals. Referrals to CCM are made by UM staff when complex needs are identified. This may occur during multidisciplinary conferences or during the concurrent review process.
- Member or caregiver referral. Members or caregivers are provided with materials containing instructions on how to self-refer and/or access Complex Care Management

- Practitioner referrals. Contracted Practitioners are provided information on how to refer for Complex Care Management. Referrals for case management or care coordination may be faxed to (213) 438-5034. A copy of the referral form can be found in Attachment C.
- Other referrals including, but not limited to:

    - L.A. Care Health Plan Medical Director Referrals
    - PPG Medical Director(s) referrals
    - External Service Partners referrals

Identifying Members for Care Management:
Multiple sources are used to identify members who may be a higher risk for adverse outcomes or transitions from their usual environment to needing a higher level of care. L.A. Care uses multiple data sources to identify members that are eligible for the program but no yet referred.
These data sources include, but are not limited to:

- Claims and Encounter Data
- Pharmacy Data
- Laboratory Data, when available
- Behavioral Health Joint Operations Report
- PPG Supplemental Reports
    - Catastrophic Medical Condition (e.g. Genetic conditions, Neoplasms, organ/tissue transplants, multiple trauma)
    - Chronic Illness (e.g. Asthma, Diabetes, Chronic Kidney Disease, HIV/AIDS)
- Data provided by purchasers
- Hospital Utilization
    - Hospital discharge data
    - Hospital Length of Stay (LOS) exceeding 10 days
    - Readmission Reports
    - Skilled Nursing facility (SNF), rehabilitation admissions
    - Acute Rehabilitation admissions
- Ambulatory Care Utilization Reports
    - Emergency Room utilization
    - Nurse Advice Line Reports/ER Referrals
- Referral Management Reports
    - Precertification Data
    - Prior Authorization Data
    - High-technology home care requiring greater than two weeks duration of home care
    - Long Term Care referrals and monitoring logs
    - Non-adherence with treatment plan

Complex Case Management services and how to refer patients
For more information about complex case management, or to make a referral, call the L.A. Care UM Department at 1-877-431-2273 and ask to speak with a

Case Manager or complete a ***CM REFERRAL FORM*** AND SUBMIT VIA FAX # **(213) 438-5077**.

Targeted Care Management
Targeted Care Management (TCM) assists Members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, Targeted Care Management is available as a carve-out Medi-Cal benefit through the State of California, Los Angeles County Public Health Department and their contractors as specified in Title 22, Section 51351. The Care Managers are responsible for identifying members that may be eligible for TCM services and must refer members, as appropriate, for the provision of TCM services. TCM services are integrated into the overall care plan, as a barometer for measuring disease progression and cost of care. State and county TCM services may include, but are not limited to, Pediatric and adult partial hospitalization programs (i.e. pediatric day care centers, and AIDS Wavier Programs) Adult day healthcare centers, MSSP and In-Home Services and Supports (IHSS) are Cal MediConnect benefits.

L.A. Care Cal MediConnect is responsible for co-management of the member's health care needs with the TCM providers, providing preventive health services and for determining the medical necessity of diagnostic and treatment services. The TCM services will serve to supplement care where needed to keep the member safe within their community based setting.

Hospice Care Services

Hospice Care Services are available through the Cal MediConnect program. Members and providers may directly contact a federally qualified hospice provider for assistance.

If you require assistance in locating a hospice provider, you may contact the UM Department at (877) 431-2273.

Members and their families shall be fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. For individuals who have elected hospice care, continuity of medical care shall be arranged, including maintaining established patient-provider relationships, to the greatest extent possible. L.A. Care Cal MediConnect and the delegated PPGs shall cover the cost of all hospice care provided as defined by the DOFR. PPGs are also responsible for all medical care not related to the terminal conditions.

Admission to a nursing facility of a member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the member's eligibility for enrollment.

- Hospice services are covered services and are not long term care

services regardless of the member's expected or actual length of stay in a nursing facility.

Members with a terminal condition covered by CCS must be clearly informed that election of hospice will terminate the child's eligibility for CCS services.

PCP responsibilities:

Member is assessed by his\her physician (generally his/her PCP/Hospice Physician) as having terminal medical condition resulting in a life expectancy of six (6) months or less.

- Hospice services are fully explained to the member by the PCP.
- Arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible.

PPG Responsibilities:

Ensure contracted PPGs are educated on end-of life care and referral procedures to a qualified hospice program.

Hospice Levels of Care:

- **Routine Home Care** - Routine home care shall be covered for each day the recipient is at home and is not receiving continuous care.
- **Continuous Home Care** - Continuous home care shall be covered only during periods of crisis when skilled nursing care is necessary on a continuous basis to achieve palliation or management of the patient's pain or symptoms in order to maintain the recipient in his/her residence. Continuous care may include homemaker and/or home health aide services but must be predominantly nursing in nature.
- **Respite Care** - shall be covered only when provided in an inpatient facility, on an occasional, intermittent and non-routine basis and only when necessary to relieve family members or other persons caring for the terminally ill individual.
- **General inpatient care** shall be covered only when the patient requires and receives general inpatient care in an inpatient facility for pain control or chronic symptom management which cannot be managed in the patient's residence.
- **Of the four levels of care described in subsection (a) above, only general inpatient care is subject to prior authorization.** Authorization for general inpatient care shall be granted only when all applicable requirements, as set forth in the Criteria for Authorization of Hospice Care section of the Department's Manual of Criteria for Medi-Cal Authorization, are met. Refer to UM Procedure 5003.9 UM Referral Management Timeframes for the DHS required In-Patient Hospice Referral timeframe.

Voluntary Statement of Election of Hospice Services: The patient or his lawfully designated representative voluntarily files a statement of election with a Medicare and Medicaid-certified hospice provider acknowledging the request for palliative services only as it relates to the terminal illness and a waiver of regular medical coverage.

The election statement must contain the following:

- Identification of the hospice provider
- The individual's or representative's acknowledgement that:
- He or she has full understanding that the hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature.
- Certain Medi-Cal benefits as specified in subsection (f) are waived by the election.
- The effective date of the election.
- Signature of the individual or representative.

Elections may be made for up to two periods of 90 days each, one subsequent period of 30 days, and one 180-day extension of the 30-day period. Hospice services shall not be covered beyond 390 days.

An election period shall be considered to continue through the initial election period and through subsequent election periods as long as the hospice provider agrees to renew the election and as long as the individual:

- Remains in the care of the hospice; and
- Does not revoke the election

Revocation or Modification of a Voluntary Statement of Election of Hospice: An individual's voluntary election may be revoked or modified at any time. To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

- A signed statement that the individual or representative revokes the individual election for Medi-Cal coverage for the remainder of the election period.
- The effective date, which may not be earlier than the date the revocation is made.
- Revocation shall constitute a waiver of the right to hospice care during the remainder of the current 90 or 30-day election period plus any extension.
- An individual may, at any time after revocation, execute a new election for any remaining entitled election period.
- An individual may, once in each election period, elect to receive services through a hospice program different from the hospice with which the election was made. Such change shall not be considered a revocation pursuant to subparagraph (A). Such change shall be made

in accordance with the procedure specified in 42 Code of Federal Regulations, Part 418, Subpart B

- An individual who voluntarily elects hospice care under subsection (c) shall waive the right to payment on his or her behalf for all Medi-Cal services related to the terminal condition for which hospice care was elected, except for:
    - A signed statement that the individual or representative revokes the individual election for Medi-Cal coverage for the remainder of the election period.
    - The effective date, which may not be earlier than the date the revocation is made.
    - Revocation shall constitute a waiver of the right to hospice care during the remainder of the current 90 or 30-day election period plus any extension.
    - An individual may at any time after revocation execute a new election for any remaining entitled election period.
    - An individual may once in each election period elect to receive services through a hospice program different from the hospice with which the election was made. Such change shall not be considered a revocation pursuant to subparagraph (A). Such change shall be made in accordance with the procedure specified in 42 Code of Federal Regulations, Part 418, Subpart B.
    - An individual who voluntarily elects hospice care under subsection (c) shall waive the right to payment on his or her behalf for all Medi-Cal services related to the terminal condition for which hospice care was elected, except for:
        - Services provided by the designated hospice
        - Services provided by another hospice through arrangement made by the designated hospice.
        - Services provided by the individual's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services
        - A plan of care shall be established by the hospice for each individual before services are provided. Services must be consistent with the plan of care. The plan of care shall conform to the standards specified in 42 Code of Federal Regulations, Part 418, Subpart C
- The following services, when reasonable and necessary for the palliation or management of a terminal illness and related conditions are covered when provided by qualified personnel:
    - Physician services when provided by any Medi-Cal enrolled physician except that the services of the hospice medical director or the physician member of the interdisciplinary group, as required under 42 Code of Federal Regulations,

Part 418, Subpart C shall be performed by a doctor of medicine or osteopathy.

- Medical social services when provided by a social worker with at least a Bachelor's degree in social work, from a school approved or accredited by the council on Social Work Education, under the direction of a physician.
- Counseling services when provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling shall, as appropriate, be provided for the purpose of training the individual's family or other caregiver to provide care and to help the individual and those caring for him or her to adjust to the individual's approaching death and to cope with feelings of grief and loss.
- Short-term inpatient care when provided in a hospice inpatient unit or in a hospital or a skilled nursing facility/Level B, that meets the standards specified in 42 Code of Federal Regulations, Part 418, Subpart E regarding staffing and patient areas.
- Drugs and Biologicals when used primarily for the relief of pain and symptom control related to the individual's terminal illness.
- Medical supplies and appliances
- Home health aide services and homemaker services when provided under the general supervision of a registered nurse. Services may include personal care services and such household services as may be necessary to maintain a safe and sanitary environment in the areas of the home used by the patient.
- Physical therapy, occupational therapy and speech-language pathology when provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

MEDI-CAL

Admissions while in a nursing facility

Admission to a nursing facility of a member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the member's eligibility for enrollment under this Contract. Hospice services are Medi-Cal covered services and are not long term care services regardless of the member's expected or actual length of stay in a nursing facility.

Members with a terminal condition covered by CCS

Members with a terminal condition covered by CCS must be clearly informed that election of hospice will terminate the child's eligibility for CCS services

Hospice

Hospice is a Medicare covered benefit, although it is carved out of the set of benefits that can be covered by Medicare managed care plans and paid for by Medicare fee-for-service. As a result, L.A. Care's Cal MediConnect plan does not cover hospice services. Claims for hospice services provided to L.A. Cal MediConnect members should be submitted to the appropriate Medicare fee-for-service fiscal intermediary.

TRANSPLANTS

Transplants are a covered benefit under the Cal MediConnect plan. The PCP and delegated PPGs are responsible for facilitating transplant evaluations arrangements with the Medicare Centers of Excellence or Medicare approved transplant centers. Members referred for potential transplants are eligible for care coordination assistance through the L.A. Care's Cal MediConnect Care Management Program (See Section: Care Management)

Referrals for the facility component must be coordinated with the L.A. Care Cal MediConnect UM Department. For a copy of the L.A. Care Cal MediConnect policy for Major Organ Transplants or a listing of the Medicare transplant centers, please contact the L.A. Care Cal MediConnect UM Department at (877) 431-2273

Medi-Cal

Transplants are a covered benefit through the MediCal Fee-For-Service program. For additional information on assisting members coordinate the transplant benefits, see Section: **Care Coordination -** Excluded Services Requiring Member Disenrollment/Transplants or you may contact the L.A. Care UM Department.

5.28 DISEASE MANAGEMENT/CHRONIC CARE IMPROVEMENT

L.A. Care Cal MediConnect does not delegate disease management to the PPGs/PCPs.

The Centers for Medicare and Medicaid Services defines disease management as a "system of coordinated health care interventions and communication for populations with conditions in which patient self-care is substantial". Disease

Management supports the provider-patient relationship and treatment plan while emphasizing prevention and self-management.

L.A. Care Cal MediConnect offers a variety of disease management programs which focus on the development, implementation and evaluation of a system of coordinated health care interventions and communication for members with chronic conditions and individuals that care for them. Using a multi-disciplinary approach, members are identified, stratified, assessed and care plans are developed to assist members and their families with navigating the managed care system and managing their chronic conditions. Programs may include:

- Self-management support
- Education and materials
- Community referrals
- Care coordination

Providers or members may contact L.A. Care Cal MediConnect Quality Management Department to inquire about the available programs.

5.29 BEHAVIORAL HEALTH AND SPECIALTY MENTAL HEALTH SERVICES

Behavioral health benefits are as defined in the benefit section.

- L.A. Care Cal MediConnect will ensure contracted PPG network and Primary Care Physicians (PCP) provide basic outpatient behavioral health services, within the scope of the PCP's practice and training, and shall ensure appropriate referral of members to and coordination of care with LAC for assessment and treatment of behavioral health conditions, outside the scope of their practice and training.

- All inpatient and outpatient behavioral health services are the responsibility of L.A. Care Cal MediConnect and managed by L.A. Care's Cal MediConnect current contracted behavioral health vendor. Members and providers may access services by calling 877-344-2858 (TTY/TDD 1-800-735-2929)

- Members and providers may directly refer to the contracted behavioral health provider by calling L.A. Care's Cal MediConnect Member Service Department at 1-888-522-1298 (TTY/TDD **1-888-212-4460**).

- L.A. Care's Cal MediConnect UM Liaison will act as a resource to the PPGs/PCP's to ensure understanding of the referral process and to define services that are part of the PPGs' and PCPs' responsibility.

- The resolution of disputes is a shared responsibility between L.A. Care Cal MediConnect and LAC/DMH and will be processed as defined in the

fully executed Memorandum of Understanding, L.A. Care Cal MediConnect policies and the established state laws and regulations.

5.30 ALCOHOL & DRUG TREATMENT PROGRAMS

- Substance abuse benefits are as defined in the CMS benefit section.

- Members and providers may directly refer to the L.A. Care's contracted behavioral health provider by calling: **877-344-2858** (TTY/TDD 1-800-735-2929)

MEDI-CAL

5.30.1 Inpatient Detoxification

5.30.1.1 L.A. Care Cal MediConnect will ensure appropriate medical inpatient detoxification is provided under the following circumstances:

5.30.1.2 Life threatening withdrawal from sedatives, barbiturates, hypnotics or medically complicated alcohol and other drug withdrawal.

5.30.1.3 Inpatient detoxification is covered in the rare cases where it is medically necessary to monitor the member for life threatening complications; two or more of the following must be present, tachycardia, hypertension, diaphoresis, significant increase or decrease in psychomotor activity, tremor, significant disturbed sleep pattern, nausea and vomiting, threatened delirium tremens.

5.30.1.4 When the member is medically stabilized, the PCP/L.A. Care shall provide a referral and follow-up to a Substance Abuse Treatment Program.

5.30.2 Outpatient Medi-Cal Services

5.30.2.1 L.A. Care Cal MediConnect will maintain processes to ensure that Alcohol and Drug Abuse Treatment Services be available to Medi-Cal members when needed and are provided as a linked and carved out benefit through the Office of Alcohol and Drug Programs of L.A. County.

5.30.2.2. The following services are provided by the Alcohol and Drug Programs of L.A. County:

- Outpatient Methadone Maintenance
- Outpatient Drug Free Treatment Services
- Perinatal Residential Services
- Day Care Habilitative Services
- Naltrexone Treatment Services (Opiate Addiction)
- Outpatient Heroin Detoxification Services

5.30.2.3 L.A. Care Cal MediConnect and its contracted PPGs will ensure Primary Care Physician (PCP) screening of L.A. Care Cal MediConnect members for substance abuse during the Initial Health Assessment and in all subsequent visits as appropriate. When substance use is recognized as a potential condition, PCPs will refer to a treatment facility serving the geographic area. Referral is done by using the substance abuse referral form or by referral to the Community Assessment Services Center toll free number (800) 564-6600.

5.30.2.4 Members can access substance abuse treatment services by self-referral, by a family referral or referral from the PCP or other appropriate provider.

5.30.2.5 During treatment for substance abuse, all medical services will continue to be provided by the PCP or other appropriate medical provider. The PCP will make relevant medical records available to the Substance Abuse Treatment Program with appropriate consent and release of medical record information following Federal and State guidelines.

5.31 DENTAL SERVICES

Preventive dental care is a covered service through L.A. Care's Cal MediConnect Program. Members have professional dental services covered through Medi-Cal's Denti-Cal program (please see description below). However, L.A. Care's Cal MediConnect plan covers anesthesia services and related medical services provided to a member in a dental office, inpatient or outpatient facility, or an ambulatory surgical center. Such services must support a dental surgery or dental procedure, provided that such anesthesia services and related medical services meet plan coverage and medical necessity requirements.

MEDI-CAL

Dental Care Treatment Services are a carved out benefit to Medi-Cal members through the Medi-Cal Denti-Cal Program. L.A. Care and its delegated PPGs are

responsible for Dental Screening and Referral of Members to the Carved out Medi-Cal Denti-Cal Program for Dental Treatment when treatment needs are identified.

Primary Care Providers should perform dental screenings as part of the IHA, periodic, and other preventive health care visits and provide referrals to Medi-Cal Denti-Cal Program for treatment in accordance with the most current:

- CHDP/American Academy of Pediatrics (AAP) guidelines for Member age 21 and younger.
- Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) for adult members {age twenty-one (21) and older}.

Dental Screening Requirements:
L.A. Care Cal MediConnect recommends dental screening for all members is included as part of the initial and periodic health assessments:

For members under twenty-one (21) years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) years or earlier if conditions warrant.

Covered Medical Services not provided by Dentist or Dental Anesthetists:

L.A. Care Cal MediConnect and its delegated PPGs shall cover and ensure the provision of covered medical services that are not provided by dentists or dental anesthetists. Covered medical services include:

- Contractually covered prescription drugs
- Laboratory service
- Pre-admission physical examinations required for admission
- to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fee and anesthesia services for both inpatient and outpatient services).

Financial Responsibility for General Anesthesia and Associated Facility Charges:

L.A. Care Cal MediConnect and its delegated PPGs are responsible to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting (*as defined by the Division of Financial Responsibility - DOFR).* A prior authorization of general anesthesia and associated charges

required for dental care procedures is required in the same manner that prior authorization is required for other covered diseases or conditions.

General anesthesia and associated facility charges are covered for only the following member, and only if the members meet the criteria as follows:

- Members who are under seven years of age.
- Members who are developmentally disabled, regardless of age.
- Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

The professional fee of the dentist and any charges of the dental procedures itself is not covered. Coverage for anesthesia and associated facility charges may be covered and are subject to the terms and conditions of the plan benefits as described in the Division of Financial Responsibility.

Referral to Medi-Cal Dental Providers through Carved Out Medi-Cal Dental Program:

L.A. Care and its delegated PPGs must refer members to the appropriate dental providers for treatment of dental care needs.

Updated lists of dental providers are made available to network providers.

CCS Referrals
Dental services for a child with complex congenital heart disease, cystic fibrosis, cerebral palsy, juvenile rheumatoid arthritis, nephrosis, or when the nature or severity of the disease makes care of the teeth complicated may be covered by CCS. Contact the L.A. Care Cal MediConnect UM Department or CCS for assistance.

When a child has a handicapping malocclusion, Orthodontia care may be covered by CCS. Contact the L.A. Care Cal MediConnect UM Department or CCS for assistance.

Routine dental care and orthodontics is not covered by CCS.

5.32 VISION SERVICES

Vision care is a covered benefit and the responsibility of L.A. Care. To access this service, members and providers should contact VSP at 800-877-7195.

MEDI-CAL

L.A. Care Cal MediConnect and its delegated PPGs shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as

appropriate for all Members according to the current Medi-Cal benefits for eye examinations and lenses.

Members are eligible for the eye examination with refractive services and dispensing of the prescription lenses every two years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions

L.A. Care Cal MediConnect and its delegated PPGs shall arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories.

Department of Health Services (DHS) is responsible for reimbursing PIA for the fabrication of the optical lenses in accordance with the contract between DHS and PIA.

5.32.1 Long Term Care (LTC) (After exhaustion of Medicare Benefits)

5.32.1.1 L.A. Care Cal MediConnect and its delegated PPGs are responsible for ensuring that members, other than members requesting hospice services, in need of nursing Facility services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs. These health care facilities include Skilled Nursing Facilities, sub-acute facilities, pediatric sub-acute facilities, and Intermediate Care Facilities.

5.32.1.2 Admission to a nursing Facility of a member who has elected hospice services as described, does not affect the member's eligibility for Enrollment. Hospice services are covered services and are not long term care services regardless of the member's expected or actual length of stay in a nursing facility.

5.32.1.3 L.A. Care Cal MediConnect and its delegated providers shall:

5.32.1.3.1 Assure that decisions to transition a member to LTC are based on the appropriate level of care based on Medi-Cal criteria.

5.32.1.3.1.1 Needs assessment and potential length of stay should be discussed with the treating provider and facility.

5.32.1.4 If the member requires LTC, in the Facility for longer than the month of admission plus one month, Delegated providers

will submit a Disenrollment request for the member to L.A. Care Cal MediConnect to submit to DHS for approval.

5.32.1.4.1 L.A. Care Cal MediConnect UM Staff are responsible for:

5.32.1.4.1.1 Coordinating the services required with the treating provider and facility

5.32.1.4.1.2 Completing appropriate documentation and forwarding to L.A. Care Member Services to complete disenrollment forms.

5.32.1.4.2 L.A. Care Member Services is responsible for:

5.32.1.4.2.1 Initiating the disenrollment process to Health Care Options

5.32.5.4.2.2 Coordinating the decision response with UM staff

5.32.5.5 When Health Care Options notifies L.A. Care Cal MediConnect that the disenrollment request is approved, an approved Disenrollment request will become effective the first day of the second month following the month of the member's admission to the facility, provided that L.A. Care Cal MediConnect submitted the disenrollment request at least 30 calendar days prior to that date.

5.32.5.6 If L.A. Care Cal MediConnect submits the disenrollment request less than thirty (30) calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least thirty (30) calendar days after submission of the disenrollment request.

5.32.6 Coordination of Care

5.32.6.1 L.A. Care Cal MediConnect and its delegated providers shall provide all Medically Necessary Covered Services to the member until the disenrollment is effective:

5.32.6.1.1 Assuring that continuity of care is not interrupted;

5.32.6.1.2 Completing all administrative work necessary to assure smooth transfer of responsibility for the health care of the member.

5.32.6.1.3 Assuring that medical necessity of continued care is reviewed regularly until patient is transitioned to Long Term Care.

5.32.6.2 Upon the disenrollment effective date, the member's orderly transfer to the Medi-Cal Fee-For-Service provider;

5.32.6.2.1 The PCP, with assistance from the Case Manager, has responsibility to ensure that the member's medical record and all appropriate information is transferred to the member's Fee For Service provider.

5.32.6.2.2 This includes notifying the member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Plan to the provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the member.

5.32.6.2.3 If the member's PCP continues to act as the patient's physician under Fee For Service, the long term care facility will be notified. If it is necessary for the member to have another physician, L.A. Care Cal MediConnect or if applicable, the delegated PPG works with the long term care facility to achieve an orderly transfer of care and records.

5.32.6.3 When Health Care Options notifies L.A. Care that the disenrollment request is not approved:

5.32.6.3.1 L.A. Care Cal MediConnect Member Services notifies the Care Manager to assist the PCP with management of patient's needs. Until Placement is available, a patient who is eligible for a waiver program will be monitored closely.

5.33 L.A. CARE CAL MEDICONNECT APPEALS PROCESS

L.A. Care Cal MediConnect does not delegate the appeal (reconsideration) process. The PPG must ensure timely submission of appeals to L.A. Care Cal MediConnect. If the PPG receives an appeal from a member, it should be faxed to L.A. Care Cal MediConnect Member Services Department **same day of receipt.** A member has the right to appeal directly to L.A. Care Cal MediConnect

for all decisions to modify or deny a request for services. A physician, acting as the member's representative, may also appeal a decision on behalf of the member.

Members and providers may also appeal L.A. Care's Cal MediConnect decision to modify or deny a service request (this does not apply to the retrospective claims review/provider dispute resolution process). The appeal request is reviewed by a physician or physician consultant not involved in the prior determination.

Member requested appeals may be initiated orally or in writing. Request may be made by contacting L.A. Care Cal MediConnect at:

L.A. Care Health Plan
Grievances & Appeals Department
1055 W. Seventh Street, 10th Floor
Los Angeles, CA 90017
(888) 452-2273
Fax # - (213) 438-5754

L.A. Care follows the federal, state and NCQA requirements for the timely resolution of member complaints. If you would like additional information on the L.A. Care Cal MediConnect appeal resolution process, please contact L.A. Care's Grievances & Appeals Department at (888) 452-2273.

Please see Section 5.18 for more details about reconsiderations of organization determinations (appeals), inpatient discharge appeals, and review of discharge from CORF, SNF and home health facilities.

5.34 SATISFACTION WITH THE UTILIZATION MANAGEMENT PROCESS

L.A. Care Cal MediConnect will evaluate both Member and Provider satisfaction with the UM process. Performance is assessed at least annually. The outcomes of the survey will be reported to the appropriate L.A. Care Cal MediConnect Quality Management committees. The Committee will identify areas of dissatisfaction, set priorities for improvement, and evaluate the effectiveness of interventions. Where opportunities for improvement are identified, PPGs may be requested to initiate action to change processes to meet defined goals and to meet Members' and Providers' expectations.

ATTACHMENT A. (See L.A. Care's annual notification for the most recent copy of the report)

Standardized ICE Reporting Document

Medicare Advantage Part C Reporting

UM Determinations

Health Plan Name:		
Medical Group/IPA		
Enter name of MG/IPA		
Management Company / TPA		
Enter name of Management Company/ (if applicable)		
Quarter		**Year**
Enter report quarter		Enter Year

Report Preparer Certification**

** The data submitted is for Federal reporting and is accurate & complete

Name	enter Report Preparer Name	
Title	enter Title of Report Preparer	
E-Mail	enter e-mail address of Report Preparer	
Phone	enter Phone# of Report Preparer	
Fax	enter Fax# of Report Preparer	

		6.1	6.2	6.3
Month	**Year**	**Determinations fully favorable**	**Determinations partially favorable**	**Determinations adverse**
1	2011	#	#	#
2	2011	#	#	#
3	2011	#	#	#
TOTALS		0	0	0

Date
Enter date report submitted

Submit to:

ICE Approved: 5/27/09

Attachment B

L.A. Care’s Cal MediConnect required excel Log format for PPG Reporting of all Initial Determinations by Case for the quarter										
DELEGATE NAME	**Beneficiary last name**	**Beneficiary first name**	**Beneficiary Medicare HIC Number**	**DELEGATE Unique Identifier**	**Date of decision**	**Fully Favorable Decision**	**Partially Favorable Decision**	**Unfavorable Decision**	**Was request expedited?**	**If yes, Date & time expedited request received**

Attachment C

Medicare Advantage Authorization Information for CMS Part C Reporting

SUMMARY:

The Centers for Medicare and Medicaid Services (CMS) has implemented reporting requirements for 2009 that require submission of data on a quarterly basis regarding organizational determinations (favorable, partial and unfavorable) for all Medicare Advantage organizations and their delegated provide groups. Collection of this data commenced beginning 1/1/09 and will continue indefinitely. Regulatory support for these measures is found in 42CFR Subpart M 422.566 – 422.576 and 42 CFR Subpart M 422.578. seq. 42 CFR Subpart K 422.516 (a) (6).

In order to simplify reporting by delegated provider groups across various health plans, the attached reporting template was developed. Each Medicare Advantage health plan is required to collect clinical authorizations and denials, similar to the ongoing ICE reporting for paid and denied claims. Reporting is a Medicare requirement from all MA plans and entities delegated for pre service organization determinations. The party responsible for reporting must be authorized on behalf of the delegated entity to attest to the accuracy of the submission. While data must be reported for each month, the data collection will be on a quarterly basis consistent with the CMS reporting requirements.

The current ICE UM reports are submitted semi-annually and some groups do not differentiate data by Health Plan, requiring separate reporting to be compiled and submitted to CMS. (ICE reporting on Claims continues separately through the ICE approved claims reporting process)

How a delegated Provider Group Can Submit Report to a MA Health Plan: Submit data in the "ICE MA Part C Clinical Decision Reporting template" Excel Workbook located on the ICE website via the following link: http://www.iceforhealth.org/library.asp?sf=&scid=1906#scid1906. Please email the MA plan-specific report to your UM contact at the MA plan. Include data only for the individual health plan members you are reporting on. Include data only for the individual health plan members you are reporting on. Include all fully favorable, partially favorable, and denied organizational determinations not related to post service claim determinations. This includes determinations based on medical necessity and benefit determinations, as well as eligibility denials. All reporting for each month is based on the **date of the decision.** You may send in monthly reports or aggregated quarterly reports. Each MA health plan must receive reports no later than the 15th day of the month following the close of each quarter, so that data can be aggregated for UM decisions for all delegated provider groups and then reported to CMS.

