EXECUTIVE COMMITTEE MEETING

BOARD OF GOVERNORS

April 26, 2023 • 2:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017

AGENDA
Executive Committee Meeting
Board of Governors

DRAFT

Wednesday, April 26, 2023, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, Conference Room 1025, Los Angeles

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=md179c06270a179d8cfd9eea701d51a31

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2499 839 0890 Password: lacare

Teleconference Site
Hilda Perez
L.A. Care Health Plan Community Resource Center
3200 E Imperial Hwy
Lynwood, CA 90262

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Attendees who log on to lacare.webex using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into WebEx to use the "chat" feature. The log in information is at the top of the meeting Agenda. The chat function will be available during the meeting so public comments can be made live and direct.

1. The "chat" will be available during the public comment periods before each item.
2. To use the "chat" during public comment periods, look at the bottom right of your screen for the icon that has the word, "chat" on it.
3. Click on the chat icon. It will open two small windows.
4. Select "Everyone" in the "To:" window,
5. The chat message must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.
6. Type your public comment in the box that says "Enter chat message here".
7. When you hit the enter key, your message is sent and everyone can see it.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

You can also send your public comments by voicemail, email or text. If we receive your comments by 2:00 P.M. on April 26, 2023, it will be provided to the members of the Executive Committee in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

Once the meeting has started, public comment submitted in writing must be received before the agenda item is called by the Chair. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section prior to the board going to closed session.

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The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Executive Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome — Al Ballesteros, MBA, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve March 22, 2023 meeting minutes p.5 — *Chair*
4. Chairperson's Report — *Chair*
5. Chief Executive Officer — John Baackes, *Chief Executive Officer*
   - Department of Managed Health Care Enforcement Matter Report p.12

Committee Issues

6. Government Affairs Update — John Baackes
7. Annual Disclosure of Broker Fees p.14 — Terry Brown, *Chief Human Resources Officer*
8. Ratify execution of Amendment to L.A. Care's Medi-Cal Contract No. 04-36069 with the Department of Health Care Services **(EXE 100)** p.18 — Augustavia J. Haydel, Esq., *General Counsel*
9. Delegation of authority to negotiate and execute the delegation amendments to the Plan Partner Services Agreements with Kaiser Foundation Health Plan, Inc., and Blue Cross of California and Ratification of the execution of the delegation amendment to the Plan Partner Services Agreement with Blue Shield of California Promise Health Plan **(EXE 101)** p.65 — Augustavia J. Haydel, Esq.
10. Authorization to establish a Provider Relations Advisory Committee **(EXE 102)** p.393 — John Baackes, Augustavia J. Haydel, Esq.
11. Approve the list of items that will be considered on a Consent Agenda for May 4, 2023 Board of Governors Meeting. — *Chair*
    - April 6, 2023 Board of Governors Meeting Minutes
    - Ratify execution of Amendment to L.A. Care's Medi-Cal Contract No. 04-36069 with the Department of Health Care Services
    - Delegation of authority to negotiate and execute the delegation amendments to the Plan Partner Services Agreements with Kaiser Foundation Health Plan, Inc., and Blue Cross of California and Ratification of the execution of the delegation amendment to the Plan Partner Services Agreement with Blue Shield of California Promise Health Plan
    - Quarterly Investment Report

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- Health Dialog Contract Amendment
- Health Integrated Association Contract Amendment
- O'Neil Digital Solutions, LLC Contract Amendment

12. Public Comment on Closed Session Items *(Please read instructions above.)* *Chair*

ADJOURN TO CLOSED SESSION (Est. time: 60 mins.) *Chair*

13. CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
- Plan Partner Rates
- Provider Rates
- DHCS Rates
- Plan Partner Services Agreements

14. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Technology, Business Plan
Estimated date of public disclosure: *April 2025*

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable)

16. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases

17. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
- Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

The next Executive Committee meeting is scheduled on Wednesday, May 24, 2023 at 2:00 p.m.
and may be conducted as a teleconference meeting.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE EXECUTIVE COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH TUESDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings **and by email request to** BoardServices@lacare.org

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings **and can be requested by email to** BoardServices@lacare.org.

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats - i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – March 22, 2023
1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

Members
Al Ballesteros, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson**
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary**
Hilda Perez**

** Absent*
*** Via Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, *General Counsel*
Linda Greenfeld, *Chief Products Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Thomas Mapp, *Chief Compliance Officer*
Marie Montgomery, *Chief Financial Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Deputy Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, *Chairperson,* called to order the regular and special supplemental meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meeting at 2:02 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	He provided information on how to submit a comment in-person, or using the "chat" feature.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Perez)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the February 22, 2023 meeting were approved as submitted.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Perez)**
CHAIRPERSON'S REPORT	Al Ballesteros, *Chairperson* commented on the recent announcement that former Los Angeles County Supervisor Gloria Molina has terminal cancer. She is a former member of the L.A. Care Board of Governors and served from 2011 to 2014. Mr. Ballesteros knows her from 1993 when she appointed him as a Commissioner on the Los Angeles County Commission on HIV. Ms. Molina is such an icon in the community and has done so much for Los Angeles. He remembers her for her support of the work on HIV in the early 1990s, when no politicians on the East Side of Los Angeles were standing up for people at risk of HIV or living with HIV. Ms. Molina helped with resources that were needed to educate a community that was hard to reach. Chairperson Ballesteros will always be thankful to her for that work and beyond that. Ms. Molina worked to support community health centers and programs to support the uninsured in Los Angeles County. Ms. Molina was steadfast in her support for people that had no insurance and needed health care. She fought for a new county hospital, organized many meetings and hearings on the size of the hospital and was steadfast in achieving what she thought was needed for Los Angeles. She worked for homeless individuals and foster care youth, and the list goes on with things this Supervisor did for Los Angeles County. Chairperson Ballesteros has so much respect for what she has done. She will always be in his thoughts as one of the greatest politicians that has worked in Los Angeles County. John Baackes, *Chief Executive Officer,* noted that it is remarkable that Ms. Molina and Yvonne Burke were the first women elected to the Los Angeles County Board of	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Supervisors, and now all five Supervisors are women. She paved the way that has been a good reflection of the diversity in Los Angeles County.	
CHIEF EXECUTIVE OFFICER REPORT	Mr. Baackes reported that L.A. Care is in solid financial shape for 2023 with a more robust reimbursement compared to prior years. The reserves are intact. There was 1.5% in revenue that was taken by the California Department of Health Care Services at the beginning the pandemic over an 18-month period, because it was believed there would be a recession. The recession never materialized, but those funds were not returned to L.A. Care. In that year, L.A. Care incurred a loss of $138 million. The following year L.A. Care bounced back with a slightly more than 1.5% operating margin, and last year experienced a thin operating margin. Over the three years, L.A. Care took in over $25 billion in revenue and posted a net gain of $33 million. For 2023, the picture is much more robust. There are strong headwinds for 2024 and beyond. California will report in the May Budget Revise a deficit in excess of $33 billion and L.A. Care should be prepared that it will be among those affected by that. In 2024, the Medi-Cal enrollment will be buffeted by the eligibility redetermination for Medi-Cal for which L.A. Care has budgeted a loss of 13% of its members, and by the loss of Kaiser as a Plan Partner due to its direct contract with California for Medi-Cal that will start in 2024. It is not clear how the contract with Kaiser will affect the rates. New members are expected to enroll when undocumented residents ages 26-49 who qualify will be eligible for Medi-Cal in January 2024. L.A. Care has made sound and conservative financial forecasts and is working diligently on mitigation plans to limit the potential loss of members during the redetermination process. The California Safety Net Coalition began in June 2022. L.A. Care invited hospitals, clinics, independent physicians and competitor health plans to address the chronic underfunding of Medi-Cal, compared to Medicare and commercial insurance. The California Safety Net Coalition (CSNC) was formed as a 501(c)(4) corporation to focus on getting an initiative on the November 2024 ballot that will redirect the proceeds from a managed care organization (MCO) tax to supplement Medi-Cal funding. Because of the current budget deficit issue, the Governor is planning to reinstate the MCO tax, with proceeds going to the general fund in California. The MCO tax is levied on Medi-Cal managed care health plans. Before the MCO tax expired last year, L.A. Care was taxed $65 per member, while commercial health plans were taxed at the rate	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	of $1.20 per member. The funds collected were claimed as state-generated revenue and were matched by the federal government. L.A. Care received funding through the Medi-Cal rates and commercial plans did not receive funding. The ballot initiative will propose to voters that the MCO tax will be redirected to supplement Medi-Cal reimbursement. CSNC has hired Jim DeBoo to lead the campaign. Mr. DeBoo was Chief of Staff for Governor Newsom in his first administration. He will be a stellar champion, with contact in the current administration, to gain support for the ballot initiative. Mr. Baackes is a member of the CSNC Steering Committee, which is vitally important to the future of Medi-Cal, and to L.A. Care and its members. He will attend the meetings in person in Sacramento. CSNC work will not be a panacea; it puts a stake in the ground to do something serious about Medi-Cal, which has not had a base rate increase since the 1990s. He will provide additional information at the April 6 Board Meeting. Board Member Booth asked if there are other taxes collected in California that are matched by the federal government. Mr. Baackes does not think there are any others than those used by Medi-Cal. When adopted 58 years ago, the cost of the Medi-Cal program was to be shared between states and the federal government, and started at a simple 50-50 split. Strategies were developed by states over the years to increase the funding stream from the federal government. States began taxing providers to increase the tax funds, and then giving providers a supplemental payment from the federal share. In California, about 2/3rds of the costs of Medi-Cal. States pay 100% of the costs for undocumented Medi-Cal beneficiaries with no matching federal funds. Board Member Booth stated that if the taxes are collected to be matched by the federal government for Medi-Cal, then the funds should be spent on Medi-Cal.	
COMMITTEE ISSUES		
Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs,* reported: • At the last Board meeting, she reported that Assembly Member Kalra introduced AB 1690 for single payer health care. It is a two-year bill to be voted on in 2024. The California Nurses Association sponsors this bill. There is currently no funding stream for this AB 1690. • SB 770 was introduced by Senator Weiner, and is intended to work in conjunction with the Kalra bill. SB 770 specifies a timeline for the state to discuss a single payer	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	program with the federal government by 2024. Government Affairs will continue to monitor both bills. • California's fiscal loss is now projected to be in excess of $30 billion. Last year, the budget included a $130 billion surplus. The Governor will release the May Budget Revise in mid-May. There will clearly be a lot of competition for state funding. • There have been quite a few meetings with legislators on hospital financing issues. AB 412 will create a hospital emergency loan program to be used to prevent hospital closures. The loan program would end in 2029. No hearings have been held yet, and more information will be reported at future meetings. • SB 870 was introduced by Senator Caballero to reinstitute the managed care organization (MCO) tax, which Mr. Baackes described in his CEO report above. The MCO tax expired last year and was not renewed. California legislature and administration are both seeking federal approval to reinstitute the tax. Currently, the bill does not include language about how the tax funds would be used. The preamble statement references the losses experienced by rural hospitals because of the pandemic and inadequate Medicaid funding. This preamble language indicates that the tax proceeds may be used to offset those losses. Mr. Baackes noted that in relation to the California Budget and some of the bills introduced, there is a high level of anxiety in the legislature about hospital finances. A small hospital closed in Madera on New Year's Eve, and it has drawn attention to the status of other hospitals in California. L.A. Care is concerned about hospitals in Los Angeles County, as there are some in financial difficulties. Hospitals that were not in good financial shape prior to the pandemic appear to be in worse shape. There have been spot bills introduced in the legislature to address this, which illustrates that legislators are concerned and will work to save the hospitals in their districts. Chairperson Ballesteros asked about the ballot initiative related to the MCO tax and how it relates to the work of the CSNC. Mr. Baackes responded that the CSNC initiative will be targeted for the ballot in November 2024. Governor Newsom will be reinstating the MCO tax in the May Budget Revise for California, with proceeds from the MCO to be placed in the general fund. CSNC would support the MCO tax for two years if there is support from the administration for the ballot initiative in November 2024. Support from the administration would be of immense value to the CSNC. The use of the tax would be different for the first two years, and after that, it would be a supplement to Medi-Cal rates.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for the April 6, 2023 Board of Governors Meeting. • March 2, 2023 Board of Governors Meeting Minutes • Customer Motivators Contract Amendment • Center for Caregiver Advancement Contract Amendment	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Perez)**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:31 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:32 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *March 2025* CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act USC Keck Hospital, et al. v. L.A. Care (AAA Case No. 01-21-0016-6078) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:33 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:34 pm.	