Submit Clinical data in the ICE MA Part C UM Reporting Excel workbook as detailed below:

For example, THE DEADLINE FOR SUBMISSION for Q3 2011 to the MA Plans is 10/15/10
The deadlines for submission of subsequent quarters are 1/15/11, 4/15/11, 7/15/11, 10/15/11 etc.

Included below is updated information from the CMS July 22 memo and attached July 21, 2009 Guidance
www.cms.hhs.gov/HealthPlansGenInfo/16_ReportingRequirements.asp

The reporting for each collection period for organization determinations includes **only those cases where final decisions were made during the reporting period**, regardless of when the case was initially received. UM determinations for Pre-Service should be included under UM; Post Service determinations are not part of the UM reporting and are included under the separate claims reporting. **Concurrent review is irrelevant for Part C data reporting requirement purposes**.

Plans and delegated entities must report those decisions that meet the definition of "organization determination" under 42 C.F.R. §422.566(b). Thus, CMS expects plans to include all pre-service network and non-network denial data.

A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) should not be counted as an organization determination for Part C Reporting purposes. A plan's review of an individual's request to continue Medicare-covered services (e.g., if a member misses the QIO review deadline) should be counted as a reconsideration for this effort.

Clinical Data:

- Include data for each health Plan's Members Separately
- Each month's data reporting is for **decisions made during the month**
- Use the attached Excel workbook titled "ICE Request for Part C Reporting" as a template for your report.
- Please provide monthly totals (for example: Month 1 of a quarter's reporting period (January), Month 2 (February), and Month 3 (March) for the number of decisions made regarding requests for services.
    - Report in each of the following categories:
        - Fully Favorable UM Organization determinations,
        - Partially Favorable UM Organization determination

        - Adverse Organization determinations adverse (Denials)
    - ***Note: Do not include requests for concurrent review or continued Medicare-covered services (e.g., a SNF stay); only the initial UM determination should be counted.***
- Please submit total numbers for each month or quarter, not line item details; numbers should be based on date of decision.
- See the second worksheet or tab (labeled “Instructions”) for field parameters and explanations.

ATTACHMENT D

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ ***Use the MA-Extension: Standard & Expedited to notify member and provider of an extension.*** Extension Notice: ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the

Type of Request	Decision	Notification Timeframes
	expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **Approvals** – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Type of Request	Decision	Notification Timeframes

Type of Request	*Decision*	*Notification Timeframes*
Expedited Initial Organization Determination **-** If Extension Requested or Needed	***May extend up to 14 calendar days.*** **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ ***Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension.*** ***Extension Notice:*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ **Approvals** – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ **Denials** – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	• Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. • The DND must include: • A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. • A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. • Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
			• Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. • Any other information required by CMS.
Type of Request	**Decision**	**Notice of Medicare Non-Coverage (NOMNC) Notification**	• Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. *Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.***	• Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

L.A. Care Medi-Cal UM Timeliness Standards

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
EMERGENCY CARE	No prior authorization required; follow the reasonable lay person standard to determine that the presenting complaint might be an emergency.	N/A	N/A
POST-STABILIZATION FOLLOWING MEDICAL SCREENING IN THE EMERGENCY ROOM	**Decision Timeframe:** Within 30 minutes of request or the requested service is deemed approved	**Practitioner: For approvals**: within 30 minutes of request, (if after hours, a tracking number is provided authorizing the requested service and follow-up the next business day with an authorization number.) **For denials/modifications:** verbal notification within 30 minutes of requests and fax (with confirmation) or electronic notification to the requesting practitioner the same day of the denial decision	**Practitioner: Written Notification: For approvals:** If no response within the required 30 minutes, the requested service is deemed approved. (If after hours, a tracking number is provided authorizing the requested service and follow-up the next business day with an authorization number.) **Practitioner and Member - For denials/ modifications:** written notification to requesting practitioner and member deposited with the United States Postal Service in time for

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
			pick-up within 3 calendar days from the receipt of the original request.
DELAY OF PRE-SERVICE URGENT Delay of Expedited Request	**D E C I S I O N T I M E F R A M E** The time limit for a decision of an expedited request may be extended past the original 72 hours by an additional 48 hours up to 5 calendar days if the member requests an extension. If more information is needed, notify the requesting practitioner or member by phone within 24 hours of receipt of the initial request. Allow at least 48 hours for the practitioner or member to provide the additional information. Make the decision within 48 hours of a) receiving a response from the member or practitioner or b) the expiration of the 48 hours allowed for the additional information to be supplied, whichever is sooner.	**Practitioner** Verbal notification to requesting practitioner and member as soon as the decision is made not to exceed 5 calendar days if the member requests an extension, or within 48 hours of receiving additional requested information or expiration of the extension without receipt of additional requested information.	**Practitioner and Member:** **For denials/ modifications,** written notification to requesting practitioner and member deposited with the United States Postal Service in time for pick-up by 5 calendar days or within 48 hours of receiving additional requested information or expiration of the extension without receipt of additional requested information not to exceed 5 calendar days. **NOA TEMPLATE: Delay**

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
PRE-SERVICE ROUTINE Non-urgent Request	**Decision Timeframe** Within 5 working days of receipt of request	**Practitioner: Initial Notification: All decisions:** Within 24 hours of the decision with confirmation **(Notification May Be Oral and/or Electronic)** **Member: Approvals:**	**Practitioner and Member:** Within 2 working days of denial/modification decision **NOA TEMPLATE: Denial or Modify**
DELAY OF PRE-SERVICE ROUTINE Non-urgent Request - Extension Needed	**Decision Timeframe** **Medi-Cal-**Within 5 working days of receipt of information not to exceed 14 calendar days from date of receipt of request **HF/HK**- Within 5 working days of receipt of information not to exceed 30 calendar days from receipt of request	**Practitioner: All decisions:** Within 24 hours of the decision with confirmation **(Notification May Be Oral and/or Electronic)**	**NOA TEMPLATE: Delay** **Medi-Cal HR/HK: Practitioner and Member:** Within 2 working days of decision to delay; however: HF/HK: 30 days allowed for delay And Medi-Cal: 14 days allowed for delay; Member can request an additional 14 days to total 28 days; (And the additional 14 days is granted only if the member or provider makes the request or the Plan/PPG can provide justification upon request by the State for the need

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
			for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. This means the decision making & notification processing, must not exceed the last day of the delay time limit (for Medi-Cal - 14 or 28 days, and HF/HK -30 days) and also when requested information has not been received, not before the last day of the delay time limit (for Medi-Cal 14 or 28 days, and for HF/HK-30 days). **Important NCQA Note:** Since the State allows only 14 days for making the decision for Medi-Cal & 30 days for HF/HK, NCQA would expect the member is given the full 14 days-Medi-Cal or 30 days for HF/HK to respond. Although we realize this provides very little time for your

Type of Request	Decision	Notification Timeframe	
		Initial Notification	Written Notification
			organization to make a decision, NCQA believes it is more important to provide the member with as much time as possible within the state's mandated requirement, to provide the information. Please also understand that delaying to ask for additional information is not a requirement: The organization may make a decision within the routine 5 business day timeframe on the information received initially with the request without requesting any additional information.
MEDI-CAL ONLY- REQUESTS TO CONTINUE ROUTINE CURRENT SERVICE/TREATMENT (such as PT, Long Term Care, etc.) Exceptions from the advance notice required	**Decision Timeframe** within 5 working days of receipt of request	**Practitioner: All decisions:** Within 24 hours of the decision with confirmation **(Notification May Be Oral and/or Electronic)**	**Practitioner and Member: Written Notification: For denials/modifications:** the notice must be mailed at least 10 days before the

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
in this section: The notice may be mailed not later than the date of action if: (a) There is factual information confirming the death of a member; (b) There is receipt of a clear written statement signed by a member that-- (1) Member no longer wishes services; or (2) Information is given that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information; (c) The member has been admitted to an institution where the member is ineligible under the plan for further services; (d) The member's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (e) The fact is established that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; (f) There is a change		**Member:** **Approvals:** Within 24 hours (Written Notification)	date of action, except as permitted by the exceptions described in column "Type of Request" **NOA Template**: Terminate

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
in the level of medical care prescribed by the Member's physician; (g) The notice involves an adverse determination made with regard to the preadmission screening requirements (h) The date of action will occur in less than 10 days- long term care exceptions to the 30 days notice			
URGENT CONCURRENT REVIEW (ACUTE HOSPITAL INPATIENT) Urgent Concurrent reviews are those reviews associated with inpatient care. A new request for inpatient care is considered urgent concurrent review and ongoing hospitalization requests are considered urgent concurrent review unless determined otherwise. Upon receipt of a new request for urgent concurrent review from a hospital, a review must be requested. If the request for authorization is made while a member is in process of receiving care,	**Decision Timeframe** Within 24 hours of receipt of the request for authorization. If the request for authorization is made while a member is in process of receiving care, the request is an urgent concurrent request if medical care requested meets the definition of urgent, even if LA Care did not approve the earlier care. For example, if LA Care finds out on day 2 that a member is in an inpatient facility, and the member's practitioner	**Practitioner: Initial Notification of Decision:** **All Decisions:** Verbal, fax (with confirmation), or electronic notification to the requesting practitioner within 24 hours of the receipt of the request **Member: Approvals:** Within 24 hours of receipt of the request	**Practitioner and Member: Written Notification: For denials/ modifications:** written notification to member and requesting practitioner within 24 hours of the receipt of the request. **NOA Template**: Terminate

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
the request is an urgent concurrent request if medical care requested meets the definition of urgent, even if LA Care did not approve the earlier care. For example, if LA Care finds out on day 2 that a member is in an inpatient facility, and the member's practitioner requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request. If L.A Care receives a request for coverage of an acute inpatient stay after the member's discharge, L.A. Care handles the request as a post service issue.	requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request. Upon receipt of a request for urgent concurrent review, LA Care UM immediately requests necessary information. For operational purposes 24 hours is considered equivalent to 1 calendar day. **Hospital Inpatient Stay Requests** Hospital Inpatient Stay Requests are considered Concurrent Urgent and the Urgent Concurrent decision timeframe applies unless: Necessary information is not received within 24 hours of receipt of the request for authorization and at least one call has been made to conduct the review or request the necessary		

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
	information. The timeframe for decision making changes from Concurrent Urgent to Pre-Service Urgent (see Pre-Service Urgent above). When the hospital inpatient care has already been received, LA Care can decide to review the request for the already-rendered care as part of the Urgent Concurrent request, or change the timeframe to Post-Service request (see Post-Service below). If the request for authorization for an acute hospital stay is received after the member's discharge, the request is considered a Post-Service request (see Post-Service below). **Course of Treatments Requests** If the request for authorization is to		

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
	extend a course of treatment beyond the period of time or number of treatments previously approved by LA Care does not meet the definition of Urgent Care, the request is handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., Pre-Service or Post-Service).		
REQUEST TO CONTINUE Concurrent review (Acute Hospital Inpatient) A concurrent review decision is any review for an extension of a previously approved ongoing course already in place	**Decision Timeframe** If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved does not meet the definition of Urgent Care, the request is handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., Pre-Service or Post-Service).	**Practitioner: All Decisions:** Within 24 hours of receipt of the request **Member: Approvals:** Within 24 hours of receipt of the request	**Practitioner and Member: Written Notification:** Within 24 hours of receipt of the request If oral notification is given within 24 hours of request, then written/ electronic notification must be given no later than 3 calendar days after the oral notification. **NOA Template:** Terminate

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification**	**Written Notification**
POST-SERVICE / RETROSPECTIVE REVIEW	**Decision timeframe:** within 30 calendar days from receipt or request	**Practitioner and Member:** None specified	**Practitioner and Member:** Within 30 calendar days of receipt of the request. **NOA Template**: Denial or Modify
HOSPICE - INPATIENT CARE	**Decision Timeframe:** Within 24 hours of receipt of request	**Practitioner: Initial Notification:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner and Member: Written Notification** Within 2 working days of making the decision **NOA Template:** Terminate

ATTACHMENT E

PPG Medicare Utilization Management Reporting to L.A. Care Health Plan Cal MediConnect Program

1. L.A. Care Cal MediConnect contracted/delegated medical groups (PPGs) are provided with required templates for quarterly reporting for Medicare Organization Determinations:
    a. For Medicare Part C Reporting – L.A. Care Cal MediConnect utilizes the ICE format with instructions/templates. (Attachment A)
    b. For Medicare logs of organization determinations –L.A. Care Cal MediConnect utilizes the CMS required format with instructions/templates. (Attachment B)

2. PPGs are required to submit the templates to L.A. Care Cal MediConnect Medical Management Department on a quarterly basis
    a. Organization Determination reports data based on the required reporting periods of
        - 1/1 through 3/31 (1st Q)
        - 4/1 through 6/30 2nd Q)
        - 7/1 through 9/30 (3rd Q)
        - 10/1 through 12/31 (4th Q)
    b. Reports are required to be submitted on the 15th of the month following the quarter by to L.A. Care's Cal MediConnect UM Delegation Oversight Coordinator by Right Fax 213-438-5710

General Directions to PPGs for reporting the number of Initial Determinations to L.A. Care Cal MediConnect **on the ICE quarterly report format (Attachment A) and also PPG's Log of Initial Determinations on L.A. Care's** Cal MediConnect **required Initial Determinations excel log format (Attachment B)**

- Exclude dismissals, withdrawals or Quality Improvement Organization reviews of request to continued Medicare-covered services (e.g. SNF).
- Includes only organizational determinations that are filed directly the delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity).
- Includes all methods by which organization determination requests are received (e.g., auth request form, by telephone, letter, fax, in-person).
- Includes all organization determinations regardless of who filed the request.

6.0 Quality Improvement Program

L.A. Care Health Plan annually prepares a comprehensive Quality Improvement Program that clearly defines L.A. Care's QI structures and processes for all L.A. Care processes and products, including Cal MediConnect. They are designed to improve the quality and safety of clinical care and services for its membership. A complete written copy of L.A. Care's Quality Improvement Program is available upon request by calling (213) 694-1250 x5023.

The L.A. Care Quality Improvement Program will:

- Define, oversee, continuously evaluate and improve the quality and efficiency of health care delivered through organizational commitment to the goals and principles of our organization.
- Ensure medically necessary covered services are available and accessible to members taking into consideration the member's cultural and linguistic needs.
- Ensure our contracted network of providers cooperate with L.A. Care quality initiatives.
- Ensure that timely, safe, medically necessary, and appropriate care is available.
- Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards.
- Promote health education and disease prevention designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.
- Maintain a well-credentialed network of providers based on recognized and mandated credentialing standards.
- Safeguard members' protected health information (PHI).

6.1 Annual QI Program Evaluation

Annually, L.A. Care reviews data reports and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a review of completed and continuing program activities and audit results; trending of performance data; analysis of the results of QI initiatives including barriers, successes, and challenges; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year.

6.2 Annual QI Work Plan

The annual QI Work Plan is developed in collaboration with staff and is based, in part upon the results of the prior year's QI Program evaluation. Each of the elements identified on the Work Plan has activities defined, responsibility assigned and the date by which completion is expected. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee and the Compliance and Quality Committee of the Board.

6.3 Committee Structure

L.A. Care's quality committees oversee various functions of the QI program. The committees serve as the major mechanism for intradepartmental collaboration for the Quality Program.

The Quality Oversight Committee (QOC), a cross functional staff committee of L.A. Care, is the cornerstone for communication within the organization. It is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care's quality improvement infrastructure. The QOC conducts the following activities:

- Review current strategic projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Review quantitative and qualitative analysis of performance data of subcommittees through formal reports as needed.
- Identify opportunities for improvement based on analysis of performance data and prioritize these opportunities.
- Track and trend quality measures though quarterly updates of the QI work plan.
- Review and make recommendations regarding quality delegated oversight activities such as reporting requirements on a quarterly basis.
- Review, modify, and approve policies and procedures.
- Review and approve the QI and UM program descriptions, QI and UM work plans, quarterly QI work plan reports, and evaluations of the QI and UM programs

There is physician network participation on many of L.A. Care's QI Committees. For example, the Joint Performance Improvement Collaborative Committee and Physician Quality Committee (Joint PICC/PQC) reviews and approves the updated Clinical Practice Guidelines so that the QOC members know that they have been approved. After this approval the information is posted on the (which website??) website and a notification to the providers will be placed in the next newsletter as to the location on the website of these updated guidelines

The Joint PICC/PQC's primary objective is to ensure practitioner participation in the QI program through planning, design and review of programs, quality improvement activities and interventions designed to improve performance. The Joint PICC/PQC provides an opportunity for L.A. Care to dialogue with the provider community and gather feedback on clinical and service initiatives. The Joint PICC/PQC reports through the QI Medical Director or designee, to the Quality Oversight Committee. The Joint PICC/PQC serves as an advisory group to L.A. Care's Quality Improvement infrastructure for the delivery of health services to the CFAD population. Participation in the Joint PICC/PQC, including committee membership, is open to network practitioners representing a broad spectrum of appropriate primary care specialties serving L.A. Care members including but not limited to practitioners who provide health care services to dually eligible members or who have expertise in managing chronic conditions (such as asthma, diabetes, congestive heart failure).

6.4 Clinical Care Measures

L.A. Care Health Plan measures clinical performance through Healthcare Effectiveness Data and Information Set (HEDIS). L.A. Care expects that the network assist the health plan in continuously improving its HEDIS rates. The network is also expected by contract to cooperate with the annual HEDIS data collection efforts and keep encounter data current and accurate.

6.5 Service Measures

L.A. Care monitors services and member satisfaction by collecting, analyzing and acting on numerous sources of data such as Member Satisfaction (CAHPS), Complaints and Appeals, Access to and Availability of Practitioners, and Provider Satisfaction.

As required by CMS, the following measures will be collected annually

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS).

Continuity and Coordination of Medical Care

How well does your office coordinate care? If referring to a specialist, contact the specialist before the patient's appointment. Have staff set up a quick phone appointment and fax over the patient's medical history. Request that the specialist also contact you once the evaluation and/or treatment is finished. Keep track of specialty referrals that require prior authorization. Talk to the PPG or IPA about getting timely hospital discharge reports that will help you follow up and coordinate care after a hospitalization or emergency room visit.

Continuity and Coordination of Medical and Behavioral Health Care

L.A. Care contracts with a vendor to provide inpatient and outpatient behavioral health services including drug and alcohol abuse services. Behavioral health care is covered when services are ordered and performed by a plan behavioral health professional. For a directory of the vendor's behavioral health providers, please refer to the electronic provider and hospital directory on L.A. Care's website. A search for a behavioral health provider will link you directly to the network.

6.6 Preventive Health Care Guidelines

http://www.cms.gov/MLNProducts/35_PreventiveServices.asp **Clinical Practice Guidelines for Acute and Chronic Medical Care**- SEE L.A. CARE WEBSITE FOR CURRENT AND UPDATED GUIDELINES INCLUDING ASTHMA AND DIABETES

Clinical Practice Guidelines for Behavioral Health Care - See L.A. Care website for current guidelines including Depression.

6.7 Disease Management Programs

The objective of each of L.A. Care Health Plan's Chronic Care Improvement Programs is to use a system of coordinated healthcare interventions and communications to improve the health status of its eligible members with chronic conditions in whom self-care efforts are significant. The programs achieve this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. Chronic Care Improvement Programs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship and plan of care. The current programs address Asthma (***L.A. Cares About Asthma***) and Diabetes (***L.A. Cares About Diabetes***). To enroll a member, contact L.A. Care at **1-866-LA-CARE6 (1-866-522-2736)**.

6.8 Patient Safety

L.A. Care Health Plan is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety in their practices. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components.

6.9 Disease Reporting Statement

L.A. Care Health Plan complies with disease reporting standards as cited by the California Code of Regulations, Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report

approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Forms to report

6.10 PPG and Other Contracted Provider and Vendor Reporting Responsibilities

L.A. Care requires that PPGs and contracted Vendors have a mechanism in place for collecting and tracking critical incidents by member, reporting quarterly all critical incidents to L.A. Care's Quality Improvement (QI) Department, and training staff on critical incidents. A "critical incident" is an incident in which the enrollee is exposed to *abuse, neglect or exploitation, a serious, life threatening, medical event for the* enrollee that requires immediate emergency evaluation by medical professional(s), the disappearance of the enrollee, a suicide attempt by the enrollee, death of the enrollee, and restraint or seclusion of the enrollee.

6.11 Categories of Critical Incidents

Abuse:

- Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any member
- Knowing, reckless, or intentional acts or failures to act which cause injury or death or which placed that member at risk of injury or death
- Rape or sexual assault
- Corporal punishment or striking
- Unauthorized use or the use of excessive force in the placement of bodily restraints
- Use of bodily or chemical restraints, which is not in compliance with federal or state laws and administrative regulations.

Exploitation:

- An act committed by a caretaker, or relative of, or any person in a fiduciary relationship with a member, means:
    - The taking or misuse of property or resources by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means
    - The use of the services without just compensation
    - The use of a member for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish.

Neglect:

- Inability of a member to secure food, shelter, clothing, health care, or services necessary to maintain his/her mental and physical health
- Failure by any caretaker to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care
- Negligent act or omission by any caretaker which causes injury or death or which places that member at risk of injury or death
- Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan
- Failure by any caretaker to provide adequate nutrition, clothing, or healthcare
- Failure by any caretaker to provide a safe environment
- Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services.

Disappearance/Missing Member (Missing Person):

Whenever there is police contact regarding a missing person regardless of the amount of time the person was missing.

Death:

The death of an individual is reported regardless of the cause or setting in which it occurred.

A Serious Life Threatening, Medical Event That Requires Immediate Emergency Evaluation by a Medical Professional:

Admission of an individual to a hospital or psychiatric facility or the provision of emergency medical services (treatment by EMS) that results in medical care which is unanticipated and/or unscheduled for the individual and which would not routinely be provided by a primary care provider.

Restraints or Seclusion:

- Every time an individual is restrained, it is:
    - Personal (the application of pressure, except physical guidance or promoting of brief duration that restricts the free movement of part or all of an individual's body)
    - Mechanical (the use of a device that restricts the free movement of part or all of an individual's body. Such devises include: an anklet, a wristlet, a camisole, a helmet with fasteners, a muff with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and restraining sheet. Such a device does not include one used to provide

support for functional body position or proper balance, such as a wheelchair belt or one used for medical treatment, such as a helmet used to prevent injury during a seizure). It also means to cause a device that for free movement to be unusable. Such as locking a wheelchair or not allowing an individual access to technology.

- Chemical (the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition).
- Seclusion: involuntary confinement in a room that the member is physically prevented from leaving.
- Isolation: forced separation or failure to include the in the social surroundings of the setting or community.

Suicide Attempt:

Defined as the intentional attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a member receiving services.

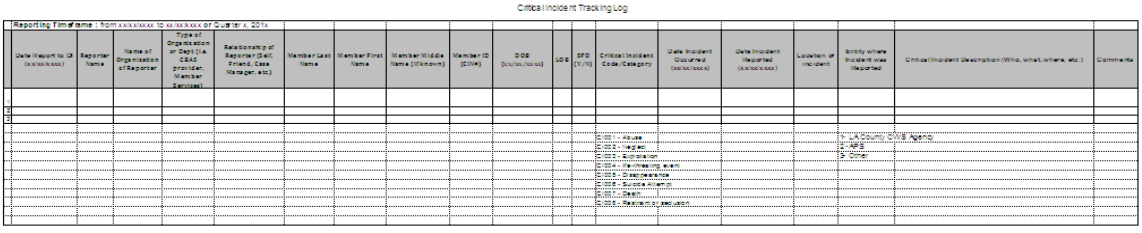
Additionally, the PPG and/or Vendors make referrals to local Adult Protective Services (APS) agencies or, when appropriate, law enforcement of identified critical incidents as required by state and/or federal regulations.

Suspected Abuse, Exploitation and Neglect **Children:** **DCFS** (Department of Children and Family Services) **Los Angeles County** Los Angeles County CWS Agency 425 Shatto Place Los Angeles, CA 90020 **800-540-4000** within CA **213-639-4500** outside CA **800-272-6699** TDD http://dcfs.co.la.ca.us/contactus/childabuse.html	**Suspected Abuse, Exploitation and Neglect** **Adult:** Adult Protective Services (APS) County Contact Information. **Los Angeles County** Community & Senior Services 3333 Wilshire Blvd. Suite 400 Los Angeles, CA 90010 **24 Hour Abuse Hotline:** (877) 477-3646 or (888) 202-4248 (626) 579-6905 (213) 738-6485 fax http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm
Seclusion and Restraint:	**Suicide Attempt:**

Report as Abuse Incident (see above) Children: DCFS Adults: APS	*For immediate threats*: **911** For non immediate threats: The 24-Hour Suicide Prevention Crisis Line 1-877-7 CRISIS (877-727-4747)
Serious Life Threatening Medical Event that Requires Immediate Emergency Evaluation by a Medical Professional: Call **911** and follow departmental procedures	**Missing Persons:** Adults **(18 years of age or older)** Adult Missing Person Unit 213-996-1800 Juveniles: **(17 years of age or younger)** Contact local area law enforcement Note: Contrary to popular belief, law enforcement agencies in California do not require a person to wait a specific period of time before reporting a missing person.
Death: Report notification of death to immediate supervisor for further reporting direction. In addition, report to Member Services	

Critical Incident Reporting Agency/Authority:

After reporting any identified critical incident (s) to the appropriate authorities as applicable, on a quarterly basis, PPGs must report the incident(s) by member to L.A. Care's Quality Improvement (QI) department by completing L.A. Care's Critical Incident Tracking Report Tool (see figure 1) and submitting it to the QI department via secure email at CI@lacare.org.


Critical Incident Tracking Log

Reporting Timeframe : from xxx.xxxx.xx to xx.xx.xxx of Quarter x, 201x

Date Report to QI (xx/xx/xxxx)	Reporter Name	Name of Organization of Reporter	Type of Organization or Dept (i.e. CBAS provider, Member Services)	Relationship of Reporter (Self, Friend, Case Manager, etc.)	Member Last Name	Member First Name	Member Middle Name (if known)	Member ID (CIN#)	DOB (xx/xx/xxxx)	LOB	SPD (Y/N)	Critical Incident Code/Category	Date Incident Occurred (xx/xx/xxxx)	Date Incident Reported (xx/xx/xxxx)	Location of Incident	Entity where Incident was Reported	Critical Incident Description (Who, what, where, etc.)	Comments
2																		
3																		
												1 - Abuse 2 - Neglect 3 - Exploitation 4 - Wandering/Lost 5 - Disappearance 6 - Suicide Attempt 7 - Death 8 - Restraint/Seclusion				1 - LA Care 2 - APS 3 - Other		

Figure 1

7.0 CREDENTIALING

7.1 OVERVIEW

7.1.1 L.A. Care Cal MediConnect contracted providers/practitioners are required to be credentialed in accordance with L.A. Care's credentialing criteria and the standards of the Department of Health Services (DHCS), National Committee on Quality Assurance (NCQA), and Centers for Medicare & Medicaid Services (CMS) requirements.

7.1.2 L.A. Care requires that all providers/practitioners who are performing services for L.A. Care Cal MediConnect members have a current license at all times to provide patient care to members and abide by State and Federal laws and regulations. All providers/practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. Failure to meet Medi-Cal, NCQA and CMS requirements may be cause for removal from L.A. Care's network

7.2 Delegation of Credentialing

Delegation is a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although the organization can delegate the authority to perform such a function, it cannot delegate the responsibility for assuring that those functions are performed appropriately.

Our credentialing department has delegated credentialing of Behavioral Health Practitioners and related entities to Beacon Health Strategies. Cal MediConnect's, managed behavioral health care partner. Their credentialing processes are described in full in their provider manual See Chapter 2: "Provider Participation in Beacon's Behavioral Health Services Network." L.A. Care monitors and oversees Beacon's credentialing activities as described for PPGs in the following sections.

7.2.1 L.A. Care is responsible for monitoring all contracted PPGs, credentialing, and re-credentialing activities. They must pass the L.A. Care Credentialing Department's due diligence (pre-delegation) credentialing audit in order to be delegated the credentialing responsibility. Otherwise, L.A. Care's Credentialing Department is responsible for credentialing activities. Regardless of a PPG's credentialing delegation status, L.A. Care retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners, based on credentialing issues at all times.

7.2.2 The PPG is accountable for credentialing and re-credentialing its practitioners, even if it delegates all or part of these activities. If the PPG delegates any credentialing and re-credentialing activities, there is evidence of oversight of the delegated activity. There must be annual evidence of a mutually agreed upon delegation agreement by both the PPG and the delegate, i.e., NCQA certified CVOs, non-certified CVOs, etc. The delegation agreement must meet all elements of NCQA's standards. As a note, CMS does not recognize NCQA certified CVOs. As such, all files are subject to full file review.

7.2.3 When delegates have access to the PPG's protected health information (PHI) on members or practitioners, or create such information in the course of their work, the mutually agreed-upon document must ensure that the information will remain protected. This is not applicable if there is no delegation arrangement, or if the delegation arrangement does not involve the use, creation or disclosure of protected health information.

7.2.4 If the delegation arrangement does not include the use of PHI in any form, an affirmative statement to that fact in the delegation agreement is sufficient, but is not required; the PPG may document the lack of PHI in a delegation arrangement in other manners.

7.2.5 Prior to delegation, L.A. Care's Credentialing Department audits the PPG (the potential delegated entity) to determine if the PPG meets L.A. Care's criteria for delegation. The Credentialing Department evaluates the potential delegated entity's ability to perform the delegated activities, which will include all activities related to credentialing and re-credentialing in accordance with the standards of L.A. Care, NCQA, DHCS and CMS. Using a modified version of the Standardized Audit Tool in accordance with L.A. Care, NCQA, DHCS and CMS standards, the Credentialing Department will evaluate delegated entity's performance.

7.2.6 Types of Delegation Status

7.2.6.1 After completion of the pre-delegation audit, the audit tool is scored and recommendations regarding delegation are presented to the Credentialing Committee as follows:

7.2.6.1.1 Delegation – PPG group scores between 80% to 100% on the pre- delegation audit. A corrective action plan must be successfully completed if score is below 100%.

7.2.6.1.2 Full delegation – PPG scores 100%. No CAP required.

7.2.6.1.3 Full delegation with a CAP – PPG scores between 80-99%. CAP required. A corrective action must be successfully completed.

7.2.6.1.4 Denial of Delegation – PPG chooses not to pursue delegation of credentialing, or it receives less than a 70% on the pre-delegation credentialing audit. PPG has a Non-Delegated credentialing status for a minimum of one year. The credentialing of PPG's practitioners is performed by L.A. Care's Credentialing department. Denial of delegation letters will be sent to the PPG.

7.2.6.2 Following recommendations by the Credentialing Committee, delegation letters will be sent to the PPG's scoring 80% or above, and Delegation Agreements for credentialing will be executed.

7.2.6.3 L.A. Care retains the right to determine in its sole discretion whether to delegate credentialing functions regardless of results of an audit.

7.2.7 Levels of Delegation

7.2.7.1 **Full** – All credentialing activities have been delegated to either the PPG or a combination of a hospital and medical group. The Delegation Agreement will identify in detail exactly what functions have been delegated to the PPG.

7.2.8 Delegation Oversight

7.2.8.1 The PPG agrees, upon delegation, to make available to L.A. Care the credentialing and re-credentialing status on the PPG's participating practitioners, including credentialing data elements as well as documents and quarterly reports, as appropriate, using the standardized ICE form or another approved L.A. Care format.

7.2.8.2 On an annual basis, L.A. Care will audit the credentialing and recredentialing activities of the PPG. The PPG's credentialing and recredentialing files will be reviewed according to the following file pull methodology: A roster of practitioners which includes Autism providers credentialed and recredentialed within the audit period and a list of the PPG's Utilization Management practitioners who make medical decisions, will be requested. In addition, a full roster of the delegate's network will also be requested. L.A. Care will also

review the delegate's quarterly reports for comparison and file selection. NCQA's 8/30 methodology will be used in evaluating files. The minimum files reviewed will be eight (8) initial files and eight (8) recredential files. If any credentialing element are deficient during the review of the 8/30 Rule, then the deficient element(s) will be reviewed for the remaining files, up to a maximum of 30 initial credentialing and 30 recredentialing files.

7.2.8.3 L.A. Care's oversight audit will include a review of the PPG's credentialing policies and procedures, Committee meeting minutes, practitioner credentialing and recredentialing files which includes Autism providers, Utilization Management practitioners who make medical decisions, a list of contracted health delivery organizations (HDOs), ongoing monitoring reports, oversight audits and any sub-delegations agreements, if applicable.

7.2.8.4 Results of L.A. Care's oversight audit will be reported to the PPG, including the corrective action plan if deficiencies are noted. L.A. Care's Credentialing Department works collaboratively with the PPG when deficiencies have been identified through the oversight process. The delegate is given a Corrective Action Plan (CAP) and asked to respond within 30 days. If no response is received within 30 days, or the CAP is not acceptable or complete, the Regulatory Affairs and Compliance (RA&C) Department sends a second letter requesting a response within 14 days and advising that failure to respond may be cause for revocation of the delegation agreement. The PPG will implement such corrective action plan within the time period stated and will permit a re-audit by L.A. Care or its agent, if requested.

7.2.8.5 If PPG fails to adequately correct the deficiencies within the required time period, L.A. Care retains the right to perform a focused audit as deemed necessary. If reoccurring deficiencies are identified during the third consecutive audit review, the PPG is subject to additional deductions and referred to Regulatory Affairs and Compliance for de-delegation. L.A. Care may de-delegate credentialing and assume responsibility for all or part of credentialing functions.

7.2.8.6 At L.A. Care's discretion, or in the event that L.A. Care determines that significant deficiencies are occurring related to performance by the delegate and are without remedy and fails to complete the corrective action plan process and has gone through the exigent process which results in de-delegation, the PPG cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as

those from previous audits, delegation will be at the sole discretion of the Credentialing Committee, regardless of the score.

7.2.8.7 A PPG that receives a rating of “excellent”, “commendable”, “accredited”, or “certified”, from NCQA, will be deemed to meet L.A. Care’s requirements for credentialing. These PPGs may be exempt from the L.A. Care audit of credentialing in elements for which they are accredited or certified. As a note, CMS does not recognize NCQA certified CVOs. In such cases, all files may be subject to full file review. If a PPG sub-delegates to an NCQA CVO for primary source activities, the PPG must still perform annual oversight of these activities for the Medicare line of business, if applicable.

7.2.8.8 If the PPG is NCQA accredited, and L.A. Care chooses to use the NCQA accreditation in lieu of a pre-delegation or annual audit, the PPG will be required to demonstrate compliance with the credentialing and recredentialing of UM Medical Director(s) annually. This will be accomplished through a signed Attestation submitted by the Medical Director(s) attesting to compliance with this requirement. If the PPG is not compliant with this process, the PPG will be subject to sanctions according to the PPGSA, Sections 1.36 and 1.37.

7.2.8.9 L.A. Care retains overall responsibility for ensuring that credentialing requirements are met and will require documentation from PPG to establish proof of NCQA accreditation status. Elements not listed in the NCQA accreditation documentation will require further validation through due diligence or annual audits. L.A. Care retains the right to perform oversight audits as necessary.

7.2.8.10 L.A. Care retains the right to approve new participating practitioners/providers and sites (delegated or sub-delegated), and to terminate, suspend, and/or limit participation of PPG’s practitioners who do not meet L.A. Care’s credentialing requirements.

7.2.9 PPG Responsibilities

7.2.9.1 PPG must have policies and procedures to address credentialing of practitioners, non-practitioner health care professionals, licensed independent practitioners, Autism providers, Utilization Management practitioners making medical decisions, and health delivery organizations that fall within in its scope of credentialing. PPG must state in policy that they do not make credentialing and re-credentialing decisions based solely on an applicant's race,

ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the practitioner specializes. A statement that the PPG does not discriminate does not meet the intent of the requirement. The policy must explicitly describe how it both monitors and prevents discriminatory practices to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner which may include but are not limited to periodic audits of credentialing files and practitioner complaints, and maintaining a heterogeneous credentialing committee decisions to sign a statement affirming that they do not discriminate.

7.2.9.2 PPG will establish standards, requirements and process for the health delivery organizations that are performing services for L.A. Care Cal MediConnect members to ensure that these practitioners and health delivery organizations are qualified to perform the services, and are licensed and/or certified consistent with L.A. Care, NCQA, DHCS, and CMS requirements. These standards, requirements and processes are applicable whether or not credentialing and re-credentialing activities are delegated. For CBAS facilities, L.A. Care annually verifies license and credentialing status.

7.2.9.3 PPG's policies must explicitly define the process used to ensure that the information submitted to L.A. Care is consistent with the information obtained during the credentialing process which is included in member materials and practitioner directories. Specifically, any practitioner information regarding qualifications given to members should match the information regarding practitioner's education, training, certification and designated specialty gathered during the credentialing process. "Specialty" refers to an area of practice, including primary care disciplines.

7.2.9.4 PPG will establish a peer review process by designating a Credentialing Committee that includes representation from a range of participating practitioners. The credentialing process can encompass separate review bodies for each specialty (e.g., practitioner, dentist, and psychologist) or a multidisciplinary committee with representation from various types of practitioners and specialties.

7.2.9.5 PPG must notify the practitioner, in writing, of any adverse actions to the practitioner and notify L.A. Care of PPG’s action taken as soon as the PPG has knowledge. The PPG must require the provider/practitioner to notify the PPG of any adverse action taken against them within 14 days of knowledge.

7.2.9.6 PPG must document the review of adverse events, actions taken, the monitoring and follow through of the process including timeframes and closure of each adverse events.

7.2.9.7 PPG must notify L.A. Care in writing, if any contracted practitioner has any adverse action or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's Cal MediConnect network.

Practitioners must not have limitations or restrictions on hospital privileges. The Plan's Credentialing Committee will make decisions based on review of any limitations or restrictions that have been imposed. If a facility should require a proprietary release form to release information on a practitioner's hospital status, the prospective participating practitioner will be required to complete the required proprietary form. Failure to do so will be considered non-compliance with the credentialing/recredentialing process.

7.2.9.8 PPGs that are delegated for credentialing and recredentialing are required to review, investigate and take appropriate action for any adverse events or criminal actions taken against a contracted provider including, but not limited to fair hearing and reporting to appropriate authorities as delegated. L.A. Care retains the right to approve, close panel to new membership and/or terminate contracted practitioners at all times.

7.2.9.9 L.A. Care reserves the right, pursuant to the Participating Practitioner Group Services Agreement, to coordinate, consolidate, and participate in any PPG participating practitioner disciplinary hearing, conducted in accordance with L.A. Care Policy and Procedures, and California Business and Professions Code Section 805.

7.2.9.10 PPG will advise L.A. Care of any changes to its credentialing and re-credentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the change. If L.A. Care deems the changed items not in compliance with L.A. Care, NCQA, DHCS, and CMS requirements, L.A. Care shall notify PPG immediately. PPG will have 30 days to be in compliance, and, if not in compliance, L.A. Care may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

7.2.9.11 PPG will provide quarterly reports to L.A. Care following the end of each report month (May 15th, August 15th, November 15th,

February 15th) with accurate and complete PPG practitioner data. PPG must provide Board certification status and Board expiration date, if applicable, when adding a practitioner to L.A. Care's network and any updates.

7.2.9.11.1 Using the standardized ICE format and Excel grid will include the following:

- Number of adds/deletes of PCPS (i.e. MDs, DOs, etc.)
- Number of adds/deletes of SCPS (i.e. MDs, and DOs, etc.)
- Numbers of adds/deletes of independent practitioners (i.e. DCs, DPMs, etc.)
- Any new or revised policies and procedures, additions of a computer system, CVO
- Practitioners termed for quality issues

7.2.9.12 PPG will submit a profile of the PCP or SCP, Mid-Levels and Autism practitioners credentialing information to L.A. Care. Along with the profile, first and last page of the contract, W-9, all addenda to the California Participating Physician Application (CPPA), and appropriate hospital coverage letter, if applicable, must be attached.

7.2.9.13 PPG profiles must meet L.A. Care's requirements as follows: Practitioners who do not have hospital privileges with a L.A. Care contracted hospital, may use the PPGs admitting panel or have a direct agreement with a practitioner who has admitting privileges within the same specialty at a L.A. Care contracted hospital. This agreement must capture responsibility for the provisions and coordination of care, when patients are discharged from the hospital, referral of patients back to PCP with a hospital discharge summary, and coordinate a seven day week, 24-hour call coverage utilizing the practitioners that are contracted with the PPG.

7.2.9.14 PPG will notify L.A. Care within thirty (30) days of any changes in the status of any of the PPG's participating practitioners, including, but not limited to, termination, resignation.

7.2.9.15 PPGs will ensure that practitioners and all of their contracted sites are reviewed in accordance with the requirements of L.A. Care, NCQA, DHCS and CMS requirements. All Practitioners must have a current (i.e., within 3 years of the date of initial credentialing/re-credentialing) full scope site review at the time of initial credentialing/re-credentialing. Practitioners who are only contracted for the Medicare program are required to undergo a

medical record review, by Cal MediConnect's Physician Quality Improvement Liaisons..

7.2.9.16 PPG's Board of Governors (Board), or the group or committee to whom the Board has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures on an annual basis.

7.3 Provisional Credentialing

7.3.1 The PPG may conduct provisional credentialing (in compliance with L.A. Care, NCQA, DHCS, and CMS requirements) of practitioners who completed residency or fellowship requirements for their particular specialty area within the 12 months before the credentialing decision.

7.4 Confidentiality and Practitioner Rights

7.4.1 PPG's credentialing policies and procedures must clearly state the confidential nature of information obtained in the credentialing process. The PPG must also describe the mechanisms in effect to ensure confidentiality of information collected in this process. The PPG must ensure that information obtained in the credentialing process is kept confidential and, ensure that practitioners can access their own credentialing information, as outlined in *Right to review information,* below.

7.4.2 During the credentialing process, all information that is obtained is considered confidential. All Committee meeting minutes and practitioner files are to be securely stored and can only be seen by an appropriate Medical Director or his/her equally qualified designee, and the Credentialing Committee members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1157 of the State of California Evidence Code and Section 1370 of the Health and Safety Code of the State of California.

7.4.3 PPG's policies and procedures must state that practitioners are notified of their right to review information obtained by the PPG to evaluate their credentialing application. The evaluation includes information obtained from any outside source (malpractice insurance carriers, state licensing boards, etc.).

7.4.4 PPG must have written policies and procedures for notifying a practitioner in the event that credentialing information obtained from other sources varies substantially from that provided by the

practitioner. The policies and procedures must clearly identify timeframes, methods, documentation and responsibility for notification.

7.4.5 PPG is not required to reveal the source of information if the information is not obtained to meet PPG credentialing verification requirements or if disclosure is prohibited by law.

7.4.6 Policies and procedures must also state the practitioner's right to correct erroneous information submitted by another source. The policy must clearly state:

7.4.6.1 Timeframe for changes
7.4.6.2 Format for submitting corrections
7.4.6.3 The person to whom corrections must be submitted
7.4.6.4 Receipt of documented corrections
7.4.6.5 How practitioners are notified of their right to correct erroneous information as outlined in this manual.

7.4.7 PPG's credentialing policies and procedures must state that practitioners have a right to be informed of the status of their applications upon request, and must describe the process for responding to such requests, including information that the PPG may share with practitioners. This element does not require the PPG to allow a practitioner to review references, recommendations or other peer-review protected information

7.5 Requirements

7.5.1 All practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. Physicians must not be excluded, suspended or ineligible or opted out for participation in the Medi-Cal or Medicare programs. Failure to meet Medi-Cal and/or CMS requirements may be cause for removal from L.A. Care's Cal MediConnect network.

7.5.2 The PPG/Vendor is required to notify the Plan immediately when providers/practitioners are identified on any sanctions or reports for removal from network.

7.5.3 These requirements include verification of the following circumstances:

7.5.3.1 Excluded Providers

7.5.3.1.1 Confirmation that practitioners or other health care providers/entities are not "excluded providers" on the

Office of the Inspector General (OIG) sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. Organizations employing or contracting with health practitioners/ providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. All contracted PPGs and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.
Lists of the excluded providers are available at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

7.5.3.2 Medi-Cal Suspended and Ineligible Providers

7.5.3.2.1 Medi-Cal law (*Welfare and Institutions Code,* Section 14123) mandates that the Department of Health Care Services (DHCS) suspends a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (b) suspended from the federal Medicare program for any reason.

7.5.3.2.2 Suspension is automatic when either of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the *California Administrative Procedures Act*.

7.5.3.2.3 All contracted PPGs and vendors, i.e., carved out contacts, are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

7.5.3.3 Opt-Out Providers

7.5.3.3.1 If a practitioner opts out of Medicare, that practitioner/ providers may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services. Payment must be made for emergency or urgently needed services furnished by an “opt-out” practitioner to a member, but payment should not otherwise be made to opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. This list must be checked on a regular basis.

7.5.3.3.2 All contracted Participating Practitioner Groups (PPGs) and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

7.5.3.4 National Provider Identifier (NPI) Number

7.5.3.4.1 All practitioners of Covered Services, including physicians and specialists, must have a valid National Provider Identifier (NPI) Number.

7.5.3.4.2 All contracted PPGs and vendors are required to verify that their contracted practitioners have a valid NPI number.

7.5.3.5 CLIA Certification

7.5.3.5.1 The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S through the Clinical Laboratory Improvement Amendments (CLIA). CLIA requires all facilities that perform even one test, including waived tests, on materials derived from human body for the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of health of, human beings to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of the tests performed.

7.5.3.5.2 All contracted PPGs and vendors shall ensure that all contracted laboratory testing sites have either a current and valid CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. This must be monitored on an ongoing basis. If a vendor is used to perform laboratory testing, the vendor is required to have a CLIA certificate and there must be a contract between both parties.

7.5.3.6 DEA or CDS Certificate, as applicable

7.5.3.6.1 The PPG must have a documented process for allowing a practitioner with a valid DEA certificate and participates within L.A. Care's Cal MediConnect network, to write all

prescriptions for a practitioner who has a pending DEA certificate, or require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications. The PPG will maintain a current DEA or CDS certificate on all contracted providers/practitioners.

7.5.3.7 Medicare Number

7.5.3.7.1 All PPGs must ensure that their contracted facilities and contracted practitioners that serve Medicare members must have a Medicare number.

7.5.3.8 Ongoing Monitoring of Sanctions, Complaints, and Quality Issues

7.5.3.8.1 PPG must implement a process for monitoring practitioner sanctions, complaints and the occurrence of adverse events between re-credentialing cycles. The PPG must conduct ongoing monitoring of all practitioners who fall within the scope of credentialing. The PPG must be fully compliant with L.A. Care, NCQA, DHCS, and CMS and use the approved current sources of sanction information.

7.5.3.8.2 PPG develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles, and takes appropriate action against practitioners when it identifies occurrences of poor quality. PPG identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

7.5.3.8.3 PPG must show how they monitor all adverse events and demonstrate this process has been reviewed by the Credentialing Committee at least every six months. The PPG's Credentials committee may vote to flag a practitioner for ongoing monitoring. The PPG must make clear, the types of monitoring they impose, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the PPG's Credentialing Committee.

7.5.3.8.4 PPG must provide proof of any practitioner identified on the OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc. The PPG must demonstrate that they have taken

action to terminate the contracted practitioner. If a practitioner has been identified on any of the lists above, they are to be terminated for all lines of business for L.A. Care, including L.A. Care Cal MediConnect..

7.5.3.8.5 PPG must notify L.A. Care promptly and no later than fourteen (14) calendar days of any adverse event or criminal action, changes in privileges, accusation, probation, other disciplinary action against a practitioner, or non-compliance with L.A. Care's policies and procedures. Failure to do so may result in the removal of the practitioner from L.A. Care's Cal MediConnect network.

7.5.3.8.6 L.A. Care retains the right, based on quality, facility site review, adverse events, criminal actions, or changes in privileges, accusations, and/or probation to close practitioners to new member assignment until such time the L.A. Care's Credentialing Committee determines otherwise.

7.5.3.8.7 PPG who fails to comply with the requested information within the specific timeframe is subject to sanctions as described in L.A. Care's policies and procedures and PPGSA, section 1.36 and 1.37. In the event that the PPG fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and will be subject to L.A. Care's policies and procedures and Credentials committee's outcome of the adverse events.

7.6 Recredentialing

7.6.1 Participating practitioners must satisfy re-credentialing standards required for continued participation in the network. Re-credentialing is completed three years from the month of initial credentialing and every three (3) years thereafter.

7.6.2 A facility site review does not need to be repeated as part of the re-credentialing process if the site has a current passing score (this applies to PCPs). A passing site review survey will be considered "current" if it is dated within the last three (3) years (with use of new tool) of the re-credentialing date, and does not need to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the Plan

7.6.3 If a practitioner/provider is contracted for the Medi-Cal and Medicare programs, they are subject to both a site review and medical record review, conducted by Cal MediConnect

Physician Quality Improvement Liaisons. However, Facility Site Review or other L. A. Care staff may visit a provider's office at any time without prior notification.

7.7 Credentialing Committee

7.7.1 The Credentialing Committee will consist of not less than three (3) participating practitioners in good standings with state and federal agencies in order to ensure accurate representation of medical specialties.

7.7.2 Administrative support staff may attend at the request of the Chair but are not entitled to vote.

7.7.3 A quorum should consist of three (3) practitioner committee members. Any action taken upon the vote of a majority of members present at a duly held meeting at which a quorum is present shall be an act of the committee.

7.8 Meetings and Reporting

7.8.1 The Credentialing Committee shall meet at least quarterly but as frequently necessary to demonstrate follow-up on all findings and required action; and maintain a permanent record of its proceedings and actions. The activities, findings, recommendations, and actions of the committee must be reported to the governing body or designee in writing on a scheduled basis.

7.8.2 Additional meetings of the Credentialing Committee may be called by the Committee Chairperson on an as-needed basis.

7.9 Committee Decisions

7.9.1 L.A. Care considers the decision made by the Credentialing Committee to be final.

7.9.2 The PPG's credentialing policies and procedures must include a time frame for notifying applicants of credentialing decisions, not to exceed sixty (60) calendar days from the Committee's decision.

7.10 Participation of Medical Director or other Designated Practitioner

7.10.1 PPG must have a practitioner (medical director or equally qualified designated practitioner) who has overall responsibility for the credentialing process. Credentialing policies and procedures must clearly indicate the Medical Director is directly responsible for the credentialing program and must include a description of his/her participation.

7.11 Committee Functions

7.11.1 Review and evaluate the qualifications of each practitioner applying for initial credentialing, and recredentialing.

7.11.2 Investigate, review and report on matters referred by the Medical Director or his/her designee or the Board regarding the qualifications, conduct, professional character or competence of any applicant or practitioner, and;

7.11.3 Review of periodic reports to the appropriate Committee and/or Board on its activities, i.e., ongoing monitoring reports, credentialing activity reports, etc.

7.11.4 Review annually policies and procedures relevant to the credentialing process, and make revision as necessary to comply with L.A. Care, NCQA, DHCS, and CMS requirements, regulations and practices.

7.11.5 PPG's Credentialing Committee must review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care. At a minimum, the Credentialing Committee must receive and review the credentials of practitioners who do not meet the PPG's established criteria.

7.11.6 PPG's Credentialing Committee must clearly document detailed discussion that reflects thoughtful consideration of credentials reviewed during its meeting in the minutes. Discussion that demonstrates approval/denial does not meet the intent of detailed discussion.

7.11.7 When the credentialing function is not delegated to the PPG, L.A. Care's Credentialing Department will be responsible for credentialing and recredentialing activities in-house.

7.11.8 L.A. Care's Credentialing Committee may terminate, suspend or modify participation of those practitioners who fail to meet eligibility criteria. The decisions to terminate, suspend, or modify participation of a contracted practitioner as a result of a reportable quality of care issue shall be subject to an appeals process by the practitioner.

7.12 Credentials Committee File Review

7.12.1 PPG's policies and procedures must describe the process used to determine and approve clean files. They must identify the Medical Director as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean and approved. With regard to clean files, the practitioner may not provide care to members until the final decision of the Credentialing Committee or the Medical Director or his or her equally qualified designee.

7.12.2 PPG's credentialing and re-credentialing policies must explicitly define the process used to reach a credentialing decision.

7.13 Appeal and Fair Hearing

7.13.1 Delegated PPG, or if not delegated, L.A. Care must have a mechanism for fair hearing and appeal process for addressing adverse decisions that could result in limitation of a practitioner's participation based on issues of quality of care and/or service, in accordance with all applicable statutes. The process should include notification to practitioner within an established time frame and established time frame for practitioner to request a hearing, scheduling of hearing requests, followed by the procedures hearings, the composition of the hearing committee and the agenda for the hearing.

7.13.2 PPG must have an appeal process for instances in which it chooses to alter the conditions of a practitioner's participation based upon issues of quality of care and/or service. Except as otherwise specified in this manual, any one or more of the following actions or recommended actions taken for a medical disciplinary cause or reason shall be deemed actual or potential adverse action and constitute grounds for a hearing:

7.13.3 The following actions entitle the practitioner the opportunity to appear before a Peer Review Committee to present rebuttal evidence before a final determination is made. The practitioner shall have the right to be represented by an attorney during this process. The following actions also entitle the practitioner the opportunity for a hearing before a hearing panel in the event that the final determination of a Peer Review Committee is adverse to the practitioner, unless the right to a hearing has been forfeited as described below. The actions to which this section applies are:

7.13.3.1	Denial of initial panel appointment
7.13.3.2	Denial of reappointment to panel
7.13.3.3	Suspension of panel appointment (except as described below)
7.13.3.4	Revocation of panel appointment
7.13.3.5	Other adverse restrictions on panel appointment (except as described below)

7.13.4 Peer Review Committee has the right to recommend suspension of a practitioner's panel appointment for up to fourteen (14) calendar days while an investigation is being conducted to determine the need for peer review action, without the practitioner having a right to the rebuttal and/or fair hearing process set forth below.

7.13.5 A Peer Review Committee has the right to recommend immediate suspension or restriction of a practitioner's membership if the committee reasonably believes that the health of any individual would be jeopardized by the continued participation of the practitioner. In the case of such an immediate suspension or limitation on privileges (summary action), the practitioner has the right to receive notice, opportunity to present rebuttal information and fair hearing, in accordance with the procedure described in L.A. Care's Policy LS-005, but those rights apply subsequent to the summary action, rather than prior to it.

7.14 Required Reporting

7.14.1 PPG must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank/Healthcare Integrity Protection Data Bank within thirty (30) calendar days after the effective date of the action, if any of the following events occur:

7.14.2 The practitioner's application for participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.

7.14.3 The practitioner's participation status is terminated or revoked for a medical disciplinary cause or reason.

7.14.4 Restrictions 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.

7.14.5 The practitioner resigns or takes a leave of absence from participation status following notice of any impending investigation based on information indicating medical disciplinary cause or reason or for any of the following:

7.14.5.1 Resigns, retires, or takes a leave of absence.
7.14.5.2 Withdraws or abandons the application.
7.14.5.3 Withdraws or abandons his or her request for renewal.

7.15 Expired License

7.15.1 L.A. Care requires that all practitioners who are performing services for L.A. Care Cal MediConnect members have a current license at all times to provide patient care to members and abide by State and Federal laws and regulations.

7.15.2 Failure to Renew

7.15.2.1 Practitioners contracted with L.A. Care shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. The license to practice medicine in California must be renewed upon expiration (every two (2) years).

7.15.2.2 If any practitioner fails to renew their license by the expiration date, the following steps will be initiated by L.A. Care.

7.15.2.3 If the identified practitioner(s) has Cal MediConnect member enrollment:

7.15.2.3.1 Close provider's panel to new members upon license expiration.

7.15.2.3.2 Notify PPG of expiration and possible reassignment of members

7.15.2.3.3 Remove assigned members from unlicensed practitioner/practitioner 5 business days following license expiration, if not renewed

7.15.2.3.4 Reassign members to a qualified licensed credentialed practitioner

7.15.2.3.5 Remove unlicensed practitioner from network

7.15.2.4 If the identified practitioner(s) has no member enrollment:

7.15.2.4.1 Close practitioner's panel to new members

7.15.2.4.2 If practitioner has not renewed by the 5th business day following the expiration date, the unlicensed practitioner will be removed from L.A. Care's Cal MediConnect network

8.0 PROVIDER NETWORK OPERATIONS (PNO)

8.1 Department Units

8.1.1 Provider Contracting

The Provider Network Contracting team is responsible for developing and negotiating financially sound contracts with physicians, Participating Physician Groups (PPGs), hospitals, ancillary providers and other health professionals in order to maintain a comprehensive network of health care providers for the provision of health care services to covered members.

8.1.2 Provider Relations

8.1.2.1 Provider Relations Manager and Provider Network Representatives are responsible for the following:

8.1.2.1.2 Serving as key contacts for PPGs, hospitals, and other providers to resolve all operational and ongoing service issues.

8.1.2.1.3 Coordinating closely with Provider Contracting, Provider Information Management, Member Services, Claims, Utilization Management, and PPGs when necessary to resolve issues.