Respectfully submitted by:

Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

_____
Al Ballesteros, *Chair*
Date: _____

LEGAL SERVICES

April 19, 2023

TO: L.A. Care Board of Governors

FROM: Augustavia Haydel, General Counsel
Nadia Grochowski, Associate Counsel III

SUBJECT: ***DMHC Enforcement Matter Report***

INTRODUCTION:

This report is provided for the Board's information. The Board has delegated authority to the CEO up to $250,000 under L.A. Care's policy LS-010 to settle threatened litigation matters, including DMHC Enforcement Matters, without Board approval. The policy does require the CEO to report the settlement to the Executive Committee and/or to the Board, but it could be either before or after the settlement. The settlement amounts listed below are within the CEO's delegated authority.

DMHC Enforcement Matter 21-434 (received 1/25/23)

- Allegation: Plan's delegate failed to properly process claims for service, and the Plan failed to timely resolve the enrollee's grievance.
- Violations: The Plan, through its capitated provider, improperly processed claims for service in connection with the enrollee's care. (Cal. Code Regs., tit. 28, § 1300.71, subd. (d)(1).) The Plan failed to timely resolve the enrollee's grievance. (Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(3).)
- Settlement Offer: $19,500 (Corrective Action Plan required); Letter of Agreement has been fully executed.

DMHC Enforcement Matter 19-1185 (received 1/30/23)

- Allegation: On November 8, 2019, the Plan notified the Department that the Plan had identified an error related to provider remittance advice (RA) issued to non-contracting providers. Specifically, some RAs issued between January 1, 2019, and September 30, 2019, erroneously assigned member liability to claim amounts for which the enrollees were not responsible.
- Violations: DMHC found that the Plan improperly processed non-contracted provider claims in violation of California Code of Regulations, title 28, section 1300.71, subdivision (d)(1). A health care service plan or its capitated provider shall not improperly deny, adjust or contest a claim. (Health & Saf. Code, § 1300.71, subd. (d)(1).)
- Settlement Offer: $125,000 (Corrective Action Plan required); Letter of Agreement has been partially executed.

DATE: March 29, 2023

TO: Executive Committee

FROM: Terry Brown, *Chief Human Resources Officer*

SUBJECT: AB 2589 – Annual Disclosure of Broker Fees

To comply with the requirements of AB 2589 in reporting insurance broker fees associated with the various health and welfare benefits L.A. Care offers to its employees, identified below are the disclosure of the commissions earned by Woodruff Sawyer, our broker of record for the majority of our various health and wellness insurers providing L.A. Care employee benefits for the last two fiscal years (2021-2022 and 2022-2023). Commission is paid to Woodruff Sawyer on a monthly or annual basis, and the amount is based on the number of participants in the benefit program.

Line of Coverage	Carrier	Broker	2021/2022 Base Commission	2022/2023 Base Commission
Medical HMO	Kaiser	Woodruff Sawyer	1.5%	1.5%
Medical HMO and PPO	Blue Shield	Woodruff Sawyer	2%	2%
Dental HMO and PPO	Cigna Dental	Woodruff Sawyer	10% HMO $2.25 pepm	10% HMO $2.25 pepm
Vision	EyeMed	Woodruff Sawyer	$0.86 pepm	$0.86 pepm
EAP	Anthem Blue Cross	Woodruff Sawyer	0%	0%
Life, Long and Short-Term Disability	Unum	Woodruff Sawyer	10%	10%
Voluntary Benefits	Unum	Woodruff Sawyer	Varies by plan 70%-90% 1st year 2.5%-10% years 2+	Varies by plan 70%-90% 1st year 2.5%-10% years 2+
Business Travel Accident	Gerber	Woodruff Sawyer	0%	0%

Line of Coverage	Carrier	Broker	2021/2022 Base Commission	2022/2023 Base Commission
Pet Insurance	Nationwide	Woodruff Sawyer	10% new and 5% renewal	10% new and 5% renewal
Executive Disability	Unum	Woodruff Sawyer	50% 1st year 5% years 2-5 2.5% years 6-10 2% years 11+	50% 1st year 5% years 2-5 2.5% years 6-10 2% years 11+
Executive Term Life (CEO only eff. 2/1/2021)	Banner/Dye & Eskin	Woodruff Sawyer	25% 1st year 4% years 2-5 2% years 6-10 .5% years 11+	25% 1st year 4% years 2-5 2% years 6-10 .5% years 11+
Executive Term Life	Protective/Dye & Eskin (eff. 2/1/2021)	Woodruff Sawyer	For Year 1 Ages 18-59: 40% Ages 60-62: 38 Ages 63-64: 36 Ages 65-69: 34 Ages 70+: 32 Years 2-10: 4% Years 11+: 1%	For Year 1 Ages 18-59: 40% Ages 60-62: 38 Ages 63-64: 36 Ages 65-69: 34 Ages 70+: 32 Years 2-10: 4% Years 11+: 1%
Universal Life (CEO)	John Hancock	Woodruff Sawyer	The rest of the residual target premium held from year 1 (total of 95% of target over 2 years) 1% years 3-10	The rest of the residual target premium held from year 1 (total of 95% of target over 2 years) 1% years 3-10

In addition to insurance placement, additional services provided by Woodruff Sawyer for the commission payment include:

- Woodruff Sawyer core consulting services
- Wellness consulting services & platform
- FSA/COBRA administration
- Assistance with development and updates to employee communications
- Self-funding actuarial reports, including reserve calculations & COBRA rates
- Compliance consulting
- Zywave online & telephonic support for Human Resources
- Employee Call Center

Our external consultant, Pearl Meyer, has reviewed the commission structures and found them to be reasonably positioned in the range of costs paid by similarly sized organizations in the state of California.

Pearl Meyer

CHICAGO
155 North Wacker Drive | Suite 840 | Chicago, IL 60606
Tel: 312.242.3050 **Fax:** 312.242.3059

chicago@pearlmeyer.com
www.pearlmeyer.com

MEMORANDUM

Date: April 5, 2023

To: Terry Brown, Chief Human Resources Officer, L.A. Care

From: Steven T. Sullivan, Managing Director
Mark Mundey, Principal

RE: Reasonableness of L.A. Care Employee Benefit Broker Commissions

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The broker costs (commissions and fees) levels paid by L.A. Care, as a percent of plan premiums for employee health insurance coverage during the 2022/2023 plan year are reasonably positioned below the range of costs paid by similar-sized organizations in the state of California. In general, there is an inverse relationship between organization size (# covered employees) and broker costs as a percent of plan premium. Larger organizations (such as L.A. Care) pay larger premiums, while the actual broker costs remain relatively constant. Broker costs as a percent of premium therefore are typically less for larger employers that than for smaller employers with less insured employees.

Observations

L.A. Care, with as many as 1,900 covered employees enrolled in health insurance plans, paid 2022/2023 plan year broker costs of **1.88%** of plan premiums across its lines of employee health insurance coverage and **2.91%** when including life and disability. 500 California employers with a median (50th percentile) employee count of 1,974 paid a median broker cost (as a percent of premium) of **3.06%**.

Based on the fact that L.A. Care has a smaller employee (enrollee) count for a number of its benefit coverages (Blue Shield with 642 enrollees, Pet Insurance with 157 enrollees), Pearl Meyer also evaluated a larger group of employers with smaller employee counts. 1,326 California employers with a median employee count of 823 paid a median broker cost (as a percent of premium) of **4.10%.**

Generally across the U.S. marketplace, health insurance broker costs are 3% to 4% of plan premiums for fully-insured plans. The California market observations in the current analysis are all based on data reflecting fully-insured plans. Market data reflecting broker costs as a percent

of plan premium for self-funded health insurance plans is not as reliable. Brokers can increase other payments in order to decrease their costs as a percent of premium.

Methodology

Pearl Meyer gathered data for the state of California for all employers that filed Form 5500s in 2020, 2021 and 2022. Plan data reflects all benefit plans with at least 100 participants. The following summarizes our approach to analyzing the data:

1) Eliminated all incomplete records
2) Eliminated all records prior to 2022
3) Eliminated all records for self-funded plans
4) The previous three steps resulted in a database of 5,286 employers
5) Eliminated all records below the 75th percentile based on employee count (reduced the database to the top quartile of employer size), resulting in 1,326 employers
6) Calculated 25th, 50th, 75th percentiles and average broker costs as a percent of plan premium
7) Eliminated all but the 500 largest employers based on employee count
8) Calculated 25th, 50th, 75th percentiles and average broker costs as a percent of plan premium

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: April 26, 2023 **Motion No. EXE 100.0523**

Committee: Executive **Chairperson:** Al Ballesteros, MBA

Issue: Request to ratify execution of one Amendment to L.A. Care's Medi-Cal contract (contract number 04-36069) with the Department of Health Care Services (DHCS).

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: L.A. Care received a revised A42 from DHCS following objections from health plans to various provisions, most of which have been removed in this revised amendment. The updates include:

- Updated references of the "PHM Program Guide" to the "PHM Policy Guide" throughout amendment
- Clarifying language updates made for PHM MIS, LTC, and Transitional Care Services
- Added an APL reference for IHAs
- Removed new MOU language from updates to Attachment 11
- Removed new language for LEA Services requiring MH/SUD coverage and Network Provider/Subcontractor Agreements
- Removed new AIHS language
- Removed new language for a "warm hand-off" to other public benefits programs
- Removed new language of providing Basic PHM resources to providers
- Removed new aid code 4C from "Eligible Beneficiary" aid code chart
- Removed the language in the LTC definition that would have been effective July 1, 2023

DHCS provided the Plan with a limited time to review the amendment; therefore, Staff is asking for approval of the executed amendment.

Member Impact: Member impact is under investigation.

Budget Impact: Business units have reviewed the amendment for any impact on relevant budgets.

Motion: To approve execution by L.A. Care Chief Executive Officer, John Baackes, of one Amendment to Medi-Cal Contract (04-36069).

IV. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEM, is amended to read:

1. Management Information System (MIS) Capability

A. Contractor's Management and Information System (MIS) shall be fully compliant with 42 CFR section 438.242 requirements and have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. All data related to this Contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

7) Financial information as specified in Exhibit A, Attachment 1, Provision 8. Administrative Duties/Responsibilities~~.~~, ~~and~~

8) Member and Member's authorized representative Alternative Format Selection(s) (AFS)**, and**

9) Data Sources specified in DHCS policies and guidance, including All Plan Letters (APLs), the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, and the Population Health Management (PHM) Policy Guide.

D. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors and sub-Subcontractors, Network Providers, other State, federal, and local governmental agencies, and other sources as needed to support Care Coordination and the overall administration of the Medi-Cal program. Contractor must have processes in place for utilizing all data made available to meet the Care Coordination requirements and other administrative functions of this Contract. Data that Contractor's MIS must be able to transmit and consume to the greatest extent possible include, but are not limited to:

1) Encounter Data,

2) Medi-Cal Fee-For-Service (FFS) claims data,

3) Carved-out claims data, including state plan services carved out of the contract and data available from partner organizations, including but not limited to the Local Education

Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services,

4) Dental claims data,

5) Specialty mental health data,

6) Substance use disorder data,

7) Medi-Cal FFS treatment authorization request data

8) California Children's Services (CCS) program data

9) Targeted Case Management (TCM) data;

10) Pharmacy claims data;

11) Risk Tier assignment data;

12) Authorization and referral data; and

13) Electronic Health Record or Health Record information, including case notes.

V. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. ~~Contractor shall review and update their cultural and linguistic services consistent with the population needs assessment (PNA) requirements stipulated below.~~

C. Population Needs Assessment (PNA)

~~Contractor shall conduct a PNA, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA.~~

~~1) Contractor shall conduct an initial PNA within 12 months from the commencement of operations within a Service Area and at least annually thereafter. For Contracts existing at the time this provision becomes effective, the next PNA will be required at a time within five (5) years from the effective date of this provision, to be determined by DHCS.~~

~~2) Contractor shall submit a report to the DHCS that must include:~~

~~a) The objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references contained in the PNA.~~

~~b) The findings and conclusions must include the following information for Medi-Cal plan Members: 1) demographic profile; 2) related health risks, problems and conditions; 3) related knowledge, attitudes and practices including cultural beliefs and practices; 4) perceived health education needs including learning needs, preferred methods of learning and literacy level; and 5) culturally competent community resources.~~

~~3) Contractor shall demonstrate that PNA and summary report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.~~

Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA). Contractor must ensure its Network Providers', Subcontractors', and sub-Subcontractors' cultural and Health Equity linguistic services programs also align with the PNA.

~~D. The results of the PNA shall be considered in the development of any Marketing or promotional materials prepared by Contractor.~~

~~C~~**D**. Cultural Competency Training

~~F~~**E**. Program Implementation and Evaluation

VI. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

3. Initial Health ~~Assessment~~ Appointment (IHA)

~~An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.~~ **Contractor must ensure the provision of an Initial Health Appointment (IHA) in accordance with 22 CCR sections 53851(b)(1), and APL 22-030. An IHA, at a minimum, must include: a history of the Member's physical and mental health; an identification of risks; an assessment of the need for preventive screens, services, and health education; a physical examination; and the diagnosis and plan for treatment of any diseases. An IHA may be waived if the Member's Primary Care Provider determines that the Member's health record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.**

A. Contractor shall cover and ensure the provision of an IHA ~~(complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to~~ **for** each new Member within timelines stipulated in Provision ~~5~~**4, Services for Members under Twenty-One (21) Years of Age,** and Provision ~~6~~**5, Services for Adults,** below.

B. Contractor shall ensure that ~~the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS-approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA~~ **a Member's completed IHA is documented in their Health Record and that appropriate assessments from the IHA are available during subsequent health visits**.

C. ~~Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.~~

~~D.~~ Contractor shall make reasonable attempts to contact a Member ~~and~~ **to** schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement. **Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions.**

~~**4. Health Risk Stratification and Assessment for SPD Beneficiaries**~~

~~Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and APL 17-013.~~

~~5~~4. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the EPSDT benefit described in 42 USC Section 1396d(r), and W&I Code section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract.

A. Provision of IHAs for Members under Age 21

3) The initial IHA assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for **their** age, ~~and an age appropriate IHEBA. See PL 13-001 for specific IHEBA requirements~~ **an Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings**.

B. Children's Preventive Services

2) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral ~~from the local Child Health and Disability Prevention (CHDP) program~~, an appointment shall be made for the Member to be examined within two (2) weeks of the request.

H. Local Education Agency Services

Contractor must reimburse Local Education Agencies, as appropriate, for the provision of school-linked EPSDT services, including but not limited to BHT as specified in Paragraph E, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services, of this Provision.

~~6~~5. Services for Adults

A. IHAs for Adults (Age 21 and older)

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

2) Contractor shall ensure that the ~~performance of the initial complete history and physical exam~~ **IHA** for adults includes, but is not limited to~~:~~ **, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations.**

~~a) blood pressure,~~

~~b) height and weight,~~

~~c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,~~

~~d) clinical breast examination for women over 40,~~

~~e) mammogram for women age 50 and over,~~

~~f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,~~

~~g) 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,~~

~~h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,~~

~~i) IHEBA.~~

B. Adult Preventive Services

Contractor shall cover and ensure the ~~delivery~~ **provision** of all preventive services and Medically Necessary diagnostic and treatment services for adult Members~~.~~ **as follows:**

1) Contractor 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, healthy adult Members [age 21 or older]. A~~ **provision of a**ll **applicable** preventive services identified as USPSTF "A" and "B" recommendations ~~must be provided. For tobacco use prevention and cessation services, Contractor may use either the USPSTF recommendations or the latest edition of the US Public Health Service "Treating Tobacco Use and Dependence: A Clinical Practice Guideline." 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 be offered in the frequency required by~~ **in accordance with** the USPSTF Guide to Clinical Preventive Services.

~~7~~6. Pregnant Women

~~8~~7. Services for All Members

A. Health Education

6) Contractor shall maintain a health education system that provides educational interventions addressing ~~the following~~ health categories and topics: **that align with Contractor's Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment 23, Provision 2, Population Health Management Strategy (PHMS) and Population Needs Assessment (PNA), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.**

~~a) Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.~~

~~b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.~~

~~c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.~~

~~10) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA; and that all existing Members complete the IHEBA at their next non-acute care visit. Contractor shall ensure: 1) that Primary Care Providers use the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the IHEBA; and 2) that the IHEBA tool is: a) administered and reviewed by the Primary Care Provider during an office visit, b) reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit, and c) re-administered by the Primary Care Provider at the appropriate age-intervals.~~

~~11) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 22.~~

~~12~~**10**) Contractor shall develop a referral policy to ensure the Member is seen by a dental Provider following an initial dental health screening. The Member shall be referred to a dental Provider to address any immediate dental needs and for comprehensive dental care which will include a comprehensive oral exam.

~~B. The Health Information Form (HIF)/Member Evaluation Tool (MET)~~

~~Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR section 438.208(b), Contractor shall, at a minimum, comply with the following:~~

~~1) Mail a DHCS-approved HIF/MET to all new Members as a part of Contractor's welcome packet and include a postage paid envelope for response.~~

~~2) Within 90 days of each new Member's effective date of enrollment:~~

~~a) Make at least two (2) telephone call attempts to remind new Members to return the HIF/MET and/or collect the HIF/MET information from new Members. This outreach can be done through head of household for Members under the care of parents, custodial parents, legal guardians, or other authorized representatives in accordance with applicable privacy laws.~~

~~b) Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this~~

~~requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and External Coordination of Care.~~

~~3) Upon a Member's disenrollment, Contractor shall make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.~~

~~C~~**B**. Hospice Care

~~D~~**C**. Vision Care – Lenses

~~E~~**D**. Behavioral Health Services

2) Contractor ~~shall~~ **must** cover and pay for all Medically Necessary Mental Health Covered Services for the Member, including the following services:

i) Dyadic Care Services and the Family Therapy Benefit for Members ages 0-20 years and/or their caregivers in an outpatient setting.

~~F~~**E**. Pharmaceutical Services

~~G~~**F**. Transportation

~~H~~**G**. Practice Guidelines

~~I~~**H**. Organ and Bone Marrow Transplant Surgeries

I. Asthma Prevention Services

J. Community Health Workers Services

K. CHW Provider Capacity

L. Identifying Members for CHW

M. Long-Term Care Services

Contractor must authorize and cover LTC. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the

Member's medical needs, unless the Member has elected hospice care.

1) LTC services are covered under this Contract. Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility or Intermediate Care Facility for the Developmentally Disabled are not LTC services consistent with 22 CCR section 51544(h).

3) Contractor must place Members in LTC facilities that are licensed and certified by the CDPH. Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

4) Contractor must provide continuity of care, as set forth in APL 18-008, to Members through continued placement in the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Provider Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

5) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by this Contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including by offering to contract with facilities within and outside of the Service Area.

N. Care Management and Care Coordination

1) **Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment 23, Provision 8, Basic Population Health Management.**

2) **Contractor must provide care management services to all Members as specified in Exhibit A, Attachment 23, Provision 8, Basic Population Health Management, and Exhibit A, Attachment 23, Provision 7, Care Management Programs. Care management services include, Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).**

VII. Exhibit A, Attachment 11, CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE, is amended to read:

1. Targeted Case Management Services

~~Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.~~

~~If a Member is receiving TCM services as specified in Title 22 CCR Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM Provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM Provider that are Covered Services under the Contract.~~

~~If Members under age 21 are not accepted for TCM services, Contractor shall ensure the Members' access to services are comparable to EPSDT TCM services per Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age.~~

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that a Member is receiving TCM services and Contractor is not already aware, Contractor must reach out to Local Government Agencies (LGAs) to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the

LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services.

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members under 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment 10, Provision 5, Services for Members under Twenty-One (21) Years of Age. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment 10, Provision 5, Paragraph F.

4. ~~Specialty~~ Mental Health Services

Contractor must use DHCS-approved screening tools as identified in DHCS guidance to ensure Members seeking mental health services, and who are not currently receiving Non-specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS), receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the county mental health plan network, in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and specified in Exhibit A, Attachment 20, Provision 6, No Wrong Door for Mental Health Services.

A. Non-Specialty Mental Health Services

Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies, including under the following circumstances:

1) When NSMHS are provided in the following instances;

a) During the assessment process;

b) Prior to determination of a diagnosis; or

c) Prior to determination of whether NSMHS criteria set forth in W&I Code section 14184.402(b)(2) are met.

2) When NSMHS were not included in a Member's individual treatment plan;

3) When a Member has a co-occurring mental health condition and substance use disorder; or

4) When NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the county mental health plan.