8.1.2.1.4 Training PPG personnel to ensure L.A. Care Cal MediConnect procedures and requirements are understood and followed.

8.1.2.1.5 Conducting Joint Operations Meetings to ensure that administrators and staff are kept informed of policy and procedure changes.

8.1.2.1.6 Provider grievance resolution.

8.1.3 Provider Network Research & Analysis Unit

The Provider Network Research & Analysis Unit (PNRA) has program responsibility over multifaceted, highly technical functions that bring together the services of information technology, provider network information, and statistical studies and reporting. In this capacity, PNRA has oversight responsibility for the management, accessibility, and usability of provider information. PNRA is also

responsible for conducting comprehensive provider related studies as mandated by the Centers for Medicare & Medicaid Services (CMS) and other governing agencies/bodies. Other key functions of the PNRA unit are the production of L.A. Care's Cal MediConnect provider directories and the entry/updating of contractual terms/rates into L.A. Care's transaction system for our directly contracted PPGs, hospitals, ancillary providers, and individual providers for claim payment purposes.

8.2 PROVIDER TRAINING AND EDUCATION

8.2.1 Provider education is implemented by L.A. Care Cal MediConnect and its PPGs. Goals, objectives, curricula, and implementation guidelines are established by L.A. Care. The PPGs are responsible for conducting provider training and orientation. L.A. Care Cal MediConnect training is required for all providers. L.A. Care provides additional resources and opportunities for provider education for Cal MediConnect.

8.2.2 L.A. Care provides special training and workshops for traditional and safety net providers. These workshops encompass focused clinical competence training, product line workshops, and other related clinical practice management issues along with the Health Promotion Services department.

8.2.3 Ultimately, the goal of provider training and education is to improve the delivery of services to members by providing appropriate forums for providers to:

8.2.3.1 Be better informed about products offered by L.A. Care and its systems and processes.

8.2.3.2 Understand the needs of L.A. Care Cal MediConnect members.

8.2.3.3 Improve clinical, patient interaction, and administrative/ management skills.

8.2.4 A training and education curriculum will be developed and implemented by the PPGs with collaborative oversight, guidance, and approval of L.A. Care or it will be provided directly by L.A. Care. L.A. Care's Health Promotion Services department and PNO share responsibility for L.A. Care's involvement in this process.

8.2.5 Failure to complete mandatory training (e.g. ICT training) may result in the following consequences:

- Limited network participation, including panel closure
- Limited participation in pay for performance incentive programs

8.3 TRAINING AND EDUCATION MATERIALS AND METHODS

All provider training and education materials produced and distributed by PPGs must be approved by L.A. Care prior to distribution. The following provider training and education materials must be used by the PPGs:

8.3.1 Provider Manuals

Each PPG must distribute a provider manual to its contracted network within Los Angeles County that includes information about L.A. Care's contracted programs, including Cal MediConnect.

8.3.2 Orientation Sessions and On-site Visits

Provider orientation sessions and on-site visits will be conducted by PPGs to provide an in-service on their provider manual and to conduct additional training, as needed, for newly contracted providers and programs within ten (10) calendar days of effective contract.

8.3.3 Provider Bulletins and Newsletters

PPGs should publish and distribute provider newsletters and/or bulletins at least semi-annually. The newsletters should provide relevant and timely information concerning applicable standards, services available to members, quality improvement activities, updates, and other pertinent issues related to the delivery of health services to L.A. Care Cal MediConnect members. Semi-annual general meetings that provide updates on health care delivery issues, hosted by PPGs and its providers, will meet the requirement of publishing semi-annual newsletters/bulletins.

8.3.4 Focused Seminars, Workshops and Symposia

L.A. Care and PPGs will work together to conduct focused seminars, workshops, and symposia on special topics.

8.4 PROVIDER DIRECTORIES

L.A. Care produces a provider directory for each product line on a regular basis. The directory includes a listing of all the PPGs, PCPs, hospitals and pharmacies. Data for the directory will be compiled by L.A. Care from

PPG provider uploads. Upon request, L.A. Care will send a directory to the requesting party for the Cal MediConnect program.

8.5 MID-LEVEL MEDICAL PRACTITIONERS

8.5.1 The use of non-physician practitioners is designed to increase members' access to appropriate primary care and specialty medical services, maximize the patient's health and well-being, and promote cost-effective care. The delegation of specified medical procedures to non-physician practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the non-physician practitioner.

8.5.2 Physicians may supervise up to four mid-level medical practitioners according to the following ratios of a full-time equivalent physician supervisor to mid-level medical practitioners:

8.5.2.1 One physician to four nurse practitioners

8.5.2.2 One physician to three certified nurse midwives

8.5.2.3 One physician to two physician assistants

8.5.2.4 Four non-physician practitioners in any combination that does not include more than three certified nurse midwives or two physician assistants and maintain the full-time equivalence limits.

8.5.3 A single non-physician practitioner can potentially increase the supervising physician's capacity by 1,000 members. However, when all practitioners are added, the physician cannot be responsible for more than 5,000 patients in total. The non-physician practitioner may only provide those medical services that he/she is competent to perform and that are consistent with the practitioner's education, training and experience, the terms of which must be delineated in writing by the supervising physician. The stipulated scope of practice must be in full compliance with standards set forth by the Physician Assistant Examining Committee of the Medical Board of California, California Board of Nursing, the Nursing Practice Act, DMHC the California Code of Regulations, the California Administrative Code, the California Business and Professions Code, and the requirements of any other applicable professional licensing body, law and regulations.

8.5.4 A scope of practice agreement which is signed by the non-physician practitioner and the supervising physician, as well as standardized procedures, must be filed and maintained at the medical practice site. The scope of practice agreement must address the following elements:

8.5.4.1 Delegated responsibilities

8.5.4.2 Disciplinary policies

8.5.4.3 Method and frequency of physician supervision

8.5.4.4 Monitoring and evaluation of the non-physician practitioner

8.5.4.5 Chart review requirements

8.5.4.6 Term of the agreement/contract

8.5.5 The following requirements must be included within the standardized procedures for mid-level medical practitioners, and reflected in written agreements as indicated above:

8.5.5.1 The supervision or back-up physician must be available in person or through electronic means at all times when the non-physician practitioner is caring for patients.

8.5.5.2 The supervising physician must review on a continual basis tasks delegated to the non-physician practitioners for competency.

8.5.5.3 Medical record documentation by the non-physician practitioner must be reviewed and counter-signed by the supervising physician within thirty (30) calendar days of the date care was provided.

8.5.6 Each PPG must set and implement credentialing elements for mid-level medical practitioners and ensure that they are consistent with the criteria and scope of practice requirements set forth in this manual and any other policies, procedures, and directives issued by L.A. Care. As part of the credentialing process, the appropriate credentialing committee, prior to the provision of care by mid-level medical practitioners, must verify that a signed scope of practice agreement, a signed set of procedures by the supervising provider, and appropriate license(s) are present. L.A. Care will audit the PPG's credentialing verification process.

8.5.7 L.A. Care's contracted provider network will be comprised of subcontracted health plan for performing the Long Term Services and Support (LTSS) activities. LTSS is a delegated activity and subcontracted health plans will be assessed to ensure health plans have the capacity to perform the function. L.A. Care's LTSS unit will serve as an expert advisor in the delegation monitoring activities.

For contracted providers that are not delegated for LTSS services, L.A. Care will directly perform the activity through an internal department or vendor service. L.A. Care will be extending the contracting LTSS provider relationships to include:

- Personal Assistance Services Council (PASC), the public authority that oversees IHSS in L.A. County, to support IHSS worker training and education, background checks and registry functions, and other functions as warranted;
- The IHSS program administered by the County
- Community Based Adult Services providers, that support independent living and delay or deter long term care placements
- Six Multipurpose Senior Services Program (MSSP) providers in L.A. County that have the experience, expertise and relationships needed to connect members to the appropriate community-based resources.

8.6 ELIGIBILITY LISTS

8.6.1 Monthly Eligibility lists (E-lists) for the Cal MediConnect Program are provided to PPGs by or on the tenth (10^{th}) business day of each month. The E-list contains the current month's eligibility information for members assigned to PCPs within each PPG. Daily eligibility can be verified by L.A. Care's IVR system or by using L.A. Care Connect.

8.6.2 Please call L.A. Care's Provider Information Line at 1-866-LACARE6 or your assigned Provider Network Representative if you have any questions about your eligibility lists.

8.7 PROCEDURE FOR HANDLING PROVIDER QUESTIONS & CONCERNS

8.7.1 Communication

Providers can communicate their questions and concerns to their PPG or to L.A. Care directly. Providers may communicate with L.A. Care by telephone, in person, in writing, or by e-mail.

8.7.2 Resolution

8.7.2.1 Provider Network Representatives from the PPG or L.A. Care will answer most provider questions and resolve provider concerns immediately. Any question or concern, which suggests a quality of care issue, will be handled as a

clinical grievance. Any question regarding Part "D" benefits will be forwarded to the L.A. Care Health Plan Part "D" hotline (1-800-633-4273).

8.7.2.2 The provider network representative will answer the provider's question and inform the provider of his/her right to file an informal complaint or formal grievance if desired. If the provider asks a question over the telephone or in person, the answer will be provided orally. If the provider writes a letter, the answer will be provided in writing within seven (7) business days.

8.8 PROVIDER GRIEVANCES

Provider administrative grievances will be handled as specified below.

8.8.1 Communication of Formal Grievances

8.8.1.1 Providers must communicate their formal grievances directly to their PPG. This communication must be in writing.

8.8.1.2 If the provider wishes to file a formal grievance, the Grievance and Appeals representative will give the provider detailed instructions for filing a grievance. The Grievance and Appeals unit will assist providers in filing grievances, including assistance with completing a grievance form, if applicable.

8.8.1.3 The Grievance and Appeals representative will record the grievance on the provider grievance log. Regardless of the method of filing of the provider's grievance, the Grievance and Appeals unit will send an acknowledgment letter to the provider within five (5) working days.

8.8.1.4 If a provider contacts L.A. Care directly with a grievance, the Grievance and Appeals representative will record the information on the provider grievance log, contact the provider's PPG, and send an acknowledgement letter within five (5) business days. The PPG will be responsible for resolving the grievance within thirty (30) calendar days and informing L.A. Care of the resolution/disposition. L.A. Care will be responsible for informing the provider of the resolution/disposition in this case.

8.8.2 Resolution

8.8.2.1 All grievances will be resolved within thirty (30) calendar days.

8.8.2.2 Extensions to grievances will be requested of the Grievance and Appeals Manager. A fifteen (15) or thirty (30) calendar day extension may be granted. If an extension is granted, a letter to the grieving provider will be sent with appropriate reasons for the extension.

8.8.2.3 The PPG and/or L.A. Care will provide written notice of grievance resolution/disposition and deliver each letter by way of certified mail.

8.8.3 Dispute Resolution

8.8.3.1 A provider has the right to file an appeal. The provider must submit a detailed written grievance, including the desired resolution and all supporting documentation and correspondence to the PNO Director at L.A. Care. L.A. Care will respond with an acknowledgement letter within five (5) business days.

8.8.3.2 A Provider Relations Subcommittee will convene within thirty (30) calendar days of receipt of the dispute to decide whether the committee has authority to address the issue. The grieving party will have the opportunity to address the issue in front of the committee if L.A. Care's committee has deemed it applicable. A resolution will be made by the committee with notification to the provider within seven (7) business days of the decision.

8.8.3.3 All providers have the right to file a grievance with the Department of Managed Health Care (DMHC). The toll-free telephone number is (800) 400-0815. If you have a grievance against L.A. Care Health Plan, contact L.A. Care and use our grievance process.

9.0 HEALTH EDUCATION

Health education is the process of providing health information, skill training, and support to individuals to enable and empower them to modify their behaviors and improve their health status. L.A. Care Health Plan is responsible for the planning, implementation, and evaluation of member health education, health promotion, and patient education for our direct lines of business members. Primary care providers (PCPs) are responsible for delivering individual education during member doctor visits, continually reinforcing positive health behavior change in patients, documenting the delivery of health education services in the patient's medical record, and administering the Individual Health Education Behavioral Assessment Tool (IHEBA). PPGs are responsible for assisting L.A. Care in educating providers about health education requirements, services and available resources.

The mission of L.A. Care Health Plan's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve direct line of business member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care. This is achieved through assisting direct line of business members to:

- Effectively use primary and preventive health care services, including health education services
- Modify personal health behaviors, achieve and maintain healthier lifestyles, and promote positive health outcomes
- Learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases, or other health conditions.
- Navigate the health system to ensure access to preventive health services

9.1 Health Education Services

***Health In Motion*™ L.A. Care Members Only,** L.A. Care Health Plan's mobile health education program brings health education directly to L.A. Care members in their communities. *Health In Motion*™ L.A. Care Members Only is for L.A. Care Health Plan's direct line of business members (Cal MediConnect, **MCLA, L.A. Care Healthy Kids, PASC-SEIU, L.A. Care Covered, and L.A. Care Medicare Advantage HMO SNP).** Services are offered as individual counseling over the phone and/or group appointments. All classes are available at no cost to the member and are conducted in English and Spanish. Interpreting services (including American Sign Language) are also available. Programs include:

Respiratory Conditions

- **Asthma Basics:** Educates adults, children and parents on risk factors, asthma trigger avoidance, medication adherence, and the use of peak flow meters and spacers. (One session)

- **Chronic Obstructive Pulmonary Disease (COPD):** Teaches adults basic COPD information in easy-to-understand terms, common symptoms, and ways to slow the progression of COPD. (One session)

Evidence-Based Self Management Series

- **Healthier Living**: Stanford University's evidence-based chronic disease self-management program includes instruction on nutrition, goal setting, and how to better communicate with providers and family members. (Six session series)

- **Living Well With A Disability:** A peer support workshop for anyone with a health challenge or disability to build skills, and maintain a life of healthy independent living. (Eight session series)

Cholesterol & Hypertension

- **Love Your Heart:** Teaches skills to prevent and manage high cholesterol and high blood pressure. Instruction includes heart-healthy diet and exercise information. (One session)

Diabetes/Pre-Diabetes

- **Diabetes Self-Management Education:** The Diabetes Self-Management and Support (DSME-S) program enables members to either prevent or delay the onset of diabetes or to manage their condition on a daily basis. The program is delivered either through group appointments or telephonically. The program adheres to the 2012 National Standards for Diabetes Self-Management Education and Support from the American Diabetes Association and the American Association of Diabetes Educators. (Up to four sessions)

- **Little Sugar in the Blood:** Designed for the member whose blood sugar is "a little high" but not high enough to be diabetes. This class focuses on healthy lifestyle changes to prevent the onset of diabetes. (Two sessions)

Nutrition and Physical Activity

- **Burn Rubber:** An exercise program where participants will "burn" calories with the use of a "rubber" resistance band. Popular resistance band exercises have been modified to perform in a chair to meet the needs of the senior population. Eight different exercises are covered for a total body workout. (One session)

- **My Healthy Plate:** Introduces "My Healthy Plate" to the entire family. It teaches how to build a healthy plate by balancing portion size and including all basic food groups. (One session)

Senior Health

- **Living with Osteoporosis**: This session helps adults understand osteoporosis basics, ways to maintain healthy bones and slow the progression of the disease. (One session)
- **Stronger and Wiser - Fall Prevention for Mature Adults:** This session helps mature adults get "stronger and wiser" by understanding the risk factors of falling, what they can do to prevent falls, and different home safety modifications. (One session)
- **Caring for a Loved One with Dementia:** Designed for caretakers of people suffering from dementia. Describes dementia and covers the causes, managing challenging behaviors, stress reduction, and financial and legal planning. (Two sessions)

Wellness/Prevention

- **Cold or Flu? Antibiotics Won't Work for You!:** Teaches participants the difference between a virus and bacteria, what antibiotics are used for and how to take them, awareness of the risk of antibiotic resistance, and ways to help relieve cold and flu symptoms without the use of antibiotics. (One session)
- **Know Your Medicine**: Teaches adults the different types of drugs and what makes them different, the difference between generic and brand-name drugs, ways to take medications safely and how to get the most of your personal pharmacist. (One session)
- **Stress and Anxiety Management:** Defines stress and anxiety and their effect on health, signs/symptoms, and ways to manage stress and anxiety. (One session)
- **Health for Her:** This workshop covers the importance of mammography and Pap smears, as well as healthy eating, stress management, and resistance band exercise. (One session)

Primary care physicians may refer L.A. Care direct line of business members, including Cal MediConnect members to health education by utilizing the on-line Health Education Referral Form located on the L.A. Care website at: http://www.lacare.org/providers/provider-resources/health-education-tools. Health education staff will contact the patient and schedule the requested health education service(s). The outcome of the health education referral will be sent back to the member's PCP. The PCP must document health education referrals and outcome data in the patient's medical record.

L.A. Care Health Plan Family Resource Centers

L.A. Care Health Plan operates two community health education resource centers in the South Los Angeles communities of Lynwood and Inglewood. L.A. Care Health Plan partners with community organizations to offer no or low-cost health education classes on asthma, diabetes, HIV, exercise, nutrition, parenting, smoking cessation, weight management, senior wellness, and activities and services for people with disabilities. New member orientations, health

screenings, and application and enrollment assistance are also provided. For more information go to: http://www.lacare.org/health-resources/community-health/family-resource-centers.

Nurse Advice Line
L.A. Care Health Plan offers a nurse advice line 24-hours a day, seven days a week to all direct line of business members.

Health Education Programs

L.A. Care's Health Education Programs are a combination of coordinated and systematic health education services, resources, and member outreach designed to target a specific health problem or population. Members are identified as eligible for Programs based on specific inclusion criteria for each program. Programs are available at no cost to members.

Tobacco Cessation Health Education Program. Adult L.A. Care Health Plan Members (Cal MediConnect, MCLA, PASC-SEIU and Medicare Advantage HMO SNP) who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, Buproprion, Varenicline) are mailed health education materials promoting available smoking cessation resources including "You Can Quit Smoking–*Support and Advice from L.A. Care Health Plan"* and a listing of free local smoking cessation resources. Outbound calls are made to members two weeks after the mailing to ensure receipt of the packet and to administer a phone survey to assess the resources used and their smoking status.

Health Education Materials and Resources

Health Education Materials

L.A. Care makes health education materials available in multiple topics and languages to meet the needs of direct line of business members. Health education topics include: arthritis, asthma, dementia, dental health, diabetes, fall prevention, exercise, HIV/STD prevention, hypertension, immunizations, nutrition, osteoporosis, palliative care, substance abuse, tobacco prevention/cessation, and weight management and more.

Providers may order L.A. Care health education materials through the health education material order form on-line application located at: http://www.lacare.org/providers/provider-resources/health-education-tools . Written Health Education Materials provided by L.A. Care comply with the guidelines set forth by DHCS. Health education materials distributed to L.A. Care members by L.A. Care Health Plan and its provider network undergo review using the Readability and Suitability Checklist (RSC). The RSC refers to the form provided by Medi-Cal Managed Care Division (MMCD) to ensure health education materials developed, adapted, or used for members are systematically evaluated to assess their suitability for Medicaid populations.

Alternative Formats – L.A. Care Health Plan makes health education materials available in alternative and cognitively accessible formats, including large print, audio and other formats) upon request.

L.A. Care Health Education and Social Services Directory

L.A. Care ensures that members are referred to culturally and linguistically appropriate services through use of various external search engines, telephonic referral agencies, and online databases, such as www.healthycity.org. L.A. Care staff, primary care physicians, and PPG staff may also utilize www.healthycity.org to identify culturally and linguistically appropriate community resources for their patients. This online resource directory is also available via the L.A. Care website (http://www.lacare.org).

Individual Health Education Behavioral Assessment Tool – "Staying Healthy Assessment"

PCPs are responsible for ensuring the use of 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). The goals of the SHA are to:

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

The SHA is available in nine age categories (0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years, adults and seniors (55+ years at physician's discretion) and 12 languages (Arabic, Armenian, Chinese, English, Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese). Arabic and Hmong are not threshold languages in Los Angeles County.

L.A. Care Health Plan makes resources and training available to providers and subcontractors to ensure the delivery of culturally and linguistically appropriate patient health education services and to ensure that the special needs of vulnerable populations, including SPDs and persons with limited English skills, are addressed in the delivery of patient services. SHA forms be downloaded from the L.A. Care Health Plan website (www.lacare.org) or ordered using the on-line Health Education and Cultural & Linguistics Materials Order Form. Providers may order supporting health education materials via the on-line Order

Form. L.A. Care Health Plan educates providers on the implementation of the SHA through periodic updates in the provider bulletin, education conducted by FSR nurses at site reviews, at joint operations meetings, and through a video posted on L.A. Care's website.

PCPs must administer the SHA to all new L.A. Care members as part of the Initial Health Assessment and to existing members at the first scheduled exam after the patient enters a new age group. The SHA must be re-administered to adults and seniors every three to five years. Annual administration is encouraged for 12-17 years and seniors due to rapidly changing risk factors.

The SHA must be reviewed annually for all age groups in the interval years between administrations.

9.2 Provider Education

The provider network must be regularly educated on health education requirements, services and available resources. L.A. Care Health Plan shares this responsibility with PPGs. Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and special trainings.

Content of provider education includes, but is not limited to:

- Communication of regulatory agencies' and L.A. Care Health Plan health education requirements
- Availability of health education services and resources
- Availability of health education materials and the process for obtaining materials
- Health education material requirements including qualified health educator oversight, reading level, field testing (if applicable), medical accuracy, availability of materials in alternative formats, and cultural/linguistic appropriateness
- Staying Healthy Assessment (SHA) requirement

L.A. Care Health Plan PPGs are responsible for educating providers on health education requirements and available L.A. Care Cal MediConnect services as listed above. Methods may include, but are not limited to: provider mailings and newsletters; meetings, seminars or other trainings; on-site visits; blast-faxes; provider manual and policies and procedures; and website postings.

10.0 CULTURAL & LINGUISTIC SERVICES

Overview

The relationship between culture, language, and health is complex and inextricably linked to the health status of individuals and subsequently communities. L.A. Care Health Plan maintains a comprehensive Cultural and Linguistic Services program, which supports and works collaboratively with other L.A. Care Health Plan departments.

The mission of L.A. Care Health Plan's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care.

Within the HECLS department there are two units: Health Education and Cultural and Linguistic Services. The goals of the Cultural and Linguistic Services unit are to:

- Ensure that limited English proficient (LEP) members receive the same scope and quality of health care services that others receive.
- Ensure the availability and accessibility of cultural and linguistic services including quality interpreting services and written materials in members' preferred language and in a manner and format that is easily understood.
- Improve health outcomes and decrease disparities.
- Continually evaluate and improve C&L programs and services.

10.1 Interpreting Services

L.A. Care Health Plan provides timely, 24-hour, 7-day a week health care interpreting services, including American Sign Language (ASL), at medical and non-medical points of contact, at no cost to members. Languages are not limited to the threshold languages.

PPG and network providers should not require, or suggest to, L.A. Care limited English proficient (LEP) members that they provide their own interpreter. A member may choose to use a family member or friend as an interpreter after they are informed of the right to professional interpreting services at no cost. If a member refuses professional interpreting services, this refusal and the member's request to use a family member or friend must be documented in the medical chart. Use of minors as interpreters is not allowed except in extraordinary circumstances such as medical emergencies.

PPG and network providers must utilize qualified interpreters when communicating with limited English proficient (LEP) L.A. Care members. PPG may access interpreting services through L.A. Care Health Plan or choose to

contract with an interpreting services vendor to communicate with members. If PPG chooses to contract with an interpreting services vendor, PPG must ensure that services are provided by qualified interpreters.

Telephonic Interpreting Services

L.A. Care's call center has the capacity to handle member calls in over 100 different languages through telephonic interpreting service vendor. To access L.A. Care's telephonic interpreting services, call one of the following numbers:

PPG:	**1-888-718-4366**
Network Provider:	**1-888-930-3031**

Have the following information ready:

- Name of PPG or Medical Board License Number
- Member's L.A. Care ID number
- Language being requested

Face-to-Face Interpreting Services

To request face-to-face skilled medical interpreting services (including American Sign Language) for L.A. Care members, call L.A. Care's Member Services Department at **1-888-522-1298** at least 5-10 business days prior to the member's medical appointment.

Have the following information ready:

- Member's Information
  - Member's name
  - Member's L.A. Care ID number
  - Member's date of birth
  - Language being requested
  - Member's requested preferred gender of interpreter
- Appointment Information
  - Provider's name
  - Provider's specialty
  - Requestor's name and phone number
  - Contact person's name at appointment site and phone number (if different from requestor)
  - Date and time of appointment
  - Duration of appointmentAddress of appointment (including facility name and suite number)
  - Purpose of appointment
  - Other special instructions, as applicable

California Relay Service (CRS) for Deaf and Hard of Hearing Members

California Relay Service (CRS) is a 24-hour, 7-day a week relay service which helps a person using a Teletypewriter/Telecommunications Device for Deaf and Hard of Hearing members or (TTY/TDD) to communicate by phone with a person who does not use a TTY/TDD. CRS can also help a non-TTY/TDD user call a TTY/TDD user. Trained relay operators are on-line to relay the conversation as it takes place. To communicate with a Deaf or hard of hearing member over the phone, call one of the following numbers:

California Relay Services (CRS)

	711
Sprint	**1-888-877-5379** (voice)
MCI	**1-800-735-2922** (voice)

Have the following information ready:

- Member's name
- Member's phone number

10.2 Translation Services

L.A. Care provides limited English proficient (LEP) members with written member informing materials in the member's identified primary threshold language. Threshold languages for Cal MediConnect are English, Spanish, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Additionally L.A. Care provides written member information materials in alternate formats such as large print, audio and other formats upon request.

L.A. Care provides templates of translated notice of action (NOA) letters to PPG. PPG is responsible for ensuring NOA letters are routinely sent to members in their preferred threshold language including member specific information in a manner and format that is easily understood.

If PPG develop a member informing material, PPG is responsible for translating the material into threshold language(s) and sending it to the member in the appropriate language and format.

Any material that is sent in English must include a notice that has been translated into the threshold language(s) informing members of availability of translation and interpreting services.

PPG must ensure all translations are an accurate meaning-for-meaning rendition of the source text in the target language(s) at the 6th grade reading level (calculated by Readability software, including but not limited to SMOG, Fry Graph, FOG, Flesch Reading Ease, and Dale-Chall) that is culturally appropriate and relevant to L.A. Care´s member population.

PPG may contract with a translation services vendor or use qualified internal bilingual staff to translate member informing materials by following the three-step process with at least two different linguists outlined in MMCD policy letter 99-04.

PPG must obtain a signed form from the translation services vendor or bilingual staff who performed translation attesting to the accuracy and completeness of the translation. PPG must keep the original (English) text, the translated document, and the attestation form on file for review.

10.3 Assessing Proficiency of Bilingual Staff

PPG, network providers, and provider staffs who communicate with members in a language other than English must be qualified and formally assessed for their capabilities. PPG must keep evidence of the results of formal language assessments on file. This information must be updated annually for provider office staffs and every three years for providers, at a minimum. If bilingual staffs are providing interpreting or translation services for members, the following information must be documented:

- Name
- Title/Position
- Department
- Spoken and written language
- Level of proficiency for spoken and written language (ICE Employee Language Skills Assessment Tool results or any other language proficiency assessment results. ICE Employee Language Skills Assessment Tool is available at: http://www.lacare.org/providers/provider-resources/provider-forms)
- Number of years of employment the individual has as an interpreter
- Successful completion of a specific type of interpreter training program
- Other reasonable alternative documentation of interpreter capability

10.4 Cultural and Linguistic Services Trainings

PPG is required to inform network providers about upcoming trainings and available resources and must receive annual education on cultural and linguistic requirements, cultural competency and available services and resources to assist with members' culturally and linguistic needs.

Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and trainings.

L.A. Care offers ongoing trainings on C&L requirements, language access, and cultural competency/sensitivity trainings to PPG, network provider and provider staff, including but not limited to the following topics:

- Legal obligations under state and federal law to communicate with LEP members
- Resources and services available to help providers comply with those obligations
- C&L Requirements
    - Posting of the interpreter poster at provider office sites
    - Ensuring 24-hour, 7 day a week access to interpreting services, including ASL, at all points of contact, including after-hours services
    - Discouraging the use of family and friends, particularly minors, as interpreters
    - Documenting Member's preferred language (if other than English)
    - Documenting request and refusal of interpreting services
    - Assessing, identifying and tracking the linguistic capability of bilingual clinical and non-clinical staff
    - Processes for filing a grievance if a patient's language needs are not met
- Cultural competency, sensitivity, and diversity awareness
    - Groups' beliefs about illness and health
    - Methods of interacting with providers and the health care structure
    - Language and literacy needs

C&L training opportunities are listed on the L.A. Care's website:
http://www.lacare.org/providers/provider-resources/classes-seminars

10.5 Cultural and Linguistic Resources

Provider Toolkit for Serving Diverse Populations

In collaboration with the ICE collaborative, L.A. Care has developed a C&L Toolkit to assist providers in providing high quality, effective, and compassionate care while meeting the changing service requirements of state and federal regulatory agencies, the *Better Communication, Better Care: A Provider Toolkit for Serving Diverse Populations* toolkit can be downloaded from the L.A. Care's website:

http://www.lacare.org/providers/provider-resources/provider-tool-kits

Language Skills Assessment Tool

L.A. Care, Plan Partners, and the ICE collaborative have developed an Employee Language Skills Assessment Tool for provider offices to use in documenting language proficiency of providers and staff. The *Employee Language Skills Self-Assessment Form* can be downloaded from the L.A. Care's website:
http://www.lacare.org/providers/provider-resources/provider-forms

Interpreting Services Poster

L.A. Care makes available and routinely distributes translated signage promoting interpreting services to provider offices. Provider offices are required to post the signage prominently in the medical office. The *Interpreter Poster can be* downloaded from the L.A. Care's website:
http://www.lacare.org/providers/provider-resources/provider-forms

The *Interpreter Poster* can be ordered online using Health Education, Cultural and Linguistic Services Order Form on the L.A. Care's website:
http://portal1.lacare.org/healtheform/faces/pages/usertypelogin.jspx

Complaint/Grievance Forms

Members have the right to file a complaint or grievance if they've been denied interpreting services, if the member information was not available in their preferred language, or alternate format (large print, audio), or if their cultural needs have not been met. All grievances are filed with L.A. Care's Member Services Department and are routed to the appropriate areas within the organization. Grievance forms in threshold languages can be downloaded from the L.A. Care website:
http://www.lacare.org/members/medicare-resources/file-a-grievance

Culturally and Linguistically Appropriate Referrals

L.A. Care ensures that members are referred to culturally and linguistically appropriate services. *Healthy City* is an interactive website offering multiple services including a searchable community resource directory and a multitude of public datasets. Network providers can connect members to information and services in the community sensitive to their language and cultural needs. *Healthy City* is available on the L.A. Care's website:
http://www.lacare.org/providers/provider-resources/social-services-directory

Additionally, network providers may refer L.A. Care direct line of business members, including Cal MediConnect members to culturally and linguistically

appropriate community services by using the *Health Education Referral Form* available on the L.A. Care website:

http://www.lacare.org/providers/provider-resources/health-education-tools

Member Demographic Report

L.A. Care publishes member demographic data on an annual basis to provider, as quality health care depends upon good communication between the provider and the member. The *Member Demographic Report* is available on the L.A. Care website:

http://www.lacare.org/providers/provider-resources/provider-forms

Patient Interpreter Services Labels

L.A. Care Health Plan providers must not require, or suggest to, LEP members that they provide their own interpreter. Relatives or friends may be used if requested by the member after being informed of the right to free interpreting services. Member refusal of professional interpreting services and request to use a family member or friend is required to be documented in the medical chart. Use of minors as interpreters is discouraged except in extraordinary circumstances such as medical emergencies, and only if interpreter assistance cannot be provided. L.A. Care has several forms in place that can be used by provider office. *Preferred Language Labels* and *Interpretation Request/Refusal Labels* are available on the L.A. Care's website:
http://www.lacare.org/providers/provider-resources/provider-forms

10.6 PPG Reporting Requirements

PPG must submit the following three reports to L.A. Care via email to **CLReports@lacare.org** according to the schedule listed below:

Annual Report	Due Date	Quarterly Report	Dates of Service		Due Date
	January 31		Q1	January – March	May 15
			Q2	April – June	August 15
			Q3	July – September	November 15
			Q4	October – December	February 15

- Annual bilingual staff list, including the following information:
  - Name
  - Title/Position
  - Department
  - Spoken and written language

    - Level of proficiency (ICE Employee Language Skills Assessment Tool results or any other language proficiency assessment results)
    - Documentation of successful completion of an interpreter training program.

- Quarterly utilization report for face-to-face and telephonic interpreting services for reporting period, only if PPG uses their own contracted interpreting services vendor. Member encounters with bilingual staff is not considered as interpreting services should not be added to this report.

- Quarterly translated document report for the reporting period, including following information:
    - Document title
    - Language(s) translated into
    - Type of document
    - Product line
    - Mailing/distribution date

11.0 FINANCE

Under contractual agreement, each month L.A. Care and Participating Physician Groups (PPGs) accept capitated payments for the provision of health services to L.A. Care members, including Cal MediConnect members, regardless of how frequently members access services. This section covers guidelines for financial reports and requirements, capitation, and other related issues.

11.1 CAPITATION PAYMENTS

11.1.1 One-hundred percent (100%) of capitation payments will be remitted to a PPG no later than the tenth (10) calendar days (except as defined in "Financial Security Requirements," and "Assumption of Financial Risk"). The payments will constitute payment in full for health care and administration services rendered under the PPG's L.A. Care Services Agreement.

11.1.2 For further information regarding PPG compensation, please refer to the Capitation Schedule of the L.A. Care Physician Capitated Services Agreement.

11.2 CAPITATION STATEMENT REPORT

11.2.1 A Capitation Statement Report will be placed in a protected PPG web site on or before the tenth (10) business day of every month. The Capitation Statement Report will provide a summary of the capitation payment for each enrolled member assigned to each PPG, and will include the following information:

- Number of current active enrollees (initial eligibles).
- Number of retroactive disenrollments (decaps). This number represents the number of retroactive disenrollment months processed.
- Capitation amount.
- Capitation total.

11.2.2 The Capitation Statement Report is also used to create the Group Capitation Payment Summary Report.

11.3 INSURANCE

Each PPG is responsible for total costs, except as provided herein, for care rendered to members enrolled with that PPG under the terms of its Services Agreement with L.A. Care. The PPG must maintain adequate insurance set forth in the following:

11.3.1 Professional Liability Insurance. The PPG has, and shall maintain at its expense throughout the term of this Agreement, Professional Liability Insurance for each employed physician with limits of not less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in the aggregate for the year of coverage or such other amount acceptable and permitted by Health Plan in writing. PPG shall provide copies of insurance policies within five (5) business days of a written request by Health Plan.

11.3.2 FTCA Alternative. In lieu of providing Professional Liability Insurance as set forth in Section 1.13(a), PPG may provide Health Plan with evidence of liability protection under the Federal Tort Claims Act by the Bureau of Primary Health Care in accordance with Section 224(h) of the Public Health Service Act, 42 U.S.C. 233(h), as amended ("FTCA Coverage"). However, PPG shall ensure that only those providers covered pursuant to section 1.13(a) or under FTCA Coverage may provide provider services to members.

11.3.3 Reinsurance/Stop-Loss Insurance. The PPG must maintain adequate stop-loss insurance to cover PPG's catastrophic cases in an amount reasonably acceptable to L.A. Care, but in no event less than thirty thousand dollars ($30,000.00) plus fifty percent (50%) of any medically necessary billed charges.
The cost of the PPG's reinsurance/stop-loss coverage is the PPG's sole financial responsibility.

11.3.4 General Liability Insurance. The PPG shall maintain general liability insurance in at least the minimum amounts acceptable to L.A. Care to cover any property loss that is not covered under any lease agreement with the landlord, or contract agreement with the management company. The limits of liability shall not be less than $100,000.00 for each claim and $300,000.00 in aggregate under each policy period.

11.3.5 Errors and Omissions. The PPG shall maintain Errors and Omissions (E&O) Insurance that covers the claims made against managed care activities. The insurance policy shall be written on a claim made basis. The limits of liability shall not be less than $100,000 for each claim and $100,000 in aggregate for each policy period.

11.3.6 Directors and Officers. The PPG shall maintain Directors and Officers (D&O) that covers claims made against directors and officers of the company. The insurance policy shall be written on a claim made basis. The limits of liability shall not be less than

$100,000 for each claim and $100,000 in aggregate for each policy period.

11.3.7 Independent Certified Public Accounting Firm Liability Insurance. PPG shall ensure that all independent certified public accounting firm conducting audits on PPG's financial statements maintain at its expense throughout the term of this agreement, liability insurance with limits of not less than two hundred and fifty thousand dollars ($250,000.00) in aggregate for the year of coverage or such other amount acceptable and permitted by health plan in writing. PPG shall provide copies of such insurance policies within five (5) business days of a written request by health plan.

11.4 MINIMUM FINANCIAL SOLVENCY STANDARDS

11.4.1 Each PPG must maintain adequate financial resources to meet its obligations as they become due. PPGs contracted with L.A. Care shall be solvent at all times, and shall maintain the following minimum financial solvency standards:

11.4.1.1 Prepare quarterly financial statements in accordance with Generally Accepted Accounting Principles (GAAP). These financial statements must include but are not limited to a Balance Sheet, a Statement of Income, and a Statement of Cash Flow and be submitted to the Financial Compliance department of L.A. Care no later than 45 calendar days after the close of each quarter of the fiscal year.

11.4.1.2 Reimburse, contest or deny at least ninety-five percent (95%) of all claims consistent with applicable law, regulation and contractual timeliness requirements.

11.4.1.3 Estimate and document, on a monthly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method as stipulated by Title 28, California Code of Regulations, Section 1300.77.2.

11.4.1.4 Maintain, at all times, a positive Working Capital (current assets net of related party receivables less current liabilities).

11.4.1.5 Maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as defined in Title 42, C.F.R., Sections 422.2, 422.504(a)(14), 423.4, and 423.505(b)(23).

11.4.1.6 Maintain a "Cash to claims ratio" (cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within 60 days divided by the organization's unpaid claims (claims payable and incurred but not reported (IBNR) claims) liability as listed per SB 260 Title 28, California Code of Regulations, Section 1300.75.4.2. Maintain, at all times, "cash to claims ratio" of .60 as of January 1, 2006, .65 as of July 1, 2006 and .75 as of January 1, 2007.

11.4.1.7 On an annual basis, submit to the Financial Compliance department of L.A. Care, financial statements, including but not limited to a Balance Sheet, a Statement of Income, and a Statement of Cash Flow audited by an independent Certified Public Accounting Firm within 150 calendar days after the close of the fiscal year.

11.4.2 Each PPG must actively monitor its providers to measure their financial stability. Copies of all reports, including findings, recommendations, corrective action plans, and other information regarding these reviews must be provided to L.A. Care upon request.

11.4.3 On a discretionary basis, the Financial Compliance department of L.A. Care will have the right to periodically schedule audits to ensure compliance with the above requirements, CMS requirements and all regulations per SB 260 Title 28, California Code of Regulation requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the line(s) of business contracted with L.A. Care. Representatives of the PPGs shall facilitate access to records necessary to complete the audit.

11.5 REIMBURSEMENT SERVICES AND REPORTS

11.5.1 In accordance with the provisions of PPG's Subcontracts, the PPG will provide all normal reimbursement services, including those relating to the payment of capitation, processing and payment of any claims on a fee-for-service basis, administration of any stop-loss and risk-sharing programs, and any other payment mechanisms. Claims processing may be delegated to PPGs in cases where utilization management is delegated.

11.5.1.1 PPGs that are delegated for the claims processing function must submit a monthly claims timeliness

report (in an ICE approved Medicare template) and a respective supporting claims data file to L.A. Care by the 15th calendar day of each month following the month being reported.

11.5.2 Upon request, the PPG will provide to L.A. Care a copy of payment records, summaries and reconciliations with respect to L.A. Care members, along with any other payment compensation reports which the PPG customarily provides to its providers.

11.6 RECORDS, REPORTS, AND INSPECTION

11.6.1 Records Each PPG will maintain all books, records, and other pertinent information that may be necessary to ensure the PPG's compliance with its L.A. Care Services Agreement, and the requirements of CMS for a period of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. These books, records, and other information must be maintained in accordance with generally accepted accounting principles, applicable state law and regulations, and CMS and DMHC requirements.

These books and records will include, without limitation, all physical records originated or prepared pursuant to the performance under this contract including but not limited to:

- Working papers
- All reports submitted to DMHC
- Financial records
- All books of account
- Encounter data
- All medical records
- Hospital discharge summaries
- Medical charts and prescription files
- Any other documentation pertaining to medical and non-medical services rendered to members
- Records of Emergency Services and other information as reasonably requested by L.A. Care and DMHC to disclose the quality, appropriateness, and/or timeliness of health care services provided to members under the PPG's Physician Capitated Services Agreement
- PPG subcontracts

- Reports from other contracted and non-contracted providers

11.6.2 Any reports deemed necessary by L.A. Care, CMS and DMHC to ensure compliance by L.A. Care with the regulatory requirements.

11.6.3 Each PPG will maintain all books and records necessary to disclose how the PPG is fulfilling and discharging its obligations under their L.A. Care Services Agreement, and their responsibilities as defined by CMS and DMHC. These books and records will be maintained to disclose the following:

- Quantity of covered services provided.
- Quality of those services.
- Method and amount of payment made for those services.
- Persons eligible to receive covered services.
- Method in which the PPG administered its daily business.
- Cost of administering its daily business.

11.6.4 Inspection of Records

PPGs will allow L.A. Care, DMHC, DHHS, the Comptroller General, or their designees and any other authorized state and federal agencies to inspect, evaluate, and audit any and all books, records, and facilities maintained by the PPG and its providers as they pertain to services rendered under the PPG's Physician Capitated Services Agreement, at any time during normal business hours, subject to the confidentiality restrictions discussed in the PPG's Physician Capitated Services Agreement.

The PPG also agrees to require all related entities, contractors, or subcontractors, and downstream entities to agree that:

- DHHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s), and downstream entities involving transactions related to L.A. Care's Cal MediConnect line of business;
- DHHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

11.6.5 Records Retention Term

Cal MediConnect Line of Business - The PPG's books and records must be maintained for a minimum of ten (10) years from the end of the fiscal year in which the PPG's contract with L.A. Care expires or is terminated.

11.6.6 Financial Statements

As required by Section 11.8 above, each PPG must provide L.A. Care with a copy of its Quarterly Financial Statements and Annual Audited Financial Statements. If requested, these financial documents, as well as any other reports required by DMHC, will be made available to DMHC, CMS and any other regulatory agencies.

This section is subject to change pursuant to receipt of supplemental regulations under Title 10.

12.0 CLAIMS

This section covers guidelines for claims processing and other claims related issues for Participating Providers with respect to L.A. Care's Cal MediConnect line of business.

12.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs), and hospitals contracted with L.A. Care are responsible for performing certain tasks for claims under the terms of their agreement in the L.A. Care Cal MediConnect Program. After reviewing this section, please refer to the "Division of Responsibility" in the agreement between the PPG, and L.A. Care to determine what entity is responsible for specific claims. **The "Division of Financial Responsibility,"** specifies which health care services are the financial responsibility of L.A. Care, and which are the financial responsibility of the PPG. The PPG is responsible for handling all claims for which it is financially responsible.

12.2 COLLECTION OF CHARGES FROM MEMBERS

Neither the PPG nor any of its providers will, in any event, submit a claim, demand payment, or otherwise collect reimbursement from an L.A. Care member or persons acting on behalf of a member for any services provided pursuant to the PPG's L.A. Care Services Agreement, except to collect authorized co-payments.

12.3 COORDINATION of BENEFITS (COB)

DEFINITION OF COB:

A. Coordination of Benefits (COB) is the procedure to determine the order of payment responsibility when a Member is covered by more than one health plan or insurer.

B. COB is applied in accordance federal law governing COB including the Order of Determination of payment.

C. L.A. Care and PPGs are responsible for identifying other health plans that are primary to L.A. CARE and must coordinate benefits for Members in accordance with federal law.

D. L.A. Care and PPGs must make reasonable efforts to appropriately determine payment of claims for covered services rendered to any Member who is fully or partially covered for the same service under any other State, Federal program, or other entitlement such as a private group or indemnification program.

E. Medicare may be the secondary payer under certain rules as delineated under Title 42, Chapter 7 of the Social Security Act and L.A. Care's Medicare - Coordination of Benefits Policy.

PROCEDURE FOR COB RECOVERY:

A. L.A. Care pays PPGs capitation rates as outlined in the L.A. Care Capitated Agreement, for all Members assigned to them regardless of other insurance coverage.

B. Since all L.A. Care Cal MediConnect members have both Medicare and Medi-Cal (Medi-Medi) coverage, the claim is processed with Medicare as the primary and Medi-Cal as the secondary, following the policies and procedures outlined in the L.A. Care Medi-Cal Provider Manual, "Coordination of Benefits" section.

C. If the Member has other health coverage in addition to Medicare and Medi-Cal, Medicare may be secondary under certain rules for coordination of benefits as outlined below. If the Member has other primary health care coverage, the claim is adjudicated at the lesser of the Medicare allowable or the primary payer allowable. L.A. Care adjudicates covered services as primary if they are not covered by the other health coverage. The provider of service must submit such claims with a denial letter or explanation of benefits from the other health coverage. The COB claim determination period is based on the period of time the Member is enrolled with L.A. Care Cal MediConnect. If the Member is not enrolled with L.A. Care Cal MediConnect on the date of service, COB is not applicable.

D. L.A. Care has the right to obtain and release COB information and may do so without the Member's or Authorized Representative's consent. Members must provide an insurer with any information needed to make COB determinations and to pay claims.

When coordinating benefits, Medicare Secondary Payer rules apply. Under those rules, Cal MediConnect is secondary under the following conditions:

- **Elderly Workers Employer Group Health Plan** – These 65 year old or older members are covered by an employer Group Health Plan (GHP) with 20 or more employees or have a spouse who is covered by an Employer Group Health Plan. The spouse's age is not material to the determination of primary coverage only the qualification of the GHP.

- **Disabled Beneficiaries Employer Group Health Plan** – These members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member's

employment. Large Group Health Plans are defined by at least one of the employers having 100 or more employees.

- Beneficiaries with End Stage Renal Disease (ESRD) and an Employer Group Health Plan – The rules for these members are complex; please see the Medicare Secondary Payer Manual (Publication # 100-05) on the CMS website for detailed information affecting the rules for members with ESRD.

- Federal Black Lung Program - The Black Lung Program was set up under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The Black Lung Program is billed for all services that relate to either respiratory or pulmonary diseases. The Medicare managed care plan is the primary payer for all other cares and service needs.

- Veterans Administration Coverage - Care and services authorized by Veteran's Administration are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. The Medicare managed care plan may supplement VA payment when the member files a claim for Part B services that were not fully reimbursable by the VA or for any member copayments made to a VA facility.

E. Medicare Secondary Payer rules supersede other federal and state law governing the coordination of benefits.

F. Providers may retain any amounts collected through COB, in addition to any capitation received.

12.4 Third-Party Liability (TPL)

This policy applies to all L.A. Care Cal MediConnect Members. PPGs may make a claim for recovery of the value of covered services rendered to a Cal MediConnect Member in cases involving the tort liability of a third party or casualty liability insurance, including Workers' Compensation and uninsured motorist's coverage. PPGS must coordinate all recoveries of Medi-Cal monies with the State Medi-Cal recoveries office and must notify L.A. Care of such effort.

PROCEDURE FOR TPL RECOVERY (for Medicare beneficiaries):

A. If the Payer becomes aware of a claim involving Third Party Liability (TPL), the Payer must pursue recovery of any monies paid in accordance with state and federal guidelines.

B. The Payer must notify the insurance plan and/or attorney of record of its intent to recover the amounts paid in connection with the injury or illness caused by the third party or employer.

C. The Payer must provide copies of all related claims if requested. The Payer should regularly follow-up with all involved parties every 30 days until resolution is complete.

D. The Payer should attempt to recover the full amount of claims already paid as well as the amount necessary to pay all anticipated future medical expense.

12.5 CLAIMS SUBMISSION

Claims submitted by the PPG or its contracted providers must be complete with all required information to ensure timely processing and payment as stipulated in the provider's contract.

12.5.1 Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 forms for facility services.

12.5.2 Claim Filing Limit

The provider shall bill using appropriate forms and in a manner acceptable to L.A. Care or the PPG within the filing limit specified in the provider's contract. If not specified in the provider contract, the filing limit for Cal MediConnect claims will apply.

12.5.3.1 **In general, physician and ancillary service claims for Cal MediConnect members will be submitted to the PPG. Inpatient hospital claims and claims for DME and ambulance services for Cal MediConnect members will be submitted to L.A. Care.** In order to determine who is responsible for paying a claim, please refer to Exhibit B, the **Division of Financial Responsibility**, in your contract with L.A. Care. The Division of Financial Responsibility specifies what entity is responsible for paying each category of claim.

12.5.3.2 If you have a question about where to send a claim, please call L.A. Care's Provider Information Line. You will access our Interactive Voice Recognition (IVR) system that will guide you to one of our Provider Network Representatives that can assist.

12.5.3.3 For all claims for which L.A. Care Cal MediConnect is financially responsible, please mail the claims to:

L.A. Care Health Plan
Attn: Claims Dept.
P.O. Box 811580
Los Angeles, CA 90081

12.5.4 Claim Status Inquiries

Please be advised that you may inquire about the status of a claim, including the date of receipt, for which L.A. Care is financially responsible by calling **1-866-LACARE6.**

12.6 CLAIMS PROCESSING

A. All claims submitted to the PPG must be processed (paid or denied) or forwarded in accordance with all federal and state laws and regulations and the L.A. Care contract.

B. All PPGs are delegated the responsibility of claims processing for the services identified as PPG's responsibility in the Division of Financial Responsibility exhibit of the L.A. Care Service Agreement and are subject to review by L.A. Care. L.A. Care provides oversight of the PPGs by monitoring, reviewing and measuring claims processing systems and payment appeals to ensure timely and accurate claims processing and appeal resolution.

C. Contracted providers of service are required to submit claims in accordance with the provisions outlined in their contract with the Payer. If the contract is silent on a timeframe for submission, or the provider of service is non-contracted, the provider of service has 1 year from the date of service to submit a claim.

D. Misdirected claims must be forwarded to the appropriate financially responsible entity within 10 calendar days of receipt for Medicare claims and 10 working days of receipt of all other claims.

E. PPGs must pay 95% of clean claims for non-contracted providers rendering services to Cal MediConnect members within 30 calendar days of receipt of the claim. All other claims for non-contracted providers must be paid or denied within 60 calendar days. Claims for contracted providers must be paid within contractual timeframes.

F. If the Payer pays clean Medicare claims from non-contracted providers after 30 days, it must pay interest in accordance with federal guidelines and at the Prompt Payment Act Interest Rate published in the Federal Register and on the United States Treasury website.

G. PPGs are expected to identify and recover overpayments resulting from a payment error or when it has been determined that the provider of service or Member was liable for the services, in accordance with federal regulations.

H. PPGs must establish and maintain a process that addresses the receipt, handling and disposition of a payment appeal in accordance with federal or state regulations and contractual guidelines. All payment appeals must be resolved within 60 calendar days of receipt of the appeal.

12.7 PROCEDURE FOR CLAIMS PROCESSING:

A. PPGs must have written procedures for claims processing that are available for review. In addition, PPGs must disclose claims filing directions, fee schedules and payment appeal processes via contract, written notification, Explanation of Benefits (EOB) or Remittance Advice (RA) at the time of payment, denial or adjustment, and/or via a website, as applicable. These written procedures and disclosures must comply with state, federal and L.A. Care contractual standards and requirements. Such disclosures must also be made available upon request to providers of service, L.A. Care or a regulatory agency.

B. PPGs' claims processing systems must identify and track all claims and payment appeals by line of business and/or program and be able to produce claims and appeals related reports as outlined in Section 12.7.2, "Initial Claims Payment Appeals."

C. Contracted providers of service must be given no lesser period to submit claims than the timeframe stipulated in the contract to submit a claim.

D. Non-contracted providers of service and contracted providers of service whose contract is silent on a submission timeframe are allowed up to 1 year from the date of service to submit a claim.

   1. Claims received after that deadline may be denied.

   2. Claims received after the filing deadline are reconsidered for payment only when the provider of service has submitted an explanation of the circumstances surrounding the late filing, or L.A. Care or the PPG is responsible due to an administrative error.

   3. If a claim is denied for untimely filing, the provider of service may file an appeal as outlined in Section 12.7.2, "Initial Claims Payment Appeals" and the claim may be reconsidered for payment upon proof of and demonstration of good cause for the delay.

E. PPGs must redirect claims that are not their financial responsibility to the appropriate responsible party within 10 working days of receipt.

   1. If the Member cannot be identified or the financially responsible entity is not affiliated with the Payer's network, the claim may be denied and/or returned to the provider of service advising the billing

provider to verify eligibility assignment and to bill the appropriate responsible party.

2. All redirected claims must be tracked and reported as outlined in "Claims and Payment Appeal Reporting."

F. Clean claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payer liability and for which no further information is required from the provider of service or a third party to develop the claim. To be considered a clean claim the claim should be prepared in accordance with the National Uniform Billing Committee standards and should include, but is not limited to the following information:

1. A claim form that contains:

   a. A description of the service rendered using valid CPT, ICD9, HCPCS, and/or Revenue codes, the number of days or units for each service line, the place of service code, the type of service code and charge for each listed service.

   b. Other claim specific information as dictated by Medicare for provider of service type (i.e., Hospital, lab, etc.).

   c. Member (patient) demographic information, which must at a minimum include the Member's last name and first name and date of birth.

   d. Provider of service name, address, tax identification number; Medicare Health Insurance Claim Number (HICN), and Providers NPI.

   e. Information pertaining to COB, if applicable.

   f. Date(s) of service.

   g. Amount billed.

   h. Signature of Member or person authorized to sign on behalf of Member.

   i. Signature of person submitting claim.

2. Other documentation necessary to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring provider information (or copy of referral) as applicable.

3. Prior authorization documentation, such as an L.A Care Cal MediConnect authorization number, a copy of the authorization form or referral form attached to the claim for services on which authorization is required.

G. If a claim is missing required information, as defined in Procedure above, or additional information in necessary order to complete the claim, the claim must be developed as follows:

1. The Payer must send a written notice to the provider of service requesting the missing information or other reasonably relevant information necessary to determine Payer liability within 30 calendar days after the date of receipt. If the Payer is requesting additional reasonably relevant information, the Payer must include a written explanation of the necessity for the request.
2. If the Payer does not receive the requested information from a provider of service within 45 calendar days after it receives the claim, the Payer must review the claim and make a decision to pay or deny the claim based on available information. That payment or denial must be issued within 60 calendar days of original receipt of the claim.
3. Upon receipt of the requested information, the Payer must pay the amount due on the claim within 30 calendar days from receipt of the additional information from a non-contracted provider, or within contractual timeframes if the provider of service is contracted.
4. If the Payer denies a claim on the basis of a failure to submit requested medical records or other information reasonably necessary to determine Payer liability, as outlined in Procedure F (2)-(4), the Payer must process any appeal from the denial of such claim in accordance with the appeals process outlined in “Initial Claims Payment Appeals”.
5. If the Provider fails to submit requested required information as defined in Procedure G (1), or the information is invalid or incomplete, the claim can be rejected or denied.

H. PPGs must establish processes for claim payment without a requirement for prior authorization for the following covered services rendered to a Cal MediConnect Member by a non-contracted provider of service:

1. Ambulance services dispatched through 911 or its local equivalent where other means of transportation may endanger the Member’s Health.
2. Emergency services
3. Urgently needed services
4. Post-stabilization care services
5. Renal dialysis services
6. Covered services that the Payer denied that were determined through the appeals process to be services to which the Member

was entitled.

I. Claims received from contracted providers of service must be appropriately paid or denied within contractual timeframes. Clean claims from non-contracted providers of service rendering services to Cal MediConnect members must be paid within 30 calendar days of receipt, or within 60 calendar days for all other claims.

1. This measurement begins on the initial date of receipt of the claim anywhere within the contracted network (i. e. the earliest date stamp) and ends when the check or denial is mailed to the provider of service, regardless of when the check is dated.

2. The payment date used to meet timeliness standards is the actual date the check is mailed, deposited into the provider of service's account or transferred electronically, regardless of the date on the check.

3. The date of receipt is the date the claim is first received by an entity within the plan's network even if that party is not financially responsible for that particular claim as indicated by its date stamp on the claim. **Claims with multiple date stamps should be deemed priority and processed immediately**.

4. "All other claims" are denied claims or those (unclean) claims that require investigation or additional information from the provider of service to develop the claim. This includes but is not limited to requests for additional information from the physician/supplier or other external source such as routine data omitted from the claim, medical information, or information to resolve discrepancies.

K. If the PPG fails to pay a Medicare clean claim from a non-contracted provider of service within 30 calendar days after receipt, the PPG must pay interest at the rate used for such late payments, as stated in federal regulations beginning on the first calendar day following 30 calendar days from the date of receipt. Interest accrues from that date until the date the check is mailed.