~~A~~**B**. Specialty Mental Health Services

1) ~~All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.~~ **Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.**

2) ~~Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:~~ **If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools as specified by DHCS, and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.**

~~a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the county mental health plan, as defined in PL 00-001 Revised and APL 13-021, the Member shall be referred to the county mental health plan in accordance with the Memorandum of Understanding (MOU) between Contractor and the county mental health plan and APL 13-018.~~

~~b) For those Members whose mental health diagnosis is not covered by the county mental health plan because the adult~~

~~Member's level of impairment is mild to moderate, or the recommended treatment for adult and child Members do not meet the criteria for Specialty Mental Health Services, the Member shall be referred to an appropriate Medi-Cal mental health Provider within Contractor's Provider Network. Contractor shall consult with the county mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services.~~

C. Mental Health Services Disputes

~~3~~**1)** Disputes between Contractor and the county mental health plan regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. **Disputes between the Contractor and MHP shall not delay the provision of Medically Necessary services by the Contractor or MHP.**

2) If Contractor and the county mental health plan cannot agree **on the appropriate place of care**, **then** disputes shall be resolved pursuant to **APL 21-013 and** ~~Title~~ 9~~,~~ CCR~~,~~ ~~S~~**s**ection 1850.505. ~~Any decision rendered by DHCS regarding a dispute between Contractor and the county mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.~~ **Specifically, as set forth in APL 21-013, Contractor and county mental health plans must complete the plan-level dispute resolution process within 15 Working Days of identifying the dispute.**

3) Contractor and the county mental health plan may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or the county mental health plan determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and the county mental health plan will have one (1) Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and the county mental health plan.

~~B~~**D**. County Mental Health Plan Coordination

Contractor shall execute a Memorandum of Understanding (MOU) with the county mental health plan as stipulated in Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination for the coordination of Specialty Mental Health Services to Members**, to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner**.

5. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program.

A. Contractor shall identify ~~individuals~~ **Members** requiring alcohol and or substance use disorder treatment services and refer the ~~individuals~~ **Members** to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin **and other opioid** detoxification Providers available through the Medi-Cal FFS program, ~~for~~ **as** appropriate ~~services~~. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within Contractor's Service Area, Contractor shall ~~pursue placement~~ **coordinate with the county department responsible for substance use disorder treatment to refer Members to available treatment** outside the **Service** ~~a~~**A**rea. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between ~~the its~~ Network Providers and the treatment programs.

B. Contractor shall execute a MOU with ~~the~~ **each** county department **responsible** for alcohol and substance use disorder treatment services.

C. Prescribing and medication management of buprenorphine and other prescribed medications for substance use disorder treatment, also known as medication- assisted treatment or MAT, are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals or other contracted medical Facilities.

7. California Children's Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS-eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor ~~shall develop and implement~~ **must maintain** written policies and procedures for identifying and referring ~~children~~ **Members** with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which:

2) ~~Assure that~~ **Instruct** Network Providers ~~understand~~ that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network; and only from the date of referral;

3) ~~Enable~~ **Ensure that Network Providers complete the** initial referrals of Member~~'~~s with **suspected** CCS-eligible conditions **the same day using modalities accepted by** ~~to be made to~~ the local CCS program ~~by telephone, same-day mail or fax, if available~~. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program~~.~~**;**

4) ~~Ensure that Contractor~~ **Instruct Network Providers of the requirement to** continue~~s to provide~~ **providing** all Medically Necessary Covered Services to the Member until CCS **program** eligibility is confirmed~~.~~**;**

5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by **the** CCS **program** and shall ensure the coordination of services and joint case management between ~~its~~ **the Member's** Primary Care Providers, the CCS ~~specialty~~ Providers, and the local CCS program. Contractor shall continue to provide case management services to ensure all ~~Medically Necessary treatment~~ **Covered Services** authorized through the CCS program ~~is~~ **are provided** timely ~~provided~~ as required in Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age. Without limitation, Contractor shall, as necessary, ~~or~~ **including** upon a Member's request, arrange for all in-home nursing hours authorized by the CCS program that a Member desires to utilize, as required by APL 20-012~~.~~**; and**

6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary

Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for ~~obtaining~~ **providing and reimbursing for the cost of** the service, if it is **determined to be** Medically Necessary~~, and paying for the service if it has been provided~~.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members. **The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.**

C. The CCS program authorizes Medi-Cal payments to Network Providers who currently are members of the CCS panel and to other Network Providers who provided CCS-covered services to the Member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling. Contractor shall inform Network Providers, except as noted above, that CCS reimburses only CCS paneled Network Providers. Contractor shall submit information to the CCS program on all Providers who have provided services to a Member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Network Provider~~, via telephone, fax, or~~ mail. In an emergency admission, Contractor or Network Provider shall be allowed until the next Working Day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

D. Contractor must maintain policies and procedures for identifying CCS-eligible Members who are aging out of the CCS program. Within 12 months of when a CCS Member will age out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) Identifying the Member's CCS-Eligible Condition;

2) Planning for the needs of the Member to transition from the CCS Program;

3) A communication plan with the Member in advance of the transition,

4) **Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS qualifying condition(s); and**

5) **Continued assessment of the Member through first 12 months of the transition.**

8. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities **(DD)**.

C. Contractor shall refer Members with ~~developmental disabilities~~ **DD** to a ~~Regional Center for the developmentally disabled~~ **regional center** for evaluation and for access to those non-medical services provided ~~\Regional Centers~~, such as but not limited to, respite, out-of-home placement, and supportive living. ~~Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services and Medically Necessary Outpatient Mental Health Services, which need to be provided to the Member.~~

E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with ~~developmental disabilities~~ **DD to ensure the non-duplication of services and to coordinate and work with the regional centers in the development of the individual development services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT)**.

10. Local Education Agency Services

A. Local Education Agency (LEA**)** assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22 CCR Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020 are not covered under this Contract. However, Contractor is responsible for providing a PCP and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's PCP cooperates and collaborates in the development of the Individual Education Plan **(IEP)** or the Individual Family Service Plan **(IFSP)**. Contractor shall provide case management and care coordination

to the Member to ensure the provision of all Medically Necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

B. Contractor must implement interventions that increase access to preventive, early intervention, and behavioral health services by school- affiliated behavioral health Providers for children in publicly funded childcare and preschool, and TK-12 children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I Code section 5961.3(b).

12. Dental

A. Contractor shall cover and ensure that dental screenings/oral health assessments for all Members are included as a part of the IHA. ~~For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening/oral health assessment shall be performed as part of every periodic assessment by a medical Provider or coordinated with a dental Provider, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.~~ Contractor shall ensure that **all** Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, **and** dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract.

B. For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening or oral health assessment is performed as part of every periodic assessment by a medical Provider or coordinated with a dental Provider, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.

C. Contractor shall ensure the provision of ~~covered medical services related to~~ **Medically Necessary** dental**-related Covered** ~~s~~**S**ervices that are not **exclusively** provided by dentists or dental anesthetists. **Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring Members to other Covered Services. Other** Covered ~~medical s~~**S**ervices include**, but are not limited to**: laboratory services; and, 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 fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of

dental procedures.

D. If ~~the~~ Contractor requires Prior Authorization for ~~these~~ **dental procedures**, Contractor shall develop and publish the **policies and** procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. Contractor shall ~~submit such procedures to~~ **coordinate with the DHCS Dental Services Division in the development of their policies and procedures for Prior Authorization of dental services, and must submit them to** DHCS for review and approval.

13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

~~A. DOT is offered by LHDs and is not covered under this Contract.~~
Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups of individuals are at risk for non-compliance for the treatment of TB:

1) Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Members with mental health conditions or substance use disorders;

4) Elderly, children**,** and adolescents~~-~~ **Members;**

5) Members with unmet housing needs;

6) Members with language and/or cultural barriers; and,

7) ~~individuals~~ **Members** who have demonstrated noncompliance (those who failed to keep office appointments).

B. Contractor shall refer Members with active TB and who have ~~any of these~~ **treatment resistance or non-compliance issue** risks to the TB Control Officer of the LHD for DOT. ~~Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.~~ If~~, in the opinion of Network~~ **a** Provider~~,~~ **finds that** a Member ~~with one (1) or more of these risk factors~~ is at risk for **treatment resistance or**

noncompliance, **Contractor must refer** the Member ~~shall be referred~~ to the LHD for DOT.

~~Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.~~

~~B~~**C**. Contractor shall execute a MOU with the LHD as stipulated in Exhibit A, Attachment 12, Provision 2, ~~for the provision of~~ **to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on** DOT.

14. Women, Infants, and Children (WIC) Supplemental Nutrition Program

B. Contractor, as part of its IHA of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c) **and PL 98-010**.

~~B~~**C**. Contractor shall execute a MOU with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program.

18. In-Home Support Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county In-Home Support Services (IHSS) program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

D. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per

the population RSS and Risk Tiering requirements in this Section; and

E. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

VIII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

10. Scope of Services

L. Submit policies and procedures for the provision of:

6) Long-Term Care

IX. Exhibit A, New Attachment 23, POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE, adds the following language:

Exhibit A, Attachment 23
POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

1. Population Health Management (PHM) Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, and care management. Contractor must assess each Member's needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care, and standardized assessment processes. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance.

B. Contractor must ensure its PHM program meets all National Committee for Quality Assurance (NCQA) PHM standards, as well as applicable federal and State requirements. Contractor must conduct a Population Needs Assessment (PNA) as described in Provision 2 of this Attachment, and submit to DHCS for approval a Population Health Management Strategy (PHMS) that details all components of

its PHM program activities in accordance with the requirements of this Attachment and the DHCS Comprehensive Quality Strategy.

C. Contractor must engage Local Health Departments (LHDs), Local Education Agencies (LEAs), Local Government Agencies (LGAs), and other stakeholders identified in Provision 2 of this Attachment to develop its PNA.

2. Population Health Management Strategy (PHMS) and Population Needs Assessment (PNA)

In accordance with 42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2), 22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), and applicable DHCS guidance, Contractor must conduct a PNA every three (3) years. The first submission under this new structure will be due to DHCS in Calendar Year 2025. Contractor must use the PNA to identify population-level health and social needs, including health disparities, and to provide and maintain culturally competent and linguistically appropriate services and translations. Contractor must implement health equity, health education, and continuous Quality Improvement (QI) programs and services, and determine relevant

subpopulations for targeted, person-centered interventions. Contractor must develop the PNA in accordance with the following requirements:

A. Contractor's PNA must evaluate, at a minimum, the following factors for its entire Member population:

1) General characteristics and health needs;

2) Health status, behaviors and utilization trends, including use of Emergency Services;

3) Health education, and cultural and linguistic needs;

4) Health disparities;

5) Social drivers of health (SDOH); and

6) Any gaps in services and resources even if they are not Covered Services under this Contract.

B. Contractor's PNA must consider all relevant data for its entire Member population, including, but not limited to:

1) Data from Subcontractors and sub-Subcontractors; and

2) Needs assessments conducted by other entities and community-based organizations within Contractor's Service Area.

C. Contractor must use reliable data sources, including Subcontractor and sub-Subcontractor level data, to conduct and update the PNA at least annually every three (3) years. Reliable data sources must include the most recent results from the Member satisfaction survey and DHCS Health Disparities data.