L. Denial Letters must be mailed to the provider of service within timeframes stated in Procedure J for paying or denying a claim, The PPG should access the Medicare Advantage Pre-Service Denial Reason Matrix on the INDUSTRY COLLABORATION EFFORT (ICE) website and conform to the approved language found there. The date of denial notification is the date the denial notice is actually mailed to the provider of service.

1. Any claim that is denied must include an accurate and clear written explanation of the actions taken. Both the provider of service and Member must be notified of the denial if there is member liability for the claim or a portion of the claim.

2. All denial notifications and the EOB and/or RA to the provider of service must include mandated language and be properly formatted in accordance with Cal MediConnect specifications. At a minimum, the denial notification must:

    a. Use approved notice language in a readable and understandable format

    b. State the specific reason for the denial

    c. Inform the Member of his or her right to reconsideration of the payment determination

    d. For payment denials, the standard reconsideration process as well as the rest of the appeal process as outlined in "Initial Claims Payment Appeals," "2nd Level Claims Payment Appeals" and "Member Appeal Resolution Process (Standard and Fast Track)"

    e. Comply with any other notice requirements specified by CMS.

3. The denial notification must incorporate appropriate denial reason language.

M. If a Payer determines that a claim has been overpaid, the Payer may attempt to recover the overpayment and send a written notice to the provider of service.

1. Individual overpayments are those overpayments resulting from incorrect payment to the provider for physician/supplier services, including but not limited to duplicate payments, payments to the wrong provider of service, processing errors.

2. The written notice must clearly identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the Payer believes the amount paid was in excess of the amount due, including interest and penalties.

4. Providers of service must respond to the request with a corrected billing, an appeal or a refund in accordance with federal guidelines or within 30 days of the date of the request. PPGs may retract the overpayment under certain circumstances outlined in federal guidelines. Payer may send a second written request and continue to follow-up with the provider of service to recover the money.

N. PPGs must establish processes that address the receipt, handling and disposition of a payment appeal in accordance with federal or state regulations and contractual guidelines, as outlined in "Initial Claims Payment Appeals".

O. L.A. Care's Claims Department is available from 8:00am - 5:00pm, Monday through Friday at (866) 522-2736 to assist and answer any questions related to claims processing.

P. The responsibility for claims payment as outlined above continues until all claims have been paid/denied for services rendered during the timeframe a Capitated Agreement existed.

Q. In the event the Payer fails to meet L.A. Care claims processing standards as indicated above, L.A. Care may elect to pay these claims on behalf of the Payer by deducting such payment from the Provider's monthly capitation check.

R. The 14-Day letter process is applied when there are unpaid claims and/or claims inquiries.

12.7.1 PROCEDURE FOR RESPONDING TO A 10 DAY LETTER:

A. The 10-Day letter is a tool used by L.A. Care to process appeals or disputes from members' providers of service related to claims issues involving alleged lack of payment or denial from the payer.

B. L.A. Care's 10-Day letter process is sent to providers of service under the following circumstances:

1. A provider of service (both contracted and non-contracted) notifies L.A. Care that no status has been provided on a claim submitted to the appropriate payer for over 60 days, or
2. L.A. Care identifies a claim that has not been paid appropriately within the claims processing timeframes.
3. A member is being billed for covered services or has filed a grievance

C. The 10-Day letter requests information on the status of the claim, as outlined in Procedure G below. The Payer must complete this form and return it to L.A. Care within 10 days from the date of the letter. A copy of the claim from the provider of service is included with the 10-Day letter sent by L.A. Care to the Payer.

D. PPGs must provide L.A. Care the following information in their response regarding the claim: the date the claim was originally received, if it was paid or denied, the date paid or denied, the amount paid, check number and/or the reason for the denial.

E. The following are examples of unacceptable responses to the 14-day letter:

1. Not Payer's Delegated Responsibility (L.A. Care confirms financial responsibility prior to 10-day notification).

2. Member Not Eligible (L.A. Care confirms eligibility prior to 10-day notification).

3. Not Authorized (it is inappropriate to deny a claim due to "No Authorization" as medical review must be performed prior to denial).

F. In the event the Payer fails to provide an acceptable written response to L.A. Care within 10 days or the requested information is returned incomplete, L.A. Care pays the provider of service directly using the prevailing Medicare fee schedule outlined below and deducts the amount paid from the Payer's monthly capitation check.

1. Non-par amounts for assigned claims by non-participating providers.

2. The par amount for participating providers.

J. Claims capitation deductions are outlined on a detail report that is sent with the capitation payment.

12.7.2 PROCEDURE FOR INITIAL CLAIM APPEALS:

A. Inquiries regarding the status of a claim or requests for intervention by L.A. Care on behalf of the billing provider in an attempt to get an initial adjudication decision (payment or denial) made on a claim by the Payer are not considered appeals and are handled in accordance with the procedure outlined in "10-Day Letters" Section.

B. Payment appeals relate to the initial determination of a payment decision or denial and are primarily complaints concerning an adverse organizational determination denying a request for payment.

1. Any appeal involving PCP P4P reimbursements should be filed in accordance with the guidelines provided in "Pay for Performance".

2. Any provider appeal not involving payment should be filed in accordance with the guidelines provided in "Appeal Resolution Process for Providers of Service: Initial Appeal Resolution".

3. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, PPGs must resolve it in accordance with their grievance policies and procedures as outlined in "Appeal Resolution Process for Providers of Service: Initial Appeal Resolution" or using the "Member Grievance Resolution Process".

C. Members, their authorized representative or providers of service acting on behalf of a Member and non-contracted providers of service must submit all payment appeals in writing to the Payer within 60 calendar days from

the date of a denial or other adverse payment determination from the Payer. The denial may be in the form of a written adverse determination from the Payer or an Explanation of Benefits (EOB) or Remittance Advice (RA) Justification and supporting documentation must be provided with the written appeal, as outlined in Procedure F below.

D. Non-contracted providers of service may file an appeal on his or her own behalf if the provider of service furnished a covered service to the Member and completes a waiver of liability statement that states that the provider of service will not bill the Member for covered services regardless of the outcome of the payment appeal.

E. Payers may accept a request for reconsideration of an appeal filed after 60 calendar days if the Member, the Member's authorized representative or non-contracted provider of service submits a written request for an extension of the timeframe for good cause.

F. Written payment appeals must be submitted to the Payer in accordance with the appeal process guidelines issued by the Payer.

1. For payment appeals involving L.A. Care as the Payer, appeals must be sent to:

Grievance and Appeals Coordination Unit
P.O. Box 811610
Los Angeles, CA 90081

2. Written payment appeals to L.A. Care must include:

   a) The Medicare health insurance claim number

   b) Specific service(s) and/or item(s) for which reconsideration is being requested and the specific date(s) of service

   c) The name and signature of the party or the representative of the party filing the appeal

   d) A clear explanation of why the appealing party disagrees with Payer's initial determination and should include supporting documentation the appealing party feels should be considering when making the reconsideration

      1) If the appeal involves a denied emergency claim, the documentation should include a copy of the Member's emergency room records, notification of the emergency room visit and a copy of the notice of determination or EOB.

      2) If the appeal involves an ambulance claim, the documentation should include a copy of the transport record, a copy of the Member's emergency room or hospitalization records relating to the ambulance trip,

including records from the triage or medical departments as applicable and a copy of the notice of determination or EOB.

3) If the appeal involves co-payment charges or co-payment reimbursement, the supporting documentation should include a copy of the Member's medical record from the corresponding hospital, emergency room or provider of service office, a copy of the utilization records if the Member was admitted, a copy of the notification of the emergency room visit or admission, and a copy of the notice of determination or EOB.

3. If supporting documentation is not available or the Payer does not have enough information to make a determination on the appeal, the Payer may send a request for additional information to the provider of service. If the provider of service fails to provide requested information within 5 calendar days of the request, the Payer must make a determination on the information available.

G. Payers must research the appeal and if it meets the criteria for a payment appeal, the Payer must send a written acknowledgement letter, an authorization for release of protected health information, and a self-addressed stamped envelope to the Member, the authorized representative or non-contracted provider of service who submitted the request, within 5 working days of the request.

H. Payers must make every effort to investigate and take into consideration all information on file or received from the provider of service. The Payer may request additional information or discuss the issue with the involved provider of service as needed to make a determination.

I. PPGs must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 60 calendar days of the receipt of the payment appeal. The notification must be sent to both the Member and appealing party, with a copy to L.A. Care.

1. Written notification of affirmative (uphold) determinations, whether in whole or in part, must be written in a manner easily understood by the Member and include:

a. A clear statement indicating the extent to which the reconsideration is favorable or unfavorable;

b. A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the re-determination;

c. An explanation of how pertinent laws, regulations, coverage rules and CMS policy applies to the facts of the case;

d. A summary of the rationale for the re-determination in clear, understandable language;

e. The procedures for obtaining additional information concerning determinations, such as specific provisions of the policy, manual or regulation used in making the determination

f. Any other requirements specified by CMS.

2. Failure to respond to the request for reconsideration with a determination within the specified timeframe must consider the failure as an affirmation of the adverse decision and the Payer must forward the request to the CMS Independent Review Entity (IRE) for review in accordance with Medicare requirements, within 60 calendar days after receiving the request for reconsideration.

J. If the written determination results in payment, payment must be made within 60 calendar days of receipt of the payment appeal, which is concurrently with the written determination. There is no interest due on payments made as a result of an appeal.

K. If the determination is to affirm or uphold the initial payment determination, the Payer must send a written determination to the Member and appealing party informing them of the decision and immediately forward the appeal and determination and supporting documentation to the IRE for final review in accordance with Medicare guidelines.

1. The information must be forwarded to the IRE within 5 calendar days of the determination or within 60 calendar days of receipt of the appeal from the appealing party, whichever occurs first.

2. The IRE will make a decision on the payment appeal in accordance with is CMS contracted timeframes.

3. The IRE may request additional information, and upon receipt of such information, L.A. Care and/or the Payer must make every effort to provide the requested information within the timeframe specified by the IRE.

4. If the IRE upholds the original adverse determination, the IRE will notify the Member and other parties to the appeal in writing of such decision following CMS guidelines.

5. If the IRE reverses or partially reverses the original adverse determination, the IRE notifies the Payer and L.A. Care. The payer in turn must notify the Member and the provider of service of the decision, with a copy to L.A. Care.

6. If payment is required as a result of the IRE, the IRE notifies the Payer of the requirement to pay the claim. Payment must be issued within 30 calendar days of receipt of the decision by the IRE. No interest is due on favorable payment determinations made by the

IRE.

L. If the appealing party is not satisfied with the decision of the IRE, and the projected value of the disputed service after reconsideration meets or exceeds the minimum requirements provided in the IRE's decision, the appealing party may request a review by an Administrative Law Judge (ALJ) within 60 calendar days of receipt of the decision from the IRE, as outlined in "Member Appeal Resolution Process (Standard and Fast-Track").

M. Subsequently, any party dissatisfied with the outcome of the Administration Law Judge Hearing, may request a Medicare Appeals Council review as outlined in "Member Appeal Resolution Process If still dissatisfied with the outcome, any party may request judicial review as outlined in "Member Appeal Resolution Process (Standard and Fast-Track)".

N. If L.A. Care receives an initial payment appeal directly for which another Payer is financially responsible, L.A. Care will forward the appeal or grievance to the Payer for resolution, as applicable and notify the involved parties.

O. At any point in the process, the appealing party may bypass L.A. Care or the Payer and submit an appeal directly to the IRE, in accordance with CMS guidelines. Additionally, any party to the appeal may withdraw the appeal at any point in the appeal process.

P. Members or providers of service not satisfied with the initial determination by the Payer where the determination is related to medical necessity, utilization management or pre-service referral denials or modifications may submit a written appeal to L.A. Care within 60 calendar days, for review as outlined in L.A. Care Policy # UM-041, "Appeals or Reconsideration".

Q. No retaliation can be made against a Member or provider of service who submits an appeal in good faith.

R. Copies of all appeals and related documentation must be retained for at least ten years. A minimum of the last two years must be easily accessible and available within five days of request from L.A. Care or regulatory agency.

S. Payers must track and report all appeals received in accordance with "Claims and Payment Appeals Reporting."

T. L.A. Care tracks, trends and analyzes appeals data, taking into account information from all other sources, including PPGs, and presents such information to the L.A. Care Governing Board with recommendations for intervention, as appropriate.

12.7.2.1 Grievance disposition letters issued by PPGs must fully describe the grievance and grievance appeal process. This must include a description of timelines as well as higher levels of consideration, including L.A. Care.

Grievance and Appeals Coordination Unit
P.O. Box 811610
Los Angeles, CA. 90081

12.7.3 Disputes Between Contracted Relationships

A. IPA's, PCPs and/or L.A. Care are responsible for authorizing medical care.

B. In the event that a particular service is not available at the assigned Hospital the PPG must coordinate with the Hospital, if capitated, or L.A. Care for contracted non-capitated Hospitals, to provide care for the Cal MediConnect Member at a mutually agreed upon facility.

C. In the event of an emergency the PPG must inform the Hospital, if capitated, or L.A. Care for contracted non-capitated Hospitals, that care is being rendered at another facility.

D. Members cannot be transferred when admissions are due to lack of specialty coverage, access standard timeframe issues or when the Member refuses to be transferred.

PROCEDURE FOR DISPUTE RESOLUTION:

A. In the event an authorization for Hospital services is provided by a PPG representative that is in breach of the above policy, the following may occur:

1. Hospital/L.A. Care reviews its incoming claims and identifies PPG contract violations that do not meet the above criteria such as:

   A. Authorized hospital services provided at a non-contracted facility.

   B. Authorized hospital services provided at another contracted facility that could have been provided at the assigned facility.

   C. Authorized ER services for non-emergent care. Appropriately licensed medical staff must perform review for medical appropriateness.

2. If the Hospital, or L.A. Care as applicable, was not notified or not amenable to these arrangements, the Hospital or L.A. Care may deny payment of these authorized services.

3. Upon denial, the Hospital or L.A. Care must send a copy of the claim to the PPG for payment with a denial letter explaining the

reasons for the denial. If denied by the Hospital a copy of the denial letter, claim, records and all supporting documentation should also be sent to L.A. Care at the following address:

L.A. Care Health Plan
Attention: Claims Department
P.O. Box 811580
Los Angeles, CA 90081

4. Hospitals may send the provider of service a letter informing them that the claim has been forwarded to the IPA for payment, however a denial should not be sent to the practitioner.
5. The IPA must pay the claim for these hospital services unless the IPA feels the services provided were emergent or that the service was justified. In the event of the latter the IPA should submit the claim with the appropriate supporting documentation to L.A. CARE at the above address with a letter of appeal explaining their position. The appeal must be submitted to L.A. Care within 60 days of the denial or payment.
6. L.A. Care will follow the procedures outlined in Section 12.7.2 “Initial Claims Payment Appeals,” in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.
7. Payment will be issued by the responsible party as outlined in “Initial Claims Payment Appeals.”

Claims Attachment

SAMPLE CLAIMS DENIAL NOTICE (see ICE website for most recent language requirements)

{Provider Name}
{Provider Mailing Address}

Member: {Member Name}
Member No: {Sub ID – Suffix}
Date of Service: {From – To Service Dates}
Claim No: {Claim ID}
Claim Amount: {Charged Amount}

NOTICE OF DENIAL OF PAYMENT

SECTION SUBJECT TO MODIFICATION UPON RECEIPT OF FINAL BENEFIT PACKAGES

Dear {Provider Name}:

We have received your claim for the above-referenced member. This claim has been denied for the following reason:

A) Contracted providers

(1) *Medical Records Requested – not received/ Contracted Prov – CONT 06*
Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim in not payable by L. A. Care Cal MediConnect. You are a contracted provider with (PMG / IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(2) Outpatient Services (Office visits, lab and diagnostic imaging) – CONT-01
According to our records, there is no authorization for the services rendered. Contracted providers are required to provide documentation or other evidence that the member was advised prior to the services being rendered that they may be financially responsible for such services. You are a contracted provider with (PGM / IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(3) Contracted Hospital or Provider Services (non-emergent – no triage call) – CONT-02

Emergency services are services needed immediately due to sudden illness, injury, or prudent layperson perception, and additional time spent to reach (PMG / IPA) would have meant risk of permanent damage to the member's health. The services you provided do not meet this definition and therefore required that you obtain prior authorization or provide documented proof the member was advised prior to services being rendered that they may be financially liable for such services. As a contracted provider, you are precluded from billing the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM.

(4) Contracted Facility (delay in care resulted in unnecessary days) CONT -03

Medical Management has reviewed the care provided and determined that a delay in services provided resulted in unnecessary inpatient days listed above. As a contracted provider, you are not allowed to balance bill the member for these non-covered services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(5) –In – area Emergency Services (non-emergent) – (presenting circumstances fail test) – ERIA -01

Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health.

(6) Required Claim Data missing or Spoiled – (A required data element or one of the nine specified data emoluments is missing or Spoiled and the Contracted provider has not responded to the Plan's request for the missing data) - CONT-04 & CONT -05

The information submitted to us was missing one or more essential items of information required under 42 CFR 422.257(d) paragraphs (1) and (4). You have not responded to our request(s) for that information. Because the federal time limit for us to obtain that information has expired, we remain unable to process the claim and must send you this notice. BY CONTRACTUAL AGREEMENT, YOU MAY NOT BILL THE MEMBER.

Unless otherwise specified, the missing or deficient items include one or more of the following items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. If you submit a complete claim to us that includes the information requested not later than the one- to two-year time limit allowed under Medicare law and regulations, we will process this claim.

[CMS -1500: CONT-04] [or] [UB-04: CONT-05] .

Patient's Name (2)	Patient Name (12)
Sex (3)	Sex (15)
Birth Date (3)	Birth Date (14)
I.D. No. (HIC or SSN) (1a)	HIC or SSN (60)
Dates of Service (24A)	From and Through Dates (6)
Diagnosis Code (24E)	Principal Diagnosis Code (67)
Procedure, Service, Supply Code (24D)	HCPCS/CPT Procedure Code (44) (Outpt.)
Days or Units (24G)	Service Units (46) (Outpt.)
Place of Service (24B)	Admission Date (17) (Inpt.)
Anesthesia/Oxygen Min. (varies) (if applic.)	Type of Bill (4)
Provider State License or UPIN (24K)	Principle Procedure Code (80)
	Date of Service (45)(Outpt.)

B) Non- Contracted Provider Denial language -

(1) Missing required data –missing or Spoiled (Medicare guidelines)

[This page presents an approach to developing these problem claims when they are received from non-contracting providers. Please note that unlike for contracting provider claims on the preceding page, non-contracting provider claims cannot initially be denied for lack of complete, correct CMS required encounter data elements. CMS required data elements includes submission of a complete claim including complete diagnosis coding required for submission of risk adjustment information to CMS. Such incomplete claims from non-contracted providers are defined as non- clean and should be developed for up to 60 calendar days. If the claim data remains incomplete after requesting complete information, the claim should be denied on day 60 for incomplete information.

Medicare requires us to report more complete information than you provided on this claim. Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. Unless otherwise specified, the missing or deficient items include one or more of the items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed.

(2) In-Area Emergency Services (non-emergent) (presenting circumstances fail test) – ERIA -04 (cc: member)

Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could

result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. Use of non-Plan providers in non-emergency situations is not payable by L. A. Care Cal MediConnect.

(*3) Medical Records requested and not received -NON -01 (cc: Member)*

Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim is not payable by L. A. Care Cal MediConnect.

C) Contracted and non-contracted providers denial language (Could be utilized by both)

C1) Eligibility

(*1) Provider Eligibility with Plan –ELIG -01*

The date you received medical services on the above claim was prior to your effective date of eligibility with L. A. Care Cal MediConnect.

. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(2) In-between Eligibility – ELIG-04

The date of service is between your eligibility for L. A. Care Cal MediConnect.

Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(*3) Postdates Eligibility with Plan – Elig-02*

The date you received medical services on the above claim was after your effective date of disenrollment with L. A. Care Cal MediConnect.

. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered

(4) Service Postdates Member's death – ELIG-03

Our records show the date of service was after the date of death.

C2) Emergency and Urgently Needed Services

(*5) In-Area Emergency Services (records not received) – ERIA-02*

Medical records requested were never received. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. The services received and circumstances do not meet these requirements based on the information available.

(*6) In-area (Partial denial of inappropriate services) ERIA-03*

Services delivered as emergency care were not consistent with presenting symptoms or emergency diagnosis

(*7) Out-of-area Emergency and Urgently Needed Services (not urgently needed) –EROA-01*
Emergency/urgent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. The services received were not emergent/urgent and were not authorized.

(*8) Out-of-Area Emergency and urgently needed Services (records not received) –EROA-02*
Emergent / urgent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. Medical records requested were never received. The services received cannot be determined to meet these requirements based on the information available.

C3) Maximum Allowable Benefit

(10) Inpatient Psychiatric – MAPY-01
Inpatient psychiatric care is covered according to Medicare guidelines and is limited to 190 days per lifetime in a Medicare certified psychiatric hospital. Our records indicate you reached 190 lifetime days on {date}.

(11) Podiatry (non-Medicare covered) – MAPO-01
The maximum calendar year additional podiatry benefit is {#} visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.

(12) Prescription Drugs (non-Medicare covered) – MARX-01
The maximum calendar year benefit allowance for outpatient prescription drugs is ${_____}. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.

(13) Skilled Nursing Facility – MASN-01
Skilled Nursing Facilities are covered by L. A. Care Cal MediConnect up to 100 days per benefit period. Our records indicate that on {date}, you reached your 100 day benefit maximum for this benefit period.

(14) Miscellaneous – MAMI-01
Insert other specific benefits with annual maximums.

C4) Not a covered Benefit

(15) Ambulance (not medically necessary) –NCAM-01

Ambulance transportation is covered if you could not have used another means of transportation without endangering your health. The transport you received does not meet this criterion.

(16) Ambulance (no patient transport) – NCAM-02
(For unauthorized services) As you were not transported by ambulance, the services are not covered by Medicare or L. A. Care Cal MediConnect.

(17) Assistant Surgeon (Medicare guidelines) – NCAS-01
Medicare does not pay for an assistant surgeon for this procedure/surgery. Payment for the assistant surgeon is denied by L. A. Care Cal MediConnect. The member has no financial responsibility for these services.

(18) Bundling (Medicare Guidelines) – NCBU-01
Medicare does not pay separately for this service. Payment is included in another service the member has received. The member has no financial liability and should not be billed for these services.

(19) Chiropractic (Medicare guidelines) NCCH-01
Medicare coverage for chiropractic care requires that you be diagnosed with subluxation of the spine. The services received do not meet this criterion and are not covered by Medicare or L. A. Care Cal MediConnect.
.
(20) Cosmetic – NCCO-01
The procedure you received is considered a cosmetic procedure. Cosmetic procedures are not a benefit covered by Medicare or L. A. Cal MediConnect for post accident repair/reconstruction. Please refer to your Health Plan's member materials for benefit guidelines.

(21) Dental Services – NCDS-01
Dental services are not a benefit covered under Medicare or L. A. Care Cal MediConnect except for surgery related to the jaw or any structure related to the jaw or any facial bone. Please refer to your Health Plan's member materials for benefit guidelines.

(22) DME- Durable Medical Equipment (does not meet Medicare DME criteria) – NCDM-01
Medicare defines durable medical equipment as an item that is medical in nature, can withstand repeated use, and is used in the home. The item received does not meet these requirements and is not payable by Medicare or L. A. Care Cal MediConnect.

(23) DME- Durable Medical equipment (not authorized) –NCDM-02
The durable medical equipment received was not prescribed/authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by L. A. Care Cal MediConnect.

(24) Hearing Aids – NCHA-01
Hearing Aids are not a benefit covered under Medicare or L. A. Care Cal MediConnect.

(25) Home Health (does not meet skilled guidelines) –NCHH-01
Home health services must include intermittent skilled care (skilled nursing, PT, or speech therapy) to qualify under Medicare guidelines. The services received were not skilled care and are not payable by Medicare or L. A. Care Cal MediConnect.

(26) Home Health (member not homebound) – NCHH-02
Home health care must meet Medicare guidelines, which require that you are confined to your home. You are not homebound and consequently the home health services received are not payable by Medicare or L. A. Care Cal MediConnect .

(27) Home Health (not authorized) – NCHH-03
The home health services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by L. A. Care Cal MediConnect.

(29) Non Medicare/FDA Approved Drugs or Devices – NCRX-02
{_____} is not approved by Medicare/the FDA and is excluded from coverage by L. A. Care Cal MediConnect. Please refer to your Cal MediConnect member materials for benefit guidelines.

(30) Not Authorized In-Area (if ER/Emergent, use emergency denial message) – NCNA-01
When you enrolled in a Medicare Advantage Plan, you selected a Primary Care Physician to coordinate/authorize your medical care. The services received were not authorized and are not payable by {L. A. Care Cal MediConnect}.

(31) Over the counter Drugs – NCRX-03
The drugs/medication received is available over the counter without a prescription and are not a benefit covered by {L. A. Care Cal MediConnect}. Please refer to your Cal MediConnect member materials for benefit guidelines.

(32) Personal comfort items – NCPC-01
The {_____} you were provided is considered a personal comfort item and is not a covered benefit under Medicare or {L. A. Care Cal MediConnect}. Please refer to your Cal MediConnect member materials for benefit guidelines.

(33) Podiatry – NCPO -01
Podiatry services for routine foot care, such as toe nail trimming, or corn/callus removal are not a benefit covered under Medicare or {L. A. Care Cal MediConnect}. Please refer to your Cal MediConnect member materials for benefit guidelines.

(34) Shoe Orthotics – NCSO-01
Shoe orthotics, including inserts and modifications, are only covered by Medicare or { Cal MediConnect } for diabetics or when the shoe is an integral part of a leg brace. Please refer to your Cal MediConnect member materials for benefit guidelines.

(35) Skilled Nursing Facility – (custodial care or not daily SNF care) – NCSN-01
Medicare guidelines require that skilled nursing facility care be needed daily, as certified by your physician. The services received were custodial in nature and/or not required daily. They are not covered by Medicare or {L. A. Cal MediConnect }.

(36) Skilled Nursing Facility (not authorized) – NCSN-02
The skilled nursing facility services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not a covered benefit under {L. A. Care Cal MediConnect }.

(37) Miscellaneous – NCMI-01
{SPECIFIC Item(s)} is not a Medicare covered benefit and excluded from coverage under {L Cal MediConnect }. Please refer to your Cal MediConnect member materials for benefit guidelines.

C5) Coordination of Benefits

(*1) Requested information not received from member –COB-01*
Our records indicate that you may have other insurance coverage. Coordination of benefits information (primary insurance carrier information) was requested from you and has not been received. In order to determine financial liability this information is required. As this information has not been received, this claim in not payable by [Health Plan}.

If you believe this determination is incorrect, you have the right to request for reconsideration. You must submit your request in writing within 60 days from the date of this notice and include the additional information which will substantiate your request for reconsideration to:

L. A. Care Health Plan
Appeals and Grievance Department
P. O. Box 712489
Los Angeles, CA 90071
Fax# (213) 623-8974

Sincerely,

13.0 MARKETING

13.1 PURPOSE:

The Regulatory Affairs and Compliance Department ensures all marketing materials such as the, Summary of Benefits, Provider Directory and are submitted to the appropriate regulatory agencies for approval. Once approved, L.A. Care uses marketing materials to inform members of benefits, rights and process to navigate through the Cal Medi Connect health care delivery system. The purpose of this Policy & Procedure is to ensure that all Marketing and or other member materials used by L.A. Care Cal MediConnect, and our contracted Providers, have been approved by the Centers for Medicare and Medicaid Services (CMS) and Department of Health Care Services (DHCS).

13.2 POLICY:

L.A. Care Health Plan shall establish Marketing standards by which L.A. Care Health Plan and its Providers may engage in Marketing Activities related to L.A. Care Health Plan's Cal MediConnect product in accordance with marketing guidance from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS).

L.A. Care may impose sanctions on a Provider in accordance with the terms of this policy or the contracted Provider agreement for any violation of this policy or in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS). .

Nothing in this policy shall affect a Provider's obligation to communicate with L.A. Care or a member pursuant to contractual, statutory, regulatory, or L.A. Care policy requirements.

13.3 DEFINITION(S):

CMS – Centers for Medicare & Medicaid, the oversight agency governing the Medicare program, including marketing.

Co-Branding – Co-branding is defined as a relationship between two or more separate legal entities, one of which is an organization ***that sponsors a Medicare plan***. The organization displays the name(s) or brand(s) of the co-branding entity or entities on its marketing materials to signify a business arrangement. Co-branding arrangements allow an organization and its co-branding partner(s) to promote enrollment into the plan. Co-branding relationships are entered into independent of the contract that the organization has with CMS.

Provider Promotional Activities – Activities that a provider may perform to educate potential enrollees or to assist potential enrollees in enrollment.

Marketing - Steering, or attempting to steer, a potential enrollee towards a plan, or limited number of plans, and for which the individual or entity performing marketing activities expects compensation directly or indirectly from the plan for such marketing activities. "Assisting in enrollment" and "education" do not constitute marketing. Marketing activities are limited to those activities in accordance with marketing guidance from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS).

Marketing Materials – Marketing materials include any informational materials that perform one or more of the following actions:

a. Promote an organization.
b. Provide enrollment information for an organization.
c. Explain the benefits of enrollment in an organization.
d. Describe the rules that apply to enrollees in an organization.
e. Explain how Medicare services are covered under an organization, including conditions that apply to such coverage.
f. Communicate with the individual on various membership operational policies, rules, and procedures.

Member – Medicare beneficiary either enrolled in Managed Care or not.

Provider – Physicians, physician groups, clinics, hospitals and others.

13.4 PROCEDURE/S:

13.4.1 Promotional Activities

L.A. Care Health Plan, or a contracted Provider may engage in Promotional Activities related to L.A Care Cal MediConnect Plan (Medicare-Medicaid Plan) product in accordance with the terms and conditions of this policy and in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS).

13.4.2 Permitted Activities:

- Providers may enter into discussions with their patients when the patient is asking for information or advice from the provider regarding their options, as long as the provider gives the patient objective information, in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS) .
- Providers may distribute plan materials or make them available in their office, provided that materials are distributed or made available for all plans with whom the provider contracts.

- Providers may display posters or other materials announcing their plan contractual arrangements, provided they do so for all plans with whom the provider contracts.
- Providers may provide the names of plans with whom they contract.
- Providers may provide information on and assistance with applying for the low-income subsidy.
- Providers may provide objective information on ALL plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
- Providers may provide objective information regarding ALL plan sponsors' specific plans being offered, such as covered benefits, cost sharing, and utilization management tools.
- Providers may distribute all Prescription Drug Plans' marketing materials with whom the provider contracts.
- Providers may refer their patients to other sources of information, such as the SHIPS, L.A. Care Field Representatives, contracted Agents, the State Medicaid Office, and local Social Security Office, CMS's website at http://www.medicare.gov/ or-1-800-MEDICARE.
- Providers may print out and share information with patients from CMS's website.
- Providers may distribute the "Medicare and You" Handbook or a printed copy of "Medicare Options Compare" in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS).
- Providers may distribute other CMS documents or materials that provide comparative and descriptive information of a broad nature about plans.
- A new L.A. Care Cal MediConnect provider may announce the new affiliation to their patients. This announcement to patients of the new affiliation with L.A. Care Cal MediConnect which only names L.A. Care and not the provider's other affiliations may only occur once if the announcement is made by direct mail or email. Any additional direct mail or email communications regarding affiliations must name all plans with whom the provider contracts.
- Any affiliation materials that describe L.A. Care and L.A. Care Cal MediConnect in any way (including, but not limited to, plan benefits and formularies) must be submitted to L.A. Care for approval. Materials that list the provider's plan affiliations and only include the plan names and contact information do not need regulatory approval.
- Providers may distribute printed information provided by a plan that compares the benefits of all the different plans with which they contract.
    - These materials may not highlight or rank order specific plans.
    - The materials must only include objective information.

- The materials must have the concurrence of all plans listed in the materials.
- The materials must be approved by CMS. (These materials are not subject to File and Use provisions.)

- Providers may provide links on the provider group website to enrollment applications, or they may provide downloadable enrollment applications. The links and/or downloadable applications must be for all plans with whom the provider contracts.
- Providers may provide a link on their website to the CMS Online Enrollment Center.

L.A. Care shall consider a health education material and wellness promotion as Marketing Materials if such material is:

a. Used in any way to promote L.A. Care, L.A. Care Cal MediConnect or a Provider;
b. Used to explain benefits; or
c. Contains any commercial message or member notification information.

L.A. Care shall consider the Internet as both Marketing Materials and Promotional Activities.

a. The Internet consists of, but may not be limited to, electronic transfer, transmittal, dissemination, and distribution through the organization's Web site.
b. L.A. Care or a Provider shall follow approval procedures set forth in this policy for all Marketing Materials and Promotional Activities conducted through the internet.

13.4.3 Marketing Standards

All Marketing Materials and Promotional Activities shall meet the following standards.

All Marketing Materials and Marketing Activities shall be in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS). Guidelines pertain to, but are not limited to, the following types of Marketing Materials and Promotional Activities:

a. Advertising and pre-enrollment materials;
b. Post-enrolment materials;
c. Outreach to members;
d. Promotional activities/events; and
e. Other marketing activities.

Marketing materials shall not contain false, misleading, or ambiguous information. L.A. Care and a Provider shall make every effort to write Marketing Materials at a reading level no greater than (6th) grade and be both culturally and linguistically appropriate.

13.4.4 All Marketing materials shall clearly be labeled with the following:

a. The year on which they were last updated;
b. The source of any representations, endorsements, or awards referred to in the Marketing Materials; and
c. The entity responsible for producing the Marketing Materials.

13.4.4.1 L.A. Care Logo

L.A. Care reserves the right to review and ensure correct usage of the L.A. care logo including the contents of the material that contains the L.A. Care logo.

L.A. Care must review and approve the use of the L.A. Care logo prior to publishing.

13.5 APPROVAL PROCESS:

A Provider shall submit all Marketing Materials and Promotional Activities to L.A. Care through the Provider Network Relations department for review and approval at least forty-five (45) calendar days prior to using such Marketing Materials or engaging in such Promotional Activities.

The exception to the 45 days is if Provider uses CMS model language without modification in Marketing Materials, L.A. Care shall submit the Marketing Materials to CMS at least ten (10) calendar days prior to using the Marketing Materials.

Mail or facsimile to:

L.A. Care Health Plan
Attn: Provider Network Operations Department
1055 West 7th Street
Los Angeles, CA 90017
Fax: 213.438.5732

Documentation of proposed Marketing Materials and Promotional Activities shall include:

a. A draft in final English layout of the proposed Marketing Materials or description of the proposed Activities;

b. A brief description of what the material will be used for.
c. A draft of translated versions of the proposed Marketing Materials with a letter attesting that the translated material conveys the same information and level of detail as the English material (translation to only occur after the English version has been approved); and
d. The total cost of the proposed Marketing Materials or Promotional Activities.

If, upon review, L.A. Care does not object to a Provider's Marketing Materials and Promotional Activities, L.A. Care shall send a written notice to the Provider within ten (10) business days after receipt of all documentation indicating L.A. Care's review of the documentation and intent to submit the proposed Marketing Materials and Promotional Activities to CMS.

If, upon review, L.A. Care objects to a Provider's Marketing Materials or Promotional Activities, L.A. Care shall send a notice to the Provider that describes its objections in detail.

a. The Provider may resubmit revisions of the Marketing Materials or Promotional Activities and all applicable documentation to L.A. Care within five (5) business days after receipt of L.A. Care's Notice.

b. L.A. Care shall review the resubmitted documentation and shall respond to the Provider within five (5) business days after receipt.

c. If approved, L.A. Care shall submit the proposed Marketing Materials or Promotional Activities to CMS.

d. If a Provider fails to resubmit revisions of Marketing Materials or Promotional Activities within five (5) working days after receipt of L.A. Care's review, the Provider shall submit such materials as new Marketing Materials or Promotional Activities.

A Provider shall **NOT** use Marketing Materials or engage in Promotional Activities prior to receipt of L.A. Care's written notice of approval.

L.A. Care shall notify the Physician Group or Provider that proposed Marketing Materials or Promotional Activities have been approved by regulatory body within five (5) working days after receipt of CMS approval.

L.A. Care shall consider Marketing Materials and Promotional Activities approved if CMS and DHCS fail to respond to L.A. Care's request to approve Marketing Materials or Promotional Activities within 45 working days.

13.6 PROHIBITED ACTIVITIES:

Prohibited activities include: engaging in prohibited activities in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS). Use of Marketing Materials or engaging in Promotional Activities without prior written approval from L.A. Care and CMS; and use of logos or other identifying information used by a government or public agency, including L.A. Care without prior authorization to include but not limited to:

- Offering sales/appointment forms.
- Accepting enrollment applications for L.A. Care Cal MediConnect.
- Directing, urging or attempting to persuade potential enrollees to enroll in a specific plan based on financial or other interests.
- Mailing marketing materials on behalf of L.A. Care.
- Offering anything of value to induce L.A. Care Cal MediConnect enrollees to select them as their provider.
- Offering inducements to persuade potential enrollees to enroll in L.A. Care Cal MediConnect.
- Distribute L.A. Care Cal MediConnect information while conducting a health screening.
- Accept any compensation directly or indirectly from L.A. Care Cal MediConnect Field Representative or contracted Agents for enrollment activities.
- Providers may not give the Field Representatives or contracted Agents patient names, addresses, or phone numbers for the solicitation of enrollment.

Failure to Comply

L.A. Care may impose Sanctions on a Provider for any violation of the terms and conditions of this policy and in accordance with marketing guidelines from the Centers for Medicare & Medicaid (CMS) and/or Department of Health Care Services (DHCS). L.A. Care may impose Sanctions including, but not limited to:

- Financial penalties;
- Immediate suspension of use of all Marketing Materials and Promotional Activities for a period not to exceed six (6) months;
- Imposition of an enrollment cap or membership cap and Contract termination.

14.0 ENCOUNTER DATA

Participating Physician Groups (PPGs) are responsible for gathering, processing, and submitting encounter data on all L.A. Care members.

Encounter Data is the primary source of information about the delivery of medical services by practitioners to L.A. Care members. Complete, accurate and timely encounter data submission will help L.A. Care staff to track utilized services and analyze the validity of capitation rates. Encounter data also is a very important source of information for determining needed changes and improvements in health care related programs administered at L.A. Care. L.A. Care will also use encounter data for monitoring and oversight functions including HEDIS reporting and meeting various regulatory requirements

L.A. Care has contracted with TransUnion Healthcare, formally knowing as Diversified Data Design (DDD), a data clearinghouse company, to assist PPGs with the proper formatting to timely and accurate submission of encounter data. PPGs must submit encounter data directly to TransUnion Healthcare.

14.1 REQUIREMENTS

PPGs are required to submit all requested encounter data, including data for services provided under the capitated arrangement, for L.A. Care members. Encounter data is required to be submitted within sixty (60) business days after the end of the month in which the encounter occurred.

The encounter data must be submitted in an electronic format in accordance with the encounter data specifications established by TransUnion Healthcare. If the PPG is unable to submit data electronically, a hard copy of the CMS 1500 can be sent to TransUnion Healthcare.

When a PPG uses TransUnion Healthcare to process its encounter data, TransUnion Healthcare will convert the PPG's encounter data into the appropriate format to meet L.A. Care's specifications.

The PPG must submit encounter data on a monthly basis. Services must use current valid CPT codes and ICD9 diagnosis codes.

PPGs must use TransUnion Healthcare's services under the below mentioned terms and conditions free of charge. L.A. Care will reimburse TransUnion Healthcare for services rendered to all contracted PPGs. Listed below is TransUnion Healthcare's contact information.

Doris Bermejo
Major Account Executive
TransUnion HealthCare
5875 Green Valley Circle
Culver City, CA 90230
310-973-2880 voice
dbermej@transunion.com
TransUnionHealthCare.com

14.2 USE OF TRANSUNION HEALTHCARE SERVICES

PPGs are required to:

- Submit data to TransUnion Healthcare within the parameters required by TransUnion Healthcare.
- Submit data to TransUnion Healthcare within timeframes to ensure routine and timely submission of encounter data to L.A. Care.
- Provide a completed encounter data batch cover sheet, which is designed to facilitate an accurate accounting of encounter data submissions, to Provider Network Operations' Business Analyst concurrently with the submission to TransUnion Healthcare.

15.0 COMPLIANCE

L.A. Care Health Plan ("L. A. Care") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all-applicable federal and state statutes, regulations and rules pertaining to the Cal MediConnect program. L.A. Care's compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners.

L. A. Care has tailored its Compliance Program to fit the unique environment of the organization. Moreover, the Compliance Program is dynamic; L.A. Care regularly reviews and enhances the Compliance Program to meet evolving compliance needs (i.e., business or legal areas of risk) as well as changes in state and federal laws and regulations.

Additionally, L.A. Care's Compliance Program is designed to ensure the provision of quality health care services to all L.A. Care members, including Cal MediConnect members. This is achieved through a variety of compliance activities. L.A. Care's Compliance Program activities include:

- Oversight and monitoring of delegated entities.
- Training and Education.
- Fraud, Waste & Abuse prevention, detection, and investigations.
- Preserving Member Rights concerning Privacy and Confidentiality.
- Ongoing monitoring of quality health care services.
- Education of PPGs about Cal MediConnect program rules and other health care compliance requirements.
- Oversight on written policies, procedures and standards of conduct
- Oversight on effective lines of Communication
- Oversight on well-Publicized disciplinary standards
- Oversight on procedures and systems for promptly responding to compliance issues

15.1 GOALS AND OBJECTIVES

The goal of L.A. Care's Compliance Program is to ensure that all L.A. Care health plan members receive appropriate and quality health care services through the provider network in compliance with all applicable California and federal rules and regulations including the Centers for Medicare and Medicaid Services ("CMS") requirements as well as L.A. Care contractual requirements.

L.A. Care's Compliance Program:

- Provides oversight and ongoing monitoring of delegated responsibilities of L.A. Care's provider network.

- Requires the implementation of corrective actions by the PPGs to address deficiencies concerning provision of health care services or L.A. Care performance standards
- Establishes policies and procedures to Identify, investigate, and resolve potential or actual fraud, waste and abuse activities.
- Establishes education/training opportunities and other available resources to assist PPGs in becoming compliant with HIPAA requirements and Member Rights concerning Privacy and Confidentiality.
- Establishes education/training opportunities and other available resources to assist PPGs in achieving and maintaining compliance with CMS MA-PD requirements.
- Establishes education/training opportunities to assist PPGs with compliance concerns and issues regarding fraud, waste, and abuse.
- Provides L. A. Care's latest Code of Conduct online training program at:

http://www.lachp.org/compliance/coc_2010_ppg.nsf/coc_login

Note: This link will be changing and you will be notified of this change.

(When taking the online training, please log-in with your name, as well as the name of the organization before beginning).

15.2 AUTHORITY AND RESPONSIBILITY

L.A. Care's Compliance Program strives to ensure compliance with federal and State of California rules and regulations affecting the administration of the Cal MediConnect program. This includes, but is not limited to, the following requirements as applicable to each PPG's contract with L.A. Care:

- Requirements set forth by CMS as described in the Medicare Managed Care Manual and other guidance or communications.
- Rules and regulations promulgated by and for the Department of Managed Health Care ("DMHC") and the Department of Health Care Services ("DHCS").
- All applicable federal rules and regulations that apply to the provision of health care services.
- Federal and State of California governing law and legal rulings.
- Terms and conditions as set forth in L.A. Care's contracts with CMS and DHCS.
- Requirements established by L.A. Care and implemented with the PPG as stated in the PPG's contract with L.A. Care.

15.3 DELEGATION OF COMPLIANCE & AUDIT PROGRAM

L.A. Care does not delegate its Compliance Program responsibilities to a PPG. However, the PPG is required to comply with all CMS Compliance Program Effectiveness requirements. L.A. Care staff works with PPG staff to administer compliance activities and implement corrective actions to rectify deficiencies. PPG staff is encouraged to work with L.A. Care compliance staff to ensure compliance with all L.A. Care performance standards.

15.4 Audit & Oversight Activities

To ensure that all L.A. Care Health Plan members receive appropriate health care services, L.A. Care staff performs an annual audit of contract responsibilities and services delegated by L.A. Care to PPG. L.A. Care's audit program for delegated PPGs includes, but is not limited to, the following activities:

- Annual on-site visit to delegated PPGs to ensure that all delegated responsibilities and services are in compliance with Cal MediConnect program requirements. The annual evaluation will be a comprehensive assessment of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote L.A. Care's overall goals and objectives for the delegated function. If any problems or deficiencies are identified, the evaluation will specify any necessary corrective action and include procedures for assuring that the corrective action is implemented.
- Ad-hoc on-site visits to review PPG activities to ensure compliance with program requirements.
- Ongoing monitoring through review of periodic reports and data required as outlined in the delegation agreement.
- Review of all PPG books and records and information as may be necessary to demonstrate PPG compliance with federal, California, and L.A. Care contractual requirements. Records include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and non-medical services rendered to members, and such other information as reasonably requested by L.A. Care.

15.5 PPG COMPLIANCE RESPONSIBILITIES

PPG agrees to comply with Medicare and Medi-Cal laws, regulations, and CMS instructions and agrees to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records (including records of education, training and supporting documentation) a minimum of 10 years.

PPG shall ensure all their related entities, contractors, or subcontractors, and downstream entities involved in transactions related to L.A. Care's Cal MediConnect maintain and provide access to all pertinent contracts, books, documents, papers, and records (including records of education, training and supporting documentation) necessary for compliance with state and federal requirements.

PPG shall require all related entities, contractors, or subcontractors, and downstream entities to agree to comply with Medicare and Medi-Cal laws, regulations, and CMS instructions and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records (including records of education, training and supporting documentation) a minimum of 10 years.

PPG shall require its managers, officers and directors responsible for the administration or delivery of Part C or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Part C and Part D benefits.

Upon contracting with a downstream entity, and related entities, PPG will require a signed certification that these entities will require its managers, officers and directors responsible for the administration or delivery of Part C or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Part C and Part D benefits.

PPG shall conduct annual general and specialized compliance training for their employees. PPG must submit documentation of general and specialized compliance training to L.A. Care's Compliance Officer annually.

PPG shall have written policies, procedures and Standards of Conduct (code of conduct) that are detailed and specific, and describe the operation of the compliance program. The policies, procedures and standards of conduct shall ensure the following:

- Articulate the PPG's commitment to comply with all applicable Federal and State standards;

- Describe compliance expectations as embodied in the Standards of Conduct;

- Implement the operation of the compliance program;

- Provide guidance to employees and others on dealing with suspected, detected or reported compliance issues;

- Identify how to communicate compliance issues to appropriate compliance personnel;

- Describe how suspected, detected or reported compliance issues are investigated and resolved by the PPG;

- Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials; and

- Describe the PPG's expectations that all employees, downstream, and related entities conduct themselves in an ethical manner; that issues of noncompliance and potential FWA are reported through appropriate mechanisms; and that reported issues will be addressed and corrected.

PPG's policies, procedures and standards of conduct shall be distributed to PPG's employees who support the PPG's Medicare business within 90 days of hire, when there are updates to the policies, and annually thereafter.

PPG shall ensure that policies, procedures and standards of conduct are distributed to downstream and related entities' employees who support the PPG's Medicare business within 90 days of hire, when there are updates to the policies, and annually thereafter.

PPG shall designate a compliance officer and a compliance committee who report directly and are accountable to the PPG's chief executive or other senior management.

PPG shall establish, implement and provide effective training and education for its employees, including the CEO, senior administrators or managers, and for the governing body members, and downstream and related entities. PPG's training and education shall include the following:

- Annual training and education for PPG's employees, including the CEO, senior administrators or managers, and for the governing body members, and downstream and related entities;

- PPG's employees (including temporary workers and volunteers), CEO, senior administrators or managers, and governing body members, and downstream and related entities receive general compliance and FWA training within 90 days of hire/contracting and annually thereafter;

- PPG ensures that general compliance information is communicated to downstream and related entities' employees; and

- PPG reviews and updates, if necessary, the general compliance training whenever there are material changes in regulations, policy or guidance, and at least annually.

PPG shall establish and implement effective lines of communication, ensuring confidentiality between the compliance officer, members of the compliance committee, the PPG's employees, managers and governing body, and the PPG's downstream and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

PPG's effective lines of communication shall include the following:

- PPG has an effective way to communicate information from the compliance officer to others;

- PPG's written Standards of Conduct and/or policies and procedures must require all employees, members of the governing body, and downstream and related entities to report compliance concerns and suspected or actual violations related to the Medicare program to L.A. Care Health Plan and the PPG;

- PPGs must have a system in place to receive, record, respond to and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees and downstream and related entities and their employees;

- PPG adopts, widely publicizes, and enforces a no-tolerance policy for retaliation or retribution against any employee or downstream and related entities who in good faith report suspected FWA;

- The methods available for reporting compliance or FWA concerns and the non-retaliation policy are publicized throughout the PPG's facilities; and

- PPG makes the reporting mechanisms user friendly, easy to access and navigate, and available 24 hours a day for employees, members of the governing body, and downstream and related entities.

PPG shall have well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals.

PPG shall establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. PPG's effective system for routine monitoring and identification of compliance risks shall include the following:

- PPG shall develop a monitoring and auditing work plan that addresses the risks associated with the Medicare Parts C and D benefits. The compliance officer and compliance committee are key participants in this process;

- PPG shall establish and implement policies and procedures to conduct a formal baseline assessment of the PPG's major compliance and FWA risk areas, such as through a risk assessment;
- PPG shall have a monitoring and auditing work plan that is based upon the results of the risk assessment;

- PPG shall have a work plan that includes a schedule that lists all of the monitoring and auditing activities for the calendar year;

- PPG's compliance officer and compliance committee shall ensure the implementation of an audit function to conduct oversight of the PPG's operation and compliance program appropriate to the PPG's size, scope and structure;

- PPG shall develop a strategy to monitor and audit its downstream and related entities to ensure that they are in compliance with all applicable laws and regulations;

- PPG shall track and document compliance efforts; and

- PPG shall review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or downstream and related entities, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

PPG shall establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements. PPG's system for promptly responding to compliance issues shall include the following:

- PPG conducts a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medicare program noncompliance or potential FWA;

- PPG undertakes appropriate corrective actions in response to potential noncompliance or potential FWA;

- The PPG ensures that PPG and downstream and related entities have corrected their deficiencies;

- The elements of the corrective action that address noncompliance or FWA committed by the PPG's employee(s) or downstream and related entities are documented, and include ramifications should the PPG's employee(s) or its downstream and related entities fail to satisfactorily implement the corrective action. The PPG enforces effective correction through disciplinary measures, including employment or contract termination, if warranted; and

PPG self-reports potential FWA discovered at the PPG level, and potential fraud and abuse by downstream and related entities, as well as significant waste and significant incidents of Medicare program noncompliance to L.A. Care Health Plan.

15.6 L.A. CARE'S SPECIAL INVESTIGATION UNIT

L.A. Care's Compliance Program includes measures to detect, correct, and prevent fraud, waste, and abuse ("FWA"). L.A. Care's Special Investigation Unit ("SIU") was created to provide oversight of FWA prevention efforts and help reduce fraudulent activities in L.A. Care's network.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste is defined as an overutilization of services or careless practices that result in unnecessary costs. Waste is generally not considered a criminally negligent action, but rather the misuse of resources.

Abuse is defined as actions that may directly or indirectly result in unnecessary costs to the Medicaid and Medicare programs or any other health care programs funded in whole or in part by the state, federal and/or local governments; improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary.

Abuse involves payment for items or services where there is no legal entitlement to that payment and the one receiving the payment has not knowingly and/or intentionally misrepresented facts to obtain payment.

The goal of the SIU is to protect and preserve the integrity and availability of health care resources for our members, stakeholders, and business partners by maintaining a comprehensive program integrity plan. Anti-fraud activities will be coordinated between L.A. Care and its PPGs, hospitals and ancillary providers.

15.6.1 Reporting Potentially Fraudulent Activities

The SIU is set up to handle all types of potentially fraudulent activities. Staff monitors activities ranging from claims to health care services provided to members. Written or verbal allegations of fraudulent activities are forwarded to L.A. Care's Regulatory Affairs & Compliance Department for follow-up.

Potentially fraudulent activities can be reported by calling L.A. Care's Compliance Helpline at **1-800-400-4889 or via the internet at www.lacare.ethicspoint.com**. The Compliance Helpline is available 24 hours a day, 7 days a week. You may also call L.A. Care's Compliance Officer directly at 213-694-1250, ext. 4292. If, for whatever reason, you are not able to report a potential fraud case by calling these phone numbers, please call L.A. Care's Provider Inquiry Line at 866-522-2736.

A written letter regarding potentially fraudulent activities can also be mailed to L.A. Care at:

Compliance Officer, Regulatory Affairs & Compliance
c/o Special Investigation Unit (SIU)
1055 W. Seventh Street, 10th Floor
Los Angeles, CA 90017

Referral Requirements

Regardless of what method you choose to use to report fraud or abuse to us, you should include the following:

- Name of Person Reporting Fraud (Optional, but highly recommended)
- Name, Address, License or Insurance ID of Subject (if known)
- Nature of Complaint
- Date of Incident(s)
- Supporting Documentation (Optional)

All cases identified as potential fraud or abuse are reported to the appropriate law enforcement and/or regulatory agency.

Non-Retaliation

Neither L.A. Care nor any of its contracted entities, including PPGs, shall retaliate against any employee, temporary employee, contractor or agent who, in good faith, reports suspected fraud, waste or abuse or Code of Conduct violations to L.A. Care, the contracted entity or to a regulatory agency. Additionally, L.A. Care's contracted entities shall require that its subcontractors abide by this non-retaliation policy.

15.6.2 COMMUNICATION OF L.A. CARE'S FRAUD & ABUSE DETECTION EFFORTS

L.A. Care uses various means to educate its provider network and membership about its fraud & abuse detection efforts. Information about L.A. Care's fraud & abuse detection activities is communicated in some of the following ways: provider bulletins; provider mailings; provider trainings; member newsletters; New Member Handbook and other sources which may include L.A. Care's Regional Community Advisory Committee meetings.

Additionally, all L.A. Care contracted PPGs must ensure the PPG employees and contracted downstream and related entities participate and complete L.A. Care's training regarding fraud, waste, and abuse and general compliance training on an annual basis. Providers that have met FWA certification standards through enrollment as a Medicare provider are deemed to have met FWA training and educational requirements, but still must fulfill the general compliance training requirements. Non-deemed Providers may also be waived from this training if able to provide evidence of participation in a similar training program through another health plan or a professional association or industry group accepted by L.A. Care.

You may access the Fraud, Waste and Abuse and General Compliance training module through the CMS Medicare Learning Network at:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

15.7 Enforcement of Disciplinary Standards

It is L.A. Care's expectation that PPG immediately report to L.A. Care any suspected compliance issues, such as noncompliant, unethical, or illegal behavior. Such behavior may include, but is not limited to, falsifying diagnoses, claims, or other documents; refusal to cooperate with state or federal audits or investigations; and other behavior. Such reports can be made directly to L.A. Care's Compliance Officer at (213) 694-1250, x4292. Anonymous complaints of noncompliant, unethical, or illegal conduct may also be reported by calling L.A. Care's Compliance Helpline at 1-800-400-4889 or via the internet at www.lacare.ethicspoint.com. The Compliance Helpline is available 24 hours a day, 7 days a week. PPG shall also assist in the resolution of reported compliance issues.

L.A. Care will timely, consistently, and effectively act when noncompliant or unethical behavior is found. Such action will be appropriate to the seriousness of the violation and may include de-delegation of a function, restriction of enrollment or assignment of members, withholding capitation, instituting monetary sanctions, or terminating a contract. Refer to the Participating Provider Group Services Agreement (PPGSA) for further details on these measures.

PPG shall ensure that it has established, implemented, and enforced disciplinary standards that are publicized to those entities with which it contracts.

It is L.A. Care's expectation that PPG will cooperate with L.A. Care's efforts to monitor compliance.

15.8 THE FEDERAL FALSE CLAIMS ACT

The federal False Claims Act permits a person who learns of fraud against the United States Government to file a lawsuit on behalf of the government against the person or business that committed the fraud. If the action is successful, the person filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery.

Who can be a plaintiff?
If the fraud has not previously been publicly disclosed, any person may bring a lawsuit called a "*qui tam* action" regardless of whether he or she has "direct" or first-hand knowledge of the fraud. Thus, where there has been no public disclosure, an employee who learns from a colleague of fraud, the employer or another employee at work may bring a *qui tam* action, even if the *qui tam* plaintiff personally has no first-hand knowledge.

What types of fraud qualify?
When a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he or she is not otherwise entitled, that person has committed fraud. This usually -- although not always -- involves money. However, under the False Claims Act, fraud has a much wider and more inclusive meaning.

Under the Act, the defendant need not have actually known that the information he or she provided to the government was false. It is sufficient that the defendant supplied the information to the government either: (i) in "deliberate ignorance" of the truth or falsity of the information; or (ii) in "reckless disregard" of the truth or falsity of the information.