D. In order to assess Member needs in Contractor's Service Area, Contractor must conduct broad community engagement as specified in DHCS policies and guidance, including the PHM Policy Guide, and engage representatives of LHDs, LEAs, LGAs, Safety Net Providers, community based organizations, county mental health plans, Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC- ODS) plans, community mental health programs, PCPs, social service providers, regional centers, California Department of Corrections and Rehabilitation, county jails and juvenile facilities, Child Welfare Agencies as well as stakeholders from special needs groups,

including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.

E. Contractor must produce its PNA in writing, make it available to the public, and post it on its website.

F. Contract must submit an annual PHM Strategy that is aligned with NCQA requirements and DHCS policies and guidance, including the PHM Policy Guide, and includes the following:

1) All components of the PHM Strategy and approach

2) Strategies and initiatives that address the Comprehensive Quality Strategy's Clinical Focus Areas and achieve the Bold Goals, in addition to specific health disparities and conditions identified in the PNA.

3. Data Integration and Exchange

In accordance with the CMS Interoperability and Patient Access final rule (CMS- 9115-F) and applicable federal and state data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment 3, Management Information Systems, as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and

Human Services Data Exchange Framework in accordance with Health & Safety Code section 130290.

4. PHM Service

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS, as follows:

A. Contractor must use the PHM Service, when applicable functionality is fully defined and deemed available by DHCS, at a minimum, to:

1) Perform Risk Stratification and Segmentation (RSS) activities using PHM Service's RSS methodologies, including identifying and assessing Member-level risks and needs through use of the PHM Service's Risk Tiering functionalities, which places Members into standardized tiers.

2) Inform and enable Member screening and assessment activities, including using pre-populating screening and assessment tools; and

3) Support Contractor's Basic PHM program, including wellness and prevention, Member engagement and health education activities.

5. Population Risk Stratification/Segmentation (RSS) and Risk Tiering

A. Contractor must meet all of the requirements for RSS listed in this Provision. Contractor must use the PHM Service, in a manner specified by DHCS, or their own RSS approach, to meet the requirements contained in this Provision, including:

1) Considering findings from the PNA and all Members' behavioral, developmental, physical, and oral health, Long-Term Services and Supports (LTSS) needs as well as health

risks, rising-risks, and health-related social needs due to SDOH;

2) Complying with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a significant change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submitting its processes to DHCS upon request regarding how it identifies significant changes in Members' health status or level of care and how it is monitoring appropriate re-stratification.

5) Use integrated data that includes data sources, specified in DHCS policies and guidance, including the PHM Policy Guide.

6) Avoid and reduce biases in its RSS approach by using evidence-based methods to prevent further exacerbation of Health Disparities. Only using utilization data would not meet standards to reduce bias.

B. Contractor must use RSS and PHM Service Risk Tiers, when available, to:

1) Connect all Members, including those with rising risk, to an appropriate Contractor-identified level of service within parameters outlined in Paragraph B.3) of this Provision, including but not limited to, care management programs, Basic PHM, and Transitional Care Services;

2) Monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of Members who require additional assessments who complete

them as well as the connection of Members to the programs and services they are eligible for.

3) In line with NCQA PHM requirements, prior to PHM Service being deemed by DHCS to be operational, assess specific Members identified as High or Medium-Rising risk as outlined in DHCS guidance, including the PHM Policy Guide, to determine care management needs.

C. Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS, and includes the following element, at a minimum:

1) Description of its RSS and Risk Tiering approach;

2) Description of how RSS and Risk Tiers are used to connect Members to appropriate services;

3) The number of Members in each Risk Tier and the programs or services for which they are eligible;

4) The penetration rate of PHM programs or services by Risk Tier:

a) The number of Members, by Risk Tier, who needed further assessment and received it;

b) The number of Members, by Risk Tier who were enrolled in programs they were eligible for; and

5) Method(s) for discovering and reducing bias within the RSS and Risk Tiering approach.

6. Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening of each Member's needs within 90 days of Enrollment and share that information with DHCS and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three (3) attempts to contact a Member to conduct the initial screening using available modalities.

B. Contractor must conduct necessary screenings to gain timely information on the health and social needs of all Members, in

accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including the PHM Policy Guide, which will include guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required screenings and assessments are completed per the specifications above.

7. Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Provision are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Provision 8 of this Attachment. Members receiving care management must have an assigned Care Manager and a Care Management Plan (CMP).

A. Enhanced Care Management (ECM) and Complex Care Management (CCM)

1) ECM is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and consistently apply comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described further in Exhibit A, Attachment 22.

2) Complex Care Management, which equates to Complex Case Management as defined by NCQA and in this Contract, is an approach to comprehensive care management that meets differing needs of high and rising-risk Members through both ongoing chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help

Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner.

3) Contractor must consider CCM to be an opt-out program, i.e. all eligible Members have the right to participate or to decline to participate.

4) Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

B. Care Management Programs

Contractor must operate and administer ECM as described in Exhibit A, Attachment 22, and CCM as stated in this Paragraph.

1) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium-rising risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with the most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

a) Must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

b) Must include comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a CMP with performance goals, monitoring and follow-up;

c) Must have an opt-out approach wherein Members meeting the criteria for CCM have the right to decline to participate;

d) Must include a variety of interventions for Members that meet the differing needs of high and medium-rising risk populations, including longer-term chronic care

coordination and interventions for episodic, temporary needs; and

e) Must incorporate disease-specific management programs, including but not limited to asthma and diabetes, that include self-management support and health education.

2) Contractor must assess Members for the need for Community Supports as part of its CCM program and provide Community Supports, if available and medically appropriate and cost effective.

C. CCM Care Manager Role

1) Assignment of Care Manager

a) Contractor must identify and assign a Care Manager for every Member receiving CCM. PCPs may be assigned as Care Managers when they are able to meet all the requirements specified in this Paragraph C.

b) When a Care Manager other than the Member's PCP is assigned, Contractor must provide to the Member's PCP with the identity of the Member's assigned Care Manager and a copy of the Member's CMP.

c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

i. Identify a lead Care Manager and communicate that lead to all treating Providers and the Member; and

ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services, and the delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.

2) Care Manager Responsibilities

a) Contractor is responsible for ensuring Care Managers comply with all of the Basic PHM requirements in

Provision 8 of this Attachment, and all NCQA CCM standards.

b) Contractor must ensure that the Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, substance use disorder, developmental, oral health, dementia, palliative care, chronic disease and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating and training the Member's parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they

are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, substance use disorder, developmental, physical, oral health, dementia, and palliative care needs, as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and behavioral health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Refer to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports, and local community organizations;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the

Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

8. Basic Population Health Management (PHM)

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that, at a minimum, meet the following Basic PHM requirements:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with the Contractor;

4) Ensure that each Member receives all needed preventive services in partnership with the Member's PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from Out-of-Network Providers;

6) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from

differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

7) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

8) Ensure all services are delivered in a culturally and linguistically competent manner in alignment with NCLAS standards that promotes health equity for all Members;

9) Coordinate health and social services between settings of care, across other Medi-Cal Managed Care Health Plans, delivery systems, and programs such asTargeted Case Management and SMHS, with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

10) Assist Members, Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and sub-Subcontractor Networks, to access Covered Services as well as services not covered under this Contract.

11) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

12) Communicate to Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

13) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical

Records in accordance with professional standards and state and federal law;

14) Facilitate exchange of necessary Member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable;

15) Maintain processes to ensure no duplication of services occurs; and

16) Provide evidence-based disease management programs in line with NCQA requirements and DHCS Comprehensive Quality Strategy (CQS) Bold Goals, including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target members for engagement, and seek to close care gaps for Members participating in these programs.

B. Wellness and Prevention Programs

Contractor must provide comprehensive wellness and prevention programs to all Members and in accordance with DHCS guidance.

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

C. Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

1) Identification of specific, proactive wellness initiatives and programs that address Member needs as identified in the PNA;

2) Initiatives, programs and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of

age, as described in Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age;

3) Initiatives, programs and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

4) Initiatives, programs and evidence-based approaches on ensuring adults have access to preventive care, as described in Exhibit A, Attachment 10, Provision 5, Services for Adults, and in compliance with all applicable State and federal laws;

5) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment 4, Provision 10, Site Review;

6) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment 10, Provision 7, Services for All Members, and in alignment with NCLAs standards; and

7) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

8) Special preventive services as required by EPSDT, in accordance with Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age.

D. Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

E. Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA

is used to design and implement evidence-based wellness and prevention strategies.

9. Other Population Health Requirements for Children

For Members who are less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for children:

A. EPSDT Case Management Responsibilities

1) Contractor must provide case management to assist Members under 21 years of age in gaining access to all Medically Necessary medical, behavioral health, dental, social, educational serves, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and W & I Code section 14059.5(b). Case management services for Members under 21 years of age also includes the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services.

2) Contractor must also provide EPSDT case management services as Medically Necessary for Members less than 21 years of age, as required in Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age, and must ensure that all Medically Necessary services for Members under 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children with Special Health Care Needs (CSHCN)

Contractor must develop and implement policies and procedures to provide services for CSHCN. CSHCN are defined as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond what is generally required by children. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation Providers, and DME and supplies. These may

include assignment to a Specialist as a PCP, Standing Referrals, or other methods;

2) Methods for monitoring and improving the quality, health equity and appropriateness of care for CSHCN; and

3) Methods for ensuring Care Coordination with California Department of Developmental Services (DDS) and local CCS Programs, as appropriate.

C. Early Intervention Services

1) Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program, and refer them to the local Early Start program. These Members include those with a condition known to lead to a developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local regional center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for such Members.

2) Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

10. Transitional Care Services

A. Contractor must provide Transitional Care Services to Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, and DHCS guidance, including the phased implementation timeline outlined in the PHM Policy Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and SNFs to home or community-based settings, Community Supports, post-acute care facilities, or LTC settings.

B. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned Care Manager provides all Transitional Care Services. If the Member is not receiving CCM or ECM, the Contractor must assign a care manager who is required to ensure all transitional

care services are complete, including making appropriate referrals and ensuring no gaps in care.

C. Contractor must implement transitional care processes that meet the following requirements, at minimum:

1) Implement a standardized discharge risk assessment that is to be completed prior to discharge, to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or substance use disorder relapse;

2) Obtain permission from Members, Members' parents, legal guardians, or authorized representatives, as appropriate, to share information with Providers to facilitate transitions, in accordance with federal and state privacy laws and regulations;

3) Ensure that medication reconciliation is conducted pre- and post-transition;

4) Refer to Community Supports and coordination with county social service agencies and waiver agencies for IHSS and other HCBS;

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five (5) Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, Health and Safety Code section 1367.01, and Exhibit A, Attachment 5, Provision 1, Utilization Management Program;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services exist

between Contractor and each of its Network Provider and Out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs; and

10) Ensure Members with substance use disorder and mental health needs receive treatment for those conditions upon discharge.

D. Contractor must provide a Discharge Planning document to Members, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor's Discharge Planning document must include the following information, at a minimum:

1) Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;

2) Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3) The hospital, institution or facility to which the Member was admitted;

4) Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;

5) Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized

representatives in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record;

6) Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

7) The name and contact information of the assigned care manager responsible for transitional care services.