Thus, if a defendant should have known that its representations to the government were not true or accurate, but did not bother to check, such recklessness may constitute a violation of the Act. Likewise, if a defendant deliberately ignores information which may reveal the falsity of the information submitted to the government, such "deliberate ignorance" may constitute a violation of the Act.

What protection is there for a plaintiff who brings an action?
The False Claims Act provides protection to employees, agents or contractors who are retaliated against by an employer because of their participation in a *qui tam* action. The protection is available to any employee, agent or contractor who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee, agent or contractor investigates, files or participates in a qui tam action.

This "whistleblower" protection includes reinstatement with the same seniority status and damages of double the amount of lost wages (back payment plus interest) and compensation for any special damages including litigation costs and reasonable attorney's fees...

California has a similar False Claims Act which mirrors almost all of the provisions of the Federal Act. The California law differs in these important respects:

- Claims of under five hundred dollars ($500) as well as claims involving workers' compensation or those against public entities and employees are prohibited in California.
- Claims where a person receives a payment which he or she discovers to be false and then fails to disclose it to the state within a reasonable time are prohibited. These are called "inadvertent submissions."
- In California, the court may also award punitive damages to an employee, contractor or agent who is seeking relief from retaliatory actions by the employer.

15.9 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") FOR MEDI-CAL AND MEDICARE PROGRAMS

If a provider receives a misdirected communication from L.A. Care, immediately notify L.A. Care's Privacy Office by calling (213) 694-1250, x4193 or e-mailing PrivacyOfficer@lacare.org. Providers should securely destroy, return to L.A. Care, or safely safeguard the misdirected communication.

As covered entities, L.A. Care expects all providers to comply with applicable privacy and security requirements outlined by federal and state regulation and guidelines, including those set forth under the HIPAA Rules. A brief overview of some of these requirements is provided below, however providers should review the actual Rules or consult with their legal counsel to understand all applicable regulations and requirements.

15.9.1 Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information ("ePHI") it creates, receives, maintains, or transmits. It also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers and other electronic devices.

The Security Rule is intended to be scalable; in other words, it does not require specific technologies to be used. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

15.9.2 Privacy Rule

The Privacy Rule is intended to protect the privacy of all individually identifiable health information in the hands of covered entities, regardless of whether the information is transmitted or maintained on paper, electronically, or verbally. The Privacy Rule also gives patients a number of rights under HIPAA, including:

- The right to access their PHI
- The right to request a restriction on certain uses and disclosures of their PHI
- The right to request changes to their PHI
- The right to receive a list (or accounting) of when the covered entity disclosed PHI, with some exceptions (such as for treatment, payment, and health care operations)

In addition these rights, the Privacy Rule includes requirements to formally notify patients of the covered entity's privacy practices, obtain a patient's permission before using or disclosing their PHI with limited exceptions, as well as other requirements that address their proper use and disclosure of patient information.

15.9.3 Breach Notification Rule

If an impermissible acquisition, access, use, or disclosure that compromises the security or privacy of PHI occurs, HIPAA's Breach Notification Rule outlines the requirements for assessment and notification. While there are specific federal requirements that outline how to assess, who to notify, and the notification timelines, there may be other state and contractual standards that also apply. Providers are strongly encouraged to familiarize themselves with all applicable requirements and guidance.

15.9.4 Transaction and Code Sets Standards

According to CMS, electronic transactions are activities involving the transfer of healthcare information for specific purposes. The HIPAA regulations have identified certain standard transactions for Electronic Data Interchange ("EDI") for the transmission of health care data. These transactions are:

- Claims and encounter information
- Payment and remittance advice
- Claims status
- Eligibility

- Enrollment and disenrollment
- Referrals and authorizations
- Coordination of benefits
- Premium payment

If a health care provider engages in one of the identified transactions electronically, they must comply with the standard for that transaction.

15.10 PRIVACY AND INFORMATION SECURITY RELATED RESOURCES & WEB SITES

U.S. Department of Health & Human Services- Office of Civil Rights
http://www.hhs.gov/ocr/hipaa/

Centers for Medicare & Medicaid Services (CMS)
http://www.cms.hhs.gov/hipaageninfo/01_overview.asp?

California Department of Health Care Services
www.privacy.ca.gov

National Committee on Vital and Health Statistics
http://www.ncvhs.hhs.gov/

National Institutes of Health
http://privacyruleandresearch.nih.gov/

National Institute of Standards and Technology
http://www.nist.gov

Centers for Medicare and Medicaid Services Regulations & Guidance
http://www.cms.gov/home/regsguidance.asp

16.0 PHARMACY

PART D PRESCRIPTION DRUG COVERAGE – Cal MediConnect
This chapter describes the key aspects of the Part D Prescription Drug benefit offered under L.A. Care Health Cal MediConnect.

16.1 Pharmacy Benefits

L.A. Care, through its pharmacy benefits manager (PBM), has contracted with a comprehensive network of pharmacies located throughout the Service Area. Additionally, MA-PD members may fill prescriptions by utilizing a mail order pharmacy. L.A. Care has made arrangements with a PBM (Pharmacy Benefit Manager) to manage these pharmacy services for Cal MediConnect members.

16.2 Systems Support for L.A. Care and its Participating Pharmacies

The PBM has developed sophisticated systems to work efficiently with L.A. Care and its Participating Pharmacies to safeguard the health of Cal MediConnect members and to facilitate access to appropriate pharmacy and therapeutic services.

a) Cal MediConnect member Eligibility, as well as Cal MediConnect member identifying information, is verified on-line, in real time by the customer services representatives

b) Formulary Compliance is monitored and facilitated through the identification of alternative medications or dosages

c) Drug Interaction(s) with potentially adverse outcomes are noted and brought to the attention of prescribing providers

16.3 Clinician's Support for L.A. Care

The PBM dedicates a support staff to work with L.A. Care and its Providers on identifying the best strategies for prescribing and dispensing pharmaceuticals considering quality, cost, and Cal MediConnect member needs.

The PBM's support staff works closely with the Plan's Pharmacy Director, Clinical Pharmacists and Medical Director to:

1) Administer the Pharmacy Benefits
2) Recommend improvements based on the experience of L.A. Care, as well as trends and innovations found throughout the managed care industry

16.4 L.A. Care's Drug Formulary for Part D

The Drug Formulary for Part D represents the efforts by the PBM's Pharmacy and Therapeutics (P&T) Committee to provide physicians, other prescribers and pharmacists with a method for evaluating the various drug products available.

The medical treatment of Cal MediConnect members is frequently related to the practical application of drug therapy. Due to the vast availability of medication therapy and treatment modalities, a reasonable program of drug product selection and drug usage has been developed. The goal of the Drug Formulary is to enhance the physician's/other prescriber's abilities to provide optimal cost effective drug therapy for our MA-PD members.

The development, maintenance, and improvement of this process are evolutionary and require constant attention. This is accomplished by the PBM's P&T and Formulary Committee for Part D. The Formulary is continuously reviewed and revised, as a necessary part of a Quality Improvement. To accommodate the necessary changes of this document, formulary updates are regularly posted on L.A. Care's website, www.lacare.org/members/medicareadvantageplan/medicarepartd. Additionally, an updated electronic version of this formulary is always available online at: http://www.lacare.org/members/medicareadvantage/helpfulinformation.

L.A. Care's Customer Services Department may also be contacted regarding Formulary updates at (888) 839-9909. Physicians/other prescribers utilizing this Drug Formulary are encouraged to review the information.

The PBM's P&T Committee use the following criteria in the evaluation of drug selection for the Drug Formulary:

a) Drug safety profile
b) Drug efficacy
c) Comparison of relevant drug benefits to current formulary agents of similar use, while minimizing duplications
d) Equitable cost and outcomes of the total cost of product and medical care
e) If drug needs authorization or is not in formulary an exception may be requested. This may be requested on the Medicare Prescription Drug Coverage Determination request form which is posted on L.A. Care's website: www.lacare.org/members/medicareadvantageplan/helpfulinformation.

   The Drug Formulary is a list of covered and preferred drug therapies for L.A. Care Health Plan Cal MediConnect Members. Drugs are listed by their generic names and/or most common proprietary (branded) name. The Formulary is arranged by medical condition and alphabetical listing. Some branded drugs listed are for reference use only, and do not denote coverage; covered branded drugs are listed entirely in capital lettering. Any drug not

found in this Drug Formulary listing or in any Formulary updates published by L.A. Care shall be considered a Non-Formulary drug.

L.A. Care's Drug Formulary does not provide information regarding the specific coverage and limitations an individual Cal MediConnect member may have. Many MA-PD members have specific Benefit inclusions, exclusions, Co-payments, or a lack of coverage, which are not reflected in the Formulary.

The Drug Formulary applies only to Outpatient drugs provided to Cal MediConnect members, and may not apply to medications used in Inpatient settings or to medications that require special handling and/or administration by a Participating Provider. If a Member has any specific questions regarding their coverage, they should contact L.A. Care at (888) 839-9909.

16.5 Medicare Part D Formulary Structure

The Medicare Part D Formulary is based on a **two-tier structure**, which includes Generic drugs (Tier 1) covered at a lower Co-payment, and Brand drugs (Tier 2) at the higher Co-payment amount. Should a Cal MediConnect member need drugs that are restricted by the Drug Formulary, a Medicare Prescription Drug Coverage Determination request form will need to be filled out and fax or mail to the PBM that is on this form.

16.6 L.A. Care's Policies Regarding Prescriptions

It is the goal of L.A. Care to provide quality care to our Cal MediConnect members by ensuring that medications prescribed by the L.A. Care's physicians/other prescribers are appropriate for the Cal MediConnect member considering his/her health status and the clinical alternatives that are available. Consequently it is the policy of the L.A. Care that:

1. **Generics will be substituted**, unless the name brand is specified by the physician/other prescriber

2. Higher Co-payments apply to name brand drugs than to generics

3. PBM's clinicians along with Plan's clinicians administer the Plan's guidelines

4. In instances where the guidelines are not sufficiently specific, L.A. Care's Clinical Pharmacist, Pharmacy Director or Medical Director will be involved in rendering a decision regarding a specific case for a determination.

5. Grievances and Appeals by Cal MediConnect members and/or physicians/other prescribers relative to pharmacy services, are handled by L.A. Care, as for all other Benefits

16.7 Coverage determination

The Coverage Determination made by L.A. Care is the starting point for dealing with requests Cal MediConnect members may have about covering or paying for a Part D prescription drug. If the Cal MediConnect members' physicians, other prescribers or pharmacists inform them that a certain prescription drug is not covered, our Cal MediConnect members or their physicians/other prescribers should contact L.A. Care and ask how to obtain a Coverage Determination. Requests for a Coverage Determination or exception may be submitted on Cal MediConnect Prescription Drug Coverage Determination request form via fax or mail that is on this form.

With this Coverage Determination decision, L.A. Care does explain whether we will provide the prescription drug requested or pay for a prescription drug already received. If L.A. Care denies the request (this is sometimes called an "adverse coverage determination"), our Cal MediConnect members can request for a redetermination of the decision within sixty (60) calendar days. If L.A. Care fails to make a timely coverage determination on a request, it will be automatically forwarded to the independent review entity (IRE) for review. For additional information, please see L.A. Care website: www.lacare.org under Cal MediConnect

The following are examples of coverage determinations:

1. A Cal MediConnect member requests payment for a prescription drug already received. This is a request for a coverage determination about payment. You can call us at 1-888-839-9909 to get help in making this request.

2. A Part D drug that is not on L.A. Care's Cal MediConnect Drug Formulary list. This is a request for a "formulary exception."

3. Exception is requested for prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception.

16.8 Utilization Management Tools:

a. Prior Authorization: L.A. Care requires prior authorization for certain drugs. This means that Cal MediConnect members, their physician/other prescriber or authorized representative will need to get

approval from us before filling a prescription. If they don't get approval, we may not cover the drug.

b. Quantity Limits: For certain drugs, L.A. Care limits the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 60 tablets for every 30 day period per prescription for Namenda.

c. Step Therapy: In some cases, L.A. Care requires a Cal MediConnect member to first try one drug to treat their medical condition before covering another drug for that condition. For example, if Drug A and Drug B both treat their medical condition, L.A. Care may require the provider to prescribe Drug A first. If Drug A does not work, then L.A. Care will cover Drug B

d. A Cal MediConnect member requests for a non-preferred drug to be provided at the preferred cost-sharing level. This is a request for a "tiering" exception.

e. Request for reimbursement for a drug obtained at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided in a physician's/other prescriber's office may be covered by the L.A. Care.

When L.A. Care makes a coverage determination(s), we are determining coverage for prescription drug(s) for our members based on their specific situation(s).

16.9 Time Frames for Coverage Determinations

A decision about whether L.A. Care will cover a prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within **72 hours)**; or it can be a "fast" coverage determination that is made more quickly (typically within **24 hours**). A fast decision is sometimes called an "expedited coverage determination."

A fast or expedited coverage determination may be requested **only** if the Cal MediConnect member or their physician/other prescriber believe that waiting for a standard decision could seriously harm a Cal MediConnect member's health or ability to function. (Fast decisions apply only to requests for drugs that a Cal MediConnect member has not received yet. Cal MediConnect members cannot get a fast decision if they are requesting payment for a drug that was already received.)

16.10 Reports on Pharmacy Services Utilization

L.A. Care conducts drug utilization reviews for all of our Cal MediConnect members to make sure that they are receiving safe and appropriate care. These reviews are especially important for Cal MediConnect members who have more than one physician/other prescriber who prescribe their medications. These drug utilization reviews occur each time a prescription may be filled and on a regular basis by reviewing the Cal MediConnect member's pharmacy records. During these reviews, we look for medication problems such as:

1. Possible medication errors
2. Duplicate drugs that are unnecessary because the Cal MediConnect member are taking another drug to treat the same medical condition
3. Drugs that are inappropriate for their age or gender
4. Possible harmful interactions between drugs you are taking
5. Drug allergies
6. Drug dosage errors

Pursuant to its agreement with L.A. Care, the PBM generates reports about the utilization of pharmacy services by/ within the health plan, physicians/other prescribers and selected specialties. This information is analyzed on a retrospective basis in accordance with general industry trends and criteria. Consideration of the specific interests of L.A. Care relative to the health status of its unique membership base and the related prescribing practices of network physicians/other prescribers are also taken into account. L.A. Care will share drug utilization reports with the Preferred Physician Groups (PPGs) on a periodic basis as part of its Quality Improvement process.

16.11 Reimbursement for Pharmacy Services

Reimbursement for pharmacy services is a responsibility of L.A. Care and has budgeted funds based on the actuarial assumptions regarding such costs for the target population.

16.12 Additional Pharmacy Services for MA-PD Members

Mail Order Prescriptions

As a convenience to our Cal MediConnect members, they have the option of obtaining an extended 90-day supply of covered medications through L.A. Care Health Plan's mail-order program. To receive medications through our mail-order service, they simply complete one of our mail-order forms and mail it in with the physician's or other prescriber's prescription to the address on the form. If our Cal MediConnect members need mail order forms, please contact L.A. Care's Member Services or go to our website at:

www.lacare.org/members/medicareadvantageplan/helpfulinformation.

Transition Policy

New Cal MediConnect members to L.A. Care may be taking drugs that are not on our Drug Formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. Cal MediConnect members should talk to their physicians or other prescribers to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. The exception process is described below. While these new Cal MediConnect members might talk to their physicians/other prescribers to determine the right course of action, we may cover the non-formulary drug in certain cases during the first 90 days of new membership.

For each of the drugs that are not on our formulary or that have coverage restrictions or limits, we will cover a temporary 90-day supply (unless the prescription is written for fewer days) when the new member goes to a participating network pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, we will provide refills for 60 more days. After 90 days L.A. Care will not pay for these drugs.
If the new Cal MediConnect member is a resident of a long-term care facility, L.A. Care will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new Cal MediConnect member of our plan.

If a new member needs a drug that is not on our formulary or subject to other restrictions, such as step therapy or dosage limits, but the new Cal MediConnect member is past the first 90 days of new membership in our plan, we will cover a 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new Cal MediConnect member pursues a formulary exception.

Medication Therapy Management (MTM) programs

L.A. Care offers Medication Therapy Management (MTM) programs thru the contracted local retail pharmacists at network pharmacies and at no additional cost for our Cal MediConnect members who have two or multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These MTM programs were developed to help us provide better care for our Cal MediConnect members. For example, these programs help us make sure that our MA-PD members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors. We offer MTM programs for Cal MediConnect members that meet specific criteria. These contracted local retail pharmacists may contact Cal MediConnect members who qualify and their physicians/other prescribers for these MTM programs. We hope you will encourage your patients to utilize the MTM programs so that we can help

manage their medications. Cal MediConnect members do not need to pay anything extra to participate.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” However these drugs may be covered through Medi-Cal. These drugs include:

Non-prescription drugs (over-the-counter drugs)*	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds*	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations*
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale*	Barbiturates and Benzodiazepines*

NOTE: Due to a change in Medicare regulation, most Medicare Part D Plans will no longer cover erectile dysfunction (ED) drugs like Viagra, Cialis, Levitra, Muse, and Caverject after January 1, 2007.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B.

17.0 Managed Long Term Services and Supports

17.1 What is MLTSS?

Managed Long Term Services and Supports (MLTSS) refers to a wide range of services that support people living independently in the community. This includes services traditionally funded by Medi-Cal as well as other services available in the community that are not Medi-Cal benefits, but are known to support independent living. As defined by the California Coordinated Care Initiative (CCI), MLTSS also includes care and support for members residing in long-term care facilities.

L.A. Care's MLTSS Department uses a person-centered care model designed to help members find the right combination of services to keep them safely in their homes or long-term facility. The various long term services and supports fall along a continuum, and members may require assistance in moving among these different services and in coordinating their care. The MLTSS Department coordinates access to, pays for, and oversees these services for members. MLTSS Department contact information includes:

- **E-mail** MLTSS@lacare.org
- **Call 855-427-1223, or**
- **Call 213-694-1250, ext. 5422**
- **Fax 213-438-4877**

Long Term Services and Supports Included in the Medi-Cal Benefit

There are five LTSS areas included in the Medi-Cal benefit. These include Long Term Care (LTC), Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) and Care Plan Options (CPO). In addition, L.A. Care also assists with referrals to community-based services outside of the Medi-Cal benefit. These services are generally provided by community-based organizations such as Independent Living Centers, Regional Centers and Area Agencies on Aging. These agencies provide LTSS services that are not a part of a member's benefit package, but they often work with Medi-Cal health plans such as L.A. Care to get plan members the services they need. The MLTSS Department is responsible for coordinating services with these agencies.

MLTSS Support and Expertise

The MLTSS Department provides a variety of support and expertise to physicians and their patients, including, but not limited to:

- Assisting members in finding the right combination of services through assessment and staff expertise.

- Coordinating access to MLTSS services, including both L.A. Care benefits and community services and supports.
- Providing oversight of MLTSS services.
- Acting as MLTSS subject matter experts on care teams.
- Facilitating participation of MLTSS providers on care teams.
- Reporting on MLTSS usage, trends, grievances and appeals.
- Working with MLTSS agencies to design and implement system improvements.

MLTSS: A Resource for Physicians

The MLTSS Department serves as an important resource for physicians and their patients. Physicians should contact the MLTSS department when they identify a member who has a need for any of the following: 1) social support; 2) caregiver support; 3) assistance with Activities of Daily Living (ADLs); or 4) Independent Activities of Daily Living (IADLs), such as personal care or household chores.

Other opportunities for the physician to contact the MLTSS Department include having a member who:

- Qualifies for nursing home placement, but wants to stay home.
- Receives MLTSS services, but has unmet needs.
- Has a condition which indicates a possible need for MLTSS in the future.
- Experiences difficulty with a particular MLTSS service (LTC, IHSS, CBAS, MSSP, or CPO) and could benefit from assistance and coordination.
- Is preparing to transition into long term care or from long term care into the community.

The MLTSS Department should be contacted to obtain authorization for LTC custodial services, CBAS services, or CPO services. Physicians may also request L.A. Care MLTSS staff member participation in the Interdisciplinary Care Team (ICT) or assistance in reaching out to a MLTSS service provider to join the ICT.

MLTSS and Care Coordination

Care coordination can include case management services for members with increased service needs, such as those who are receiving episodic care, requiring increased resources, receiving multiple services along the continuum, and otherwise accessing MLTSS services. L.A. Care's care coordination process holds multiple benefits to members accessing MLTSS services, including the following:

- Central point of contact at Health Plan level and with member, family, legal representatives, physicians/providers to accomplish care plan goals

- Targeted assessment of identified member needs
- Creation of individualized care plan (ICP)
- MLTSS providers assess and develop care plans that contribute to the ICP
- Facilitation of identified referrals
- Facilitation of continuity of care with non-contracted providers
- Development of short term goals
- Follow up communications
- Discussion of ICP with Interdisciplinary Care Team (ICT)
- MLTSS providers participate in the ICT
- Care teams and MLTSS providers work together to ensure members get needed and unduplicated services.

Physicians may access care coordination services for members receiving MLTSS by contacting the MLTSS Department (see contact info above).

17.2 Long Term Care (LTC)

What is LTC?

LTC is the provision of medical, social, and personal care services in either an institution or private home. Most LTC services are provided in Skilled Nursing Facilities. The primary purpose is to assist the individual in activities of daily living, such as assistance in walking, getting in and out of bed, bathing dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that can usually be self-administered. LTC is essentially personal care that does not require the continuing attention or supervision of trained, medical or paramedical personnel. Those who are eligible for LTC include Medi-Cal recipients who require 24-hour long or short-term medical care and are eligible to receive services in a skilled nursing facility. Criteria for LTC may be found in state regulations under Title 22, CCR, Section 51335.

LTC Referral and Authorization Process

The first step in the LTC referral process is for providers to verify that the patient is an L.A. Care member. For referrals from a Primary Care Physician (PCP), the LTC Custodial Referral Form must be submitted to L.A. Care's MLTSS Department for review. This form is accessible via the Provider Portal at www.lacare.org. The PCP must prescribe services for LTC authorization. For referrals to a skilled level of care, the PCP should contact the L.A. Care utilization management team (not the MLTSS Department) at **877-431-2273.** Once the LTC referral has been received, L.A. Care will notify the referral source of the LTC referral outcome within five business days for routine situations and 72 hours for urgent situations.

If a referral meets custodial LTC criteria, L.A. Care will issue authorization to the nursing facility and notify the referral source. If the referral does not meet custodial LTC criteria, the request will be referred to the appropriate MLTSS team within L.A. Care (IHSS, CBAS, MSSP) and/or to L.A. Care Case Management (Social Work, Complex Case Management, Disease Case Management).

The MLTSS Department assists members with LTC by recommending and authorizing LTC Services, monitoring member progress, assisting with transitions outside of LTC services, and coordinating LTC services with other health plan benefits.

LTC Concurrent Review Process

As part of the LTC concurrent review process, a custodial LTC member will be assigned to the appropriate physician or physician group. L.A. Care's LTC Nurse Specialist will support the assigned physician on facilitation and coordination of care needs. L.A. Care's LTC Nurse Specialist will also conduct regular on-site or telephonic clinical review of members in nursing facilities.

Case Management, Utilization Management and Care Coordination for Individuals in LTC

L.A. Care's LTC Nurse Specialist is responsible for Case Management, Utilization Management and coordination of services for members in an LTC facility. L.A. Care's Nurse Specialist authorizes and facilitates specialty services such as, but not limited to the following:

- Specialty physician referrals (i.e. Behavioral Health, Podiatry)
- Labs
- Diagnostics
- Transportation
- DME
- Home Health
- Hospice and Palliative Care

17.3 Community Based Adult Services (CBAS)

What is CBAS?

CBAS is a facility-based program that provides core services such as skilled nursing and medication management, social services, physical, occupational, and speech therapies, personal care, and family/caregiver training and support. The program also provides mental health/psychiatric services, registered dietitian services, meals and transportation (to/from a member's residence). CBAS has

been an L.A. Care plan benefit since 2012, when it replaced adult day health care. Members enrolled in CBAS can go to a center during the day for assistance with their daily needs. The goal is to delay the placement of eligible members into nursing homes or more expensive care settings.

Over 150 CBAS centers serve approximately 20,000 individuals in L.A. County. To qualify for CBAS, members must be over 18 years of age, certified for nursing home placement, and have other specialized disabilities or health conditions, such as traumatic brain injury, mild cognitive impairment, dementia, or a developmental disability.

CBAS Referral Process

CBAS services must be ordered by the PCP. Orders are made by completing an L.A. Care CBAS Request for Services Form. This form is accessible via the Provider Portal at www.lacare.org. Completed request forms may be submitted to L.A. Care's CBAS Team via fax at **213-438-5739.**

The MLTSS Department refers eligible members to local CBAS centers, authorizes CBAS services, and coordinates CBAS services with other benefits.

17.4 In Home Supportive Services (IHSS)

What is IHSS?
IHSS is a state entitlement program that pays for homecare services that enable eligible seniors and individuals who are disabled (including children) to remain safely in their own homes. An IHSS Homecare Provider can assist with **personal care services**, such as bathing, grooming, dressing and feeding; **domestic services**, such as cooking, house cleaning and laundry; **protective supervision** for individuals with mental impairment; **paramedical services**, such as assistance with medications, bowel and bladder care, and catheter insertion; and **other services**, such as accompaniment to medical appointments.

IHSS serves approximately 192,000 individuals in L.A. County. To qualify for IHSS, individuals must be a California resident and a U.S. citizen/legal resident living in their own home and receiving (or eligible to receive) Supplemental Security Income/State Supplemental Payment (SSI/SSP) or Medi-Cal benefits. They must be 65 years of age or older, legally blind, or disabled by Social Security standards. And they must submit a health care certification form (SOC 873) from a licensed health care professional indicating that they need assistance to stay living at home.

IHSS Referral and Authorization Process

In order for members to access IHSS services, the Los Angeles County Department of Public Social Services must conduct an assessment and

authorize IHSS. The member then hires, trains, and supervises their IHSS worker. L.A. Care is financially responsible for IHSS and assists members as needed (for instance, helping with navigation of the IHSS grievance process) and coordinates with other care a member is receiving.

Physicians may refer members needing IHSS to either the L.A. County IHSS Application Hotline at **888-944-4477** or L.A. Care's MLTSS Department at **855-427-1223.** The physician may also assist with completion of required IHSS forms and provide members with other documentation to support their need for IHSS services. Members who have questions about their IHSS may be referred to the MLTSS Department for assistance.

MLTSS is able to assist members by coordinating and navigating the IHSS assessment and re-assessment process, resolving IHSS-related issues, navigating the DPSS grievance and appeals processes, and coordinating IHSS benefits with other health plan benefits.

17.5 Multipurpose Senior Services Program (MSSP)

What is MSSP?

MSSP is an intensive case management program for seniors who are certified for nursing home placement, but wish to remain at home. MSSP provides **Care Management**, such as needs assessments, care plan development, and monitoring of care; **Care Management Assistance**, such as help accessing services and personal advocacy; and **Purchased Services**, such as supplemental chore and personal care services, diet and nutrition, handyman services, respite care, transportation and appliance assistance**. Note: the total cost of services must not exceed the cost of SNF placement.**

Six MSSP sites serve nearly 3,400 individuals in L.A. County. In order to be eligible for MSSP services, a member must be 65 years of age or older, live within an MSSP service area, be eligible for Medi-Cal and be certified for nursing home placement. If the member does not meet the eligibility requirements for MSSP the MLTSS staff will work with the ICT and members to identify alternative services.

Accessing MSSP Services

L.A. Care contracts with MSSP sites. MSSP then assesses for and provides both social and health care management services. There are a limited number of statewide waiver slots. If an L.A. Care member is eligible, but the MSSP does not have an open slot:

- The MSSP will notify the MLTSS Department that the member is being placed on a waitlist.

- L.A. Care will work with the member, internal staff, and other community-based providers to ensure the member is getting assistance through other services and programs.

If a physician believes a member might benefit from MSSP services, he or she should refer the member to L.A. Care's MLTSS Department. MLTSS is able to assist members with MSSP by identifying members eligible for MSSP services, referring eligible members to the appropriate MSSP site for assessment, and coordinating MSSP benefits with other health plan benefits.

17.6 Care Plan Options (CPO)

What is CPO?

Care Plan Options are additional services that L.A. Care may arrange to help Cal MediConnect members stay living in their home safely. This may include a wide range of services that are outside of the normal scope of previously mentioned MLTSS services, such as respite care/provider support, supplemental IHSS-like services, home modification/maintenance, and nutritional services.

Accessing CPO Services

If a physician believes a member might benefit from CPO services, the physician should refer the member to L.A. Care's MLTSS Department. Members who wish to access CPO services may also contact the MLTSS Department directly.