E. Nursing Facility Transitions

When transitioning Members to and from SNFs, Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

1) Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and transitional care services during all transitions;

2) Assist Members being discharged or Members' parents, legal guardians, or authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS;

3) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

4) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

5) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

6) Follow-up with Members, Members' parents, legal guardians, or authorized representatives, as appropriate, regarding the

new care setting to ensure compliance with transitional care services requirements.

X. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

16. Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative established in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the ~~DHCS website~~ **DHCS website at www.dhcs.ca.gov**.

C. Contractor must comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the ~~DHCS website~~ **DHCS website at www.dhcs.ca.gov**.

D. To participate in Member direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) by the U.S. Department of Health and Human Services Division of Cost Allocation Services, with CMS concurrence, Contractor must comply with the terms of those programs as set forth in the PACAP in a form and manner specified by DHCS through APLs or other technical guidance. For Rating Periods in which Member direct incentive programs are effective, commencing with the Rating Period starting January 1, 2021, DHCS shall make the terms of each approved Member direct incentive program available on the ~~DHCS website~~ **DHCS website at www.dhcs.ca.gov.**

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at www.dhcs.ca.gov.

XI. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

Dyadic Care Services means a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one (1) of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2C, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7S, 7W, 81, 82, 86, 8E, 8P, 8R, 8U, K1, M3, M7, M9, P5, P7, P9, 5C, 5D, 5V, E6, E7, H1, H2, H3, H4, H5, M5, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76
Adult & Family/Optional Targeted Low- Income Child (Dual)	**0A,** 0E, 2V, 30, 32, 33, 34, 35, 38, 39, **3A, 3C,** 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, **5C, 5D,** 5V, 72, 8U, 7A, 7J, **7S,** 7W, 7X, 82, 8E, 8P, 8R, **E6, E7, H1, H2, H3, H4, H5,** K1, M3, **M5,** M7, M9, P5, P7, P9, R1, **T1, T2, T3, T4, T5**	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 86, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD	10, 14, 16, 1E, 1H 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long Term Care/Full Dual	13, 23, **53,** 63	
Long Term Care/ Non-Full Dual	13, 23, **53,** 63	
SPD /Dual	10, 14, 16, 1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X,	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

Long-Term Care (LTC) means **specialized rehabilitative services and care** provided in a ~~s~~**S**killed ~~n~~**N**ursing ~~f~~**F**acility and subacute care services that lasts longer than ~~60 days~~ **the remainder of the month of admission plus one (1) month**.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services.

XII. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213A_DHCS (Rev. 06/16)

☒ Check here if additional pages are added: 45 Page(s)

Agreement Number	Amendment Number
04-36069	A42
Registration Number:	

1. This Agreement is entered into between the State Agency and Contractor named below:

State Agency's Name (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

Contractor's Name (Also referred to as Contractor)
L.A. Care Health Plan

2. The term of this Agreement is: April 1, 2005 through December 31, 2023

3. The maximum amount of this Agreement after this amendment is: Budget Act Line Items 4260-601-0912 and 4260-601-0555

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. **Amendment effective date:** January 1, 2023, or until approved by DGS (if DGS approval is required).

II. **Purpose of amendment:** This amendment incorporates changes and new requirements for Population Health Management, Dyadic Care Services and the Family Therapy Benefit, Risk Sharing Mechanisms, and adds new aid codes.

III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR		**CALIFORNIA Department of General Services Use Only**
Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)* L.A. Care Health Plan		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing John Baackes, Chief Executive Officer		
Address 1055 West 7th Street, 10th Floor Los Angeles, CA 90017		
STATE OF CALIFORNIA		
Agency Name Department of Health Care Services		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing Michelle Retke, Chief Managed Care Operations Division		☒ Exempt per: W&I Code Section 14087.55(c)
Address 1501 Capitol Avenue, MS 4415, P.O. Box 997413 Sacramento, CA 95899-7413		

L.A. Care HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: April 26, 2023 **Motion No. EXE 101.0523**

Committee: Executive **Chairperson:** Al Ballesteros, MBA

Issue:
(a) Request to delegate authority to negotiate and execute the delegation amendments to the Plan Partner Services Agreements (PPSA) with Kaiser Foundation Health Plan, Inc. (Kaiser) (A41) and Blue Cross of California (Anthem Blue Cross) (A54).
(b) Request to ratify the execution of the delegation amendment to the PPSA with Blue Shield of California Promise Health Plan (Promise) (A48).

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: The delegation standards exhibit of the PPSA is being revised to incorporate current National Committee for Quality Assurance criteria, among other revisions.

Member Impact: Members will benefit from these revised criteria.

Budget Impact: No budget impact.

Motion: **To approve and/or delegate authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and execute Amendments to Plan Partner Services Agreements between L.A. Care Health Plan and Kaiser, Anthem Blue Cross, and Promise, and to ratify any non-substantive changes to the associated Amendments which may be made or negotiated by the Chief Executive Officer and/or his designees.**

Amendment No. ~~42~~54
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Anthem Blue Cross

This Amendment No. ~~42~~ 54 is effective as of July 1, 2021~~2020~~, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Cross of California dba Anthem Blue Cross***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq.*) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

IN WITNESS WHEREOF, the parties have entered into this Amendment No. ~~42~~ 54 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: _____
John Baackes
Chief Executive Officer

Date: _____, 202~~3~~2

Blue Cross of California dba Anthem Blue Cross
A California health care services plan

By: _____
Les Ybarra
President
Medicaid Health Plan for California

Date: _____, 202~~3~~2

By: _____
~~Hector De La Torre~~Alvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: _____, 202~~3~~2

I. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Anthem Blue Cross (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management, (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, and (vii) claims recovery, and (viii) claims processing.~~.~~ All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and implementation timelines set and required by NCQA and State and Federal regulatory requirements, as modified from time to time. Anthem Blue Cross agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Anthem is responsible for sub-delegation oversight of any sub-delegated activities. Anthem Blue Cross will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Anthem Blue Cross as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Anthem Blue Cross will provide a specific corrective action plan acceptable to L.A. Care. If Anthem Blue Cross does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Anthem Blue Cross, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS ~~starting~~ January 1, 2022~~in 2021~~, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request.L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY IMPROVEMENT	
Program Structure and Operations Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026 (NCQA ~~2020~~ QI 1)	~~**Element A:**~~ **QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated physician in the QI program 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership ~~**Element B:**~~ **Annual Work Plan**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. ~~**Element C:**~~ **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices ~~**Element D:**~~ **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions 2. Analyzes and evaluates the results of QI activities 3. Ensures practitioner participation in the QI program through planning, design, implementation or review 4. Identifies needed actions 5. Ensures follow-up, as appropriate **Promoting Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	
Health Services Contracting Applicable L.A. Care Policy: QI-007 (NCQA ~~2020~~ QI 2)	~~**Element A:**~~ **Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities; 2. Practitioners allow the organization to use their performance data ~~**Element B:**~~ **Provider Contracts**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Contracts with ~~organization providers~~practitioners specifically require that: 1. Providers cooperate with QI activities. ~~2.~~ Providers allow the plan to use their performance data. ~~3.~~ ~~As reference by NCQA, *"Use of practitioner manual or organization's policies. The organization may use its practitioner manual or policies as evidence of performance against this element in the following circumstances.*~~ ~~• *Practitioner contracts specify that the manual or policy is an extension of the contract and that practitioners must abide by the conditions set forth in the contract and in the manual or policy.*~~ ~~• *The manual or policy includes the requirements specified in factors 1 and 2. The organization includes an addendum addressing any factors not included in the contract."*~~ ~~4.~~2.	
Continuity and Coordination of Medical Care Applicable Policy QI-0026 (NCQA ~~2020~~ QI 3)	~~**Element A:**~~ **Identifying Opportunities** The organization annually identifies opportunites to improve coordination of medical care by: 1. Collecting data on member movement between practitioners 2. Collecting data on member movement across settings 3. Conducting quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting one opportunity for improvement 5. Identifying and selecting a second opportunity for improvement 6. Identifying and selecting a third opportunity for improvement 7. Identifying and selecting a fourth opportunity for improvement ~~**Element B:**~~ **Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Taking action on the first opportunity identified in Element A, factor 4. 2. Taking action on the second opportunity identified in Element A, factor 5	

Standard	Delegated Activities	Retained by L.A. Care
	3. Taking action on the third opportunity identified in Element A, factor 6 ~~**Element C:**~~ **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity 2. The second opportunity 3. The third opportunity ~~**Element D:**~~ **Transition to Other Care** Refer to Utilization Management Delegated Activities Section	

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination between Medical and Behavioral Healthcare Applicable L.A. Care Policy: QI-0026 (NCQA ~~2020~~ QI 4)	**~~Element A:~~ Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care 3. Appropriate use of psychotropic medications 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders 5. Primary or secondary preventive behavioral healthcare program implementation 6. Special needs of members with severe and persistent mental illness. **~~Element B:~~ Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A 4. Identifying and selecting a second opportunity for improvement from Element A 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **~~Element C:~~ Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity ~~2.~~ The second opportunity 2.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; ~~d.~~ Standards for the availability of medical records d.	
Sub-Delegation of QI Applicable L.A. Care Policy: QI-007 (NCQA ~~2020~~ QI 5)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities.	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization~~ ~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested.*~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation begins.~~ ~~**Element C: Review of QI Program**~~ ~~For arrangements in effect for 12 months or longer, the organization:~~ ~~1. Annually reviews its delegate's QI program~~ ~~2. Annually evaluates delegate performance against NCQA standards for delegated activities~~ ~~3. Semiannually evaluates regular reports, as specified in Element A~~ ~~**Element D: Opportunities for Improvement**~~

Standard	Delegated Activities	Retained by L.A. Care
	3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.~~ ~~*L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption~~
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA ~~2020~~ PHM 1)	~~**Element A:**~~ **Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. 3. Activities that are not direct member interventions, 4. How member programs are coordinated. 5. How members are informed about available PHM programs. ~~**Element B:**~~ **Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate. 2. How to use program services. 3. How to opt in or opt out of the program.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Population Identification (NCQA ~~2020~~ PHM 2)	~~**Element A:**~~ **Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters. 2. Pharmacy claims. 3. Laboratory results. 4. Health appraisal results. 5. Electronic health records.	

Standard	Delegated Activities	Retained by L.A. Care
	6. Health Services programs within the organization. 7. Advanced data sources. ~~**Element B:**~~ **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Asseses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI). 6. Assesses the needs of of members racial or ethnic groups. ~~5.~~7. Assesses the needs of members with limited English proficiency ~~**Element C:**~~ **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs. 2. Review and update its PHM resources to address member needs. ~~2.~~3. Review and update activities or resources to address health care disparities for at least one identified population. ~~3.~~4. Review community resources for integration into program offerings to address member needs. ~~**Element D:**~~ **Segmentation** 1. ~~At least annually, the organization s~~Segments or stratifies its entire population into subsets for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA ~~2020~~ PHM 3)	~~**Element A:**~~ **Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data. 2. Offering ~~evidence-based or~~ certified shared -decision-making aids.	~~**Element B:**~~ **Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Standard	Delegated Activities	Retained by L.A. Care
	3. Providing practice transformation support to primary care practitioners. 4. Providing comparative quality information on selected specialties. 5. Providing comparative pricing information for selected services. 6. One additional activity to support practitioners or providers in achieving PHM goals.	
Wellness and Prevention (NCQA ~~2020~~ PHM 4)	~~**Element A:**~~ **Frequency of Health Appraisal Completion** The organization has the capability to administer an HA annually. ~~**Element B:**~~ **Topics of Self-Management Tools** The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating 5. Managing stress. 6. Avoiding at-risk drinking. ~~7.~~ Identifying depressive symptoms. 7.	
Complex Case Management (NCQA ~~2020~~ PHM 5)	~~**Element A:**~~ **Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. ~~**Element B:**~~ **Case Management Systems** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred; 3. Automated prompts for follow-up as required by the case management plan. ~~**Element C:**~~ **Case Management Process** The organization's complex case management procedures address the following:	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	1. Initial assessment of member health status, including condition-specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of activities of daily living. 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Initial assessment of life-planning activities. 7. Evaluation of cultural and linguistic needs, preferences or limitations. 8. Evaluation of visual and hearing needs, preferences or limitations. 9. Evaluation of caregiver resources and involvement. 10. Evaluation of available benefits. 11. Evaluation of community resources. 12. Development of an individualized case management plan, including prioritized goals that considers the member and caregiver goals, preferences and desired level of involvement in the case management plan. 13. Identification of barriers to the member meeting goals or complying. with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals. 15. Development of a schedule for follow-up and communication with members. 16. Development and communication of a member self-management plan. 17. A process to assess member progress against the case management plan. ~~**Element D:**~~ **Initial Assessment** An NCQA review of a sample of the organization's complex case mangagement files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues. 2. Documentation of clinical history, including medications.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Initial assessment of activities of daily living (ADL). 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Evaluation of cultural and linguistic needs, preferences or limitations. 7. Evaluation of visual and hearing needs, preferences or limitations. 8. Evaluation of caregiver resources and involvement. 9. Evaluation of available benefits 10. Evaluation of available community resources. 11. Assessment of life planning activities. ~~**Element E:**~~ **Case Management: Ongoing Management** NCQA's review of a sample of the organization's complex case management files demonstrates that the organization follows its documented process for: 1. Development of case management plans that includeg prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the case management plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. ~~5.~~ Assessment of progress against case management plans and goals, and modification as needed. 5.	
Population Health Management Impact (NCQA ~~2020~~ PHM 6)	~~**Element A:**~~ **Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. ~~**Element B:**~~ **Improvement and Action**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization uses results from the PHM impact analysis to annually: ~~1.~~7. Identify opportunities for improvement. ~~2.~~8. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA ~~2020~~ PHM 7)	**Sub-Delegation Agreement (LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization~~ ~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested*~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation begins.~~ ~~**Element C: Review of PHM Program**~~ ~~For arrangements in effect for 12 months or longer, the organization:~~ ~~1. Annually reviews its delegate's PHM program~~ ~~2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable~~ ~~3. Annually evaluates delegate performance against NCQA standards for delegated activities~~ ~~4. Semiannually evaluates regular reports, as specified in Element A~~ ~~**Element D: Opportunities for Improvement**~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.~~ ~~** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A.~~

Standard	Delegated Activities	Retained by L.A. Care
	delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	~~*Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*~~
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA ~~2020~~ NET 1)	~~**Element A:**~~ **Cultural Needs and Preferences** The organization: 1. Assesses the cultural, ethnic, racial and linguistic needs of its members. 2. Adjusts the availability of practitioners within its network, if necessary. ~~**Element B:**~~ **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine, and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care. 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. ~~**Element C:**~~ **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of high volume and high-impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists 4. Establish measureable standards for the geographic distribution of each type of high-impact specialist 5. Analyzes its performance against the established standards at least annually ~~**Element D:**~~ **Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against the standards annually	
Accessibility of Services (NCQA ~~2020~~ NET 2)	~~**Element A:**~~ **Access to Primary Care** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments; 2. Urgent care appointments; 3. After-hours care ~~**Element B:**~~ **Access to Behavioral Healthcare** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours. 2. Urgent care within 48 hours. 3. Initial visit for routine care within 10 business days. 4. Follow-up routine care. ~~**Element C:**~~ **Access to Specialty Care**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	
Assessment of Network Adequacy (NCQA ~~2020~~ NET 3)	**~~Element A:~~ Assessment of Member Experience Accessing the Network** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from Behavioral Healthcare and Services.ME 7, Element E 3. Compiling and analyzing requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **~~Element B:~~ Opportunities to Improve Access to Nonbehavioral Healthcare Services** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements B and C), accessibility,(NET 2, Elements A and C), and member experience accessing the network (NET 3, Element A, factors 1 and 3) 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions if applicable. **~~Element C:~~ Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: ~~1.~~ Prioritizes opportunities for improvement ~~opportunities~~ identified from analyses of availability(NET 1, Element D), accessibility (NET 2, Element B), and member experience accessing the network (NET 3, Elements A and D, factor 2 and 4)	

Standard	Delegated Activities	Retained by L.A. Care
	1. Implements interventions on at least one opportunity, if applicable. 2. Measures the effectiveness of the interventions, if applicable.	
Continued Access to Care (NCQA ~~2020~~ NET 4)	~~**Element A:**~~ **Notification of Termination** Refer to Utilization Management Delegated Activities Section. The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective terminaton date, and helps them select a new practitioner. ~~**Element B:**~~ **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section If a practitioner's contract is discontinued, the organization allows affected member continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. ~~*L. A. Care combined NCQA Standard NET 4, Continued Access to Care, Element A and B under NCQA Standard, QI 3 Element D, Coordination of Medical Care.*~~	
Physician and Hospital Directories (NCQA ~~2020~~ NET 5)	~~**Element A:**~~ **Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Board certification. 7. Accepting new patients. 8. Language spoken by the physician or clinical staff. 9. Office locations and phone numbers.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	~~**Element B:**~~ **Physician Directory Updates** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. ~~**Element C:**~~ **Assessment of Physician Directory Accuracy** Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers. 2. Accuracy of hospital affiliations. 3. Accuracy of accepting new patients. 4. Awareness of physician office staff of physician's participation in the organization's networks. ~~**Element D:**~~ **Identifying and Acting on Opportunities** ~~1.~~ Based on results of the analysis performed in Element C, at least annually, the organization: ~~2.~~1. ~~3.~~ Identifies opportunities to improve the accuracy of the information in its physician directories. 2. ~~4.~~3. Takes action to improve the accuracy of the information in its physician directories. ~~**Element E:**~~ **Searchable Physician Web-Based Directory** The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Accepting new patients. 7. Languages spoken by the physician or clinical staff. 8. Office locations. ~~**Element F:**~~ **Hospital Directory Data**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has a web-based hospital directory that includes the following information: 1. Hospital name. 2. Hospital location and phone number. 3. Hospital accreditation status. 4. Hospital quality data from recognized sources. ~~**Element G:**~~ **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the hospital. ~~**Element H:**~~ **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name. 2. Hospital location. ~~**Element I:**~~ **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level. 2. Intuitive content organization, 3. Ease of navigation. 4. Directories in additional languages, if applicable to the membership. ~~**Element J:**~~ **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print. 2. Telephone.	
Sub-Delegation of NET (NCQA ~~2020~~ NET 6)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization~~

Standard	Delegated Activities	Retained by L.A. Care
	4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested *~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.~~ ~~**Element C: Review of Delegated Activities**~~ ~~For arrangements in effect for 12 months or longer, the organization:~~ ~~1. Annually reviews its delegate's network management procedures~~ ~~2. Annually evaluates delegate performance against NCQA standards for delegated activities~~ ~~3. Semiannually evaluates regular reports, as specified in Element A~~ ~~**Element D: Opportunities for Improvement**~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.~~ ~~** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*~~
~~**UTILIZATION MANAGEMENT**~~		
	UTILIZATION MANAGEMENT	
Continued Access to Care ~~(NCQA NET 4)~~ and Continuity and Coordination of Medical Care	~~**NET 4 Element A:**~~ **Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least thirty (30) calendar days	

Standard	Delegated Activities	Retained by L.A. Care
-(NCQA Net 4 and QI 3)	prior to the effective termination date and helps them select a new practitioner. ~~NET 4 Element B:~~ **Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. ~~QI 3 Element D:~~ **Transition to Other Care** The organization helps with members' transition to other care when their benefit ends, if necessary]	
Program Structure (NCQA ~~2020~~ UM 1)	~~Element A:~~ **Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated senior-level physician in UM program implementation. 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes to determine benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. ~~Element B:~~ **Annual Evaluation** The organization annually evaluates and updates the UM Program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA ~~2020~~ UM 2)	~~Element A:~~ **UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. ~~**Element B:**~~ **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria. ~~2.~~ Makes the criteria available to its practitioners upon request. 2. ~~**Element C:**~~ **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	
Communication Services (NCQA ~~2020~~ UM 3)	~~**Element A:**~~ **Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA ~~2020~~ UM 4)	~~**Element A:**~~ **Licensed Health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. ~~**Element B:**~~ **Use of Practitioners for UM Decisions**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training,or professional experience in medical or clinical practice 2. A current clinical license to practice or an administrative license to review UM cases. ~~**Element C:**~~ **Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional as appropriate, to review any non-behavioral healthcare denial based on medical necessity. ~~**Element D:**~~ **Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. ~~**Element E:**~~ **Practitioner Review of Pharmacy Denials** The organization uses a physician or pharmacist to review pharmacy denials based on medical necessity. ~~**Element F:**~~ **Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations. ~~2.~~ Provides evidence that it uses board-certified consultants are used for medical necessity determinations. 2.	
Timeliness of UM Decisions (NCQA ~~2020~~ UM 5)	~~**Element A:**~~ **Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of	

Standard	Delegated Activities	Retained by L.A. Care
	the decision to members and practitioners ~~and members~~ within 72 hours of the request. 4. For non-urgent Medicaid preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 14 calendar days of the request. 5. For post-service decsions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. ~~5.~~6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **~~Element B:~~ Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 72 hours of the request. 4. For Medicaid non-urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 14 calendar days of the request. 5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 30 calendar days of the request. **~~Element C: Notification of Pharmacy Decisions~~**	

Standard	Delegated Activities	Retained by L.A. Care
	~~The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:~~ ~~1. For urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within 24 hours of the request.~~ ~~2. For urgent preservice decisions, electronic or written notification of the decision to members and practitioners within 72 hours of the request.~~ ~~3. For nonurgent preservice decisions, electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.~~ ~~4. For postservice decisions, electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.~~ **Element D: UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Nonbehavioral UM decision making. 2. Notification of nonbehavioral UM decisions. 3. Behavioral UM decision making. 4. Notification of behavioral UM decisions. ~~4.~~ ~~5. Pharmacy UM decision making.~~ ~~6. Notification of pharmacy UM decisions.~~ ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards*** Note: This only applies to pharmaceuticals covered under the medical benefit.	
Clinical Information (NCQA ~~2020~~ UM 6)	~~**Element A:**~~ **Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. ~~**Element B:**~~ **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information	

Standard	Delegated Activities	Retained by L.A. Care
	consistently to support behavioral healthcare UM decision making. ~~**Element C:**~~ **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals covered under the medical benefit.	
Denial Notices (NCQA 2020 UM 7)	~~**Element A:**~~ **Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. ~~**Element B:**~~ **Written Notification of Nonbehavioral Healthcare Denials** The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. ~~**Element C**~~ **Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written nonbehavioral denial notifications to members and their treating practitioners contain the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant the appeal. 2. An explanation of the appeal process, including members' rights to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with	

Standard	Delegated Activities	Retained by L.A. Care
	the internal appeals process for urgent care. **~~Element D:~~ Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer **~~Element E:~~ Written notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Writen Notification of~~Element F:~~ Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **~~Element G:~~ Discussing a Pharmacy Denial With a Reviewer**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization gives practitioners the opportunity to discuss pharmacy UM denials decisions with a physician or pharmacist. ~~**Element H:**~~ **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. ~~**Element I:**~~ **Pharmacy Notice of Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceutical covered under the medical benefit.	
Policies for Appeals (NCQA ~~2020~~ UM 8)	~~**Element A:**~~ **Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least 60 calendar days after notification of the denial for the member to file the appeal 2. Documenting the substance of the appeal and any actions taken	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. Fully investigating the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal. 5. 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 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar ~~(defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems)~~ specialty. 7. The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request. 8. The decision for a post service appeal and notification to the member within 30 calendar days of receipt of the request. 9. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 10. Notification to the member about further appeal rights 11. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based. 12. Giving the member reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. 13. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.	

Standard	Delegated Activities	Retained by L.A. Care
	14. Allowing an authorized representative to act on behalf of the member 15. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 16. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA ~~2020~~ UM 9)	**~~Element A:~~ Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documention of the substance of appeals 2. Investigation of appeals 3. Appropriate response to the substance of the appeal. **~~Element B:~~ Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice, and expedited appeal process is within the specified time frames: 1. The organization resolves preservice appeals within 30 calendar days of receipt of the request 2. The organization resolves postservice appeals within 30 calendar days of receipt of the request 3. The organization resolves expedited appeals within 72 hours of receipt of the request **~~Element C:~~ Appeal Reviewers** The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-imilar specialist review, as appropriate. **~~Element D:~~ Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request. 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review ~~6.~~ A description of the next level of appeal within the organization or to an independent external organization, as applicable, along with relevant written procedures. 6.	
Evaluation of New Technology (NCQA ~~2020~~ UM 10)		~~**Element A:**~~ **Written Process** The organization's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plan includes an evaluation of the following: 1. Medical procedures. 2. Behavioral healthcare procedures. 3. Pharmaceuticals. 4. Devices This element is NA: • For Medicaid product lines if the state mandates all benefits and new technology determinations. – The organization provides the state's language. • If the organization does not determine which technologies, pharmaceuticals, devices, procedures or other services are included in benefits plans it offers to members. – For example, when these determinations are made by all purchasers of the organization's services. **Element B: Description of the Evaluation Process** This element is NA for Medicaid product lines if the state mandates all benefits and new technology determinations. The organization must produce documentation that demonstrates this. This element is NA if the organization does not determine which technologies, pharmaceuticals, devices, procedures or other services are included in benefits plans it offers to members. For example, when these determinations are made by all purchasers of the organization's services.

Standard	Delegated Activities	Retained by L.A. Care
Procedures for Pharmaceutical Management (NCQA ~~2020~~ UM 11)	**Element A: Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures 4. A process to provide procedures to practitioners annually and when it makes changes. **Element B: Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicatesto members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions and preferences. 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The organization's process for generic substitution, therapeutic interchange and step-therapy protocols. **SB1052**: Anthem shall post formulary on its Internet website and update that posting with changes on a monthly basis. **Element C: Pharmaceutical Patient Safety Issues** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification. 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **Element D: Reviewing and Updating Procedures**	

Standard	Delegated Activities	Retained by L.A. Care
	With the participation of physicians and pharmacists, the organization annually: 1. Reviews the procedures. 2. Reviews the list of pharmaceuticals. 3. Updates the procedures as appropriate. 4. Update the list of pharmaceuticals as appropriate. SB1052: Anthem shall post the formulary list with changes on its Internet website on a monthly basis. . **Element E: Considering Exceptions** Implementing policies and procedures for considering exceptions when a closed formulary is used, which include: 1. Making an exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of exception requests ~~5.~~ Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request. 5.	
UM System Controls (NCQA ~~2020~~ UM 12)	**Element A: UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **Element B: UM Appeal System Controls**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. ~~7.~~ Describe how the organization audits the processes and procedures in factors 1-6. 7.	
Sub Delegation of UM (NCQA ~~2020~~ UM 13)		**Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and responsibilities of organization and delegated entity 3. Requires at least semiannual reporting by the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested* 6. Describes the remedies available to organization . if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the delegate evaluates delegate capacity to meet NCQA requirements before delegation began. **Element C: Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program 2. Annually audits UM denials and appeals files against regulatory guidelines and NCQA standards for each year that delegation has been in effect

Standard	Delegated Activities	Retained by L.A. Care
		3. Annually evaluates delegate performance against NCQA standards for delegated activities 4. Semiannually evaluates regular reports as specified in Element A. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable. ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*
~~CREDENTIALING~~		
	CREDENTIALING	
Credentialing Policies (NCQA ~~2020~~ CR1) DHCS 6.5.4.2 DHCS APL 19-004	The organization has well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. **Element A: Practitioner Credentialing Guidelines** The organization specifies: 1. The types of practitioners to credential and re-credential [*State Contract 6.5.4.2: include all administrative physician reviewers responsible for making medical decisions*] 2. The verification sources it uses. 3. The criteria for credentialing and re-credentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet organization's established criteria. • Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files). The organization may present all practitioner files to the Credentialing Committee or may designate	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	approval authority of clean files to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. a. Credentialing policies and procedures: ▪ State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes. ▪ Specify the process for preventing discriminatory practices.-Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. ▪ Specify how the organization monitors the credentialing and recredentialing processes. for discriminatory practices, at least annually. – Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes. 7. The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization. 8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data,	

Standard	Delegated Activities	Retained by L.A. Care
	including education, training, board certification and specialty. **Element B: Practitioner Rights** The organization notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. • The timeframe for making corrections. • The format for submitting corrections. • Where to submit corrections. 3. Receive the status of their credentialing or recredentialing application, upon request. **Element C: Credentialing System Controls** The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. • If the organization contracts with an external entity to outsource storage of credentialing information, the contract describes how the contracted entity ensures the security of the stored information . 5. How the organization audits the processes and procedures in factors 1–4. **Medi-Cal FFS Enrollment *** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 2. The process for ensuring and verifying Medi-Cal enrollment. 3. The process for practitioners whose enrollment application is in process. 4. The process for monitoring between recredentialing cycles to validate continued enrollment.	

Standard	Delegated Activities	Retained by L.A. Care
	5. Process for practitioners not currently enrolled in the Medi-Cal program. 6. Process for practitioners deactivated or suspended from the Medi-Cal program *Anthem supports this requirement under its Network Management operations.	
Credentialing Committee (NCQA ~~2020~~ CR 2)	The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. **Element A: Credentialing Committee** The organization's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. • The Credentialing Committee is a peer-review body with members from the range of practitioners participating in the organization's network. • The organization may have separate review bodies for each practitioner type (e.g., physician, oral surgeon, psychologist), specialty or multidisciplinary committee, with representation from various specialties. • If the organization is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review committee for the local organization. 2. Reviews credentials for practitioners who do not meet established thresholds. The Credentialing Committee: • Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network. • Gives thoughtful consideration to credentialing information. • Documents discussions about credentialing in meeting minutes. 3. Ensures that files meet established criteria are reviewed and approved by a medical director or designated physician. Has a process for medical director or qualified physician review and approve clean files.	

Standard	Delegated Activities	Retained by L.A. Care
Credentialing Verification (NCQA ~~2020~~ CR 3) DHCS 6.5.4.2 APL 19-004	The organization verifies credentialing information through primary sources, unless otherwise indicated. The organization conducts timely verification of information to ensure that practitioners have legal authority and relevant training and experience to provide quality care. **Element A: Verification of Credentials** The organization verifies that the following are within the prescribed time limits: 1. A current, valid license to practice. (Develop a process to ensure providers licenses are kept current at all times). 2. A valid DEA or CDS certificate and must able to dispense schedules 2 through 5 or schedules applicable to the provider's speciality. • Pending DEA certificates and practitioners who do not have schedules 2 through 5, if applicable: The organization may credential a practitioner whose DEA certificate is pending or missing schedules if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending or missing schedules until the practitioner has a valid DEA certificate and able to dispense schedules appropriate to the practitioners specialty type. 3. Education and training as specified in the explanation. • The organization verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate: Board certification • Residency • Graduation from medical or professional school. 4. Board certified status, if applicable. • The organization verifies current certification status of practitioners who state that they are board certified. The organization documents the expiration date of the board certification in the credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status), the organization verifies that board certification is current and documents the date of verification. 5. Work history. The organization obtains a minimum of the most recent five years of work history as a health professional through	

Standard	Delegated Activities	Retained by L.A. Care
	the practitioner's application or CV. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date. Gaps in work history. The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. • The organization obtains confirmation of the past five years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The five-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship • DHCS APL 19-004: Medi-Cal FFS enrollment. [*Anthem supports this requirement under its Network Management operations.]* • Verification of practioner enrollment of DHCS FFS. • Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network. All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network	
Sanction Information (NCQA ~~2020~~ CR 3) State Contract 6.5.4.2	**Element B: Sanction Information** The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, and limitations on scope of practice. 2. Medicare and Medicaid sanctions. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application	**Element C: Credentialing Application**	

Standard	Delegated Activities	Retained by L.A. Care
(NCQA ~~2020~~ CR 3) State Contract 6.5.4.2	Applications for credentialing include the following: 1. Reasons for inability to perform the essential functions of the position 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary action. 5. Current malpractice insurance coverage. ~~6.~~ Current and signed attestation confirming the correctness and completeness of the application. *6.*	
Re-credentialing Cycle Length (NCQA ~~2020~~ CR 4) State Contract 6.5.4.2	**Element A: Recredentialing Cycle Length** Recredentialing all practitioners at least every 36-months.	
Ongoing Monitoring and Interventions (NCQA ~~2020~~ CR 5) State Contract 6.5.4.2	The organization Develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. **Element A: Ongoing Monitoring and Interventions** The organization implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information fromidentified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the delegate b. What type of monitoring is being performed c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and proceduresThe Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following:Requesting what action will be taken by the DelegateWhat type of monitoring is being performedWhat interventions are being implemented, including closing panel, moving members, or removal of practitioner from the networkThe notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA ~~2020~~ CR 6) State Contract 6.5.4.2	The organization uses objective evidence and patient-care consideration when deciding on a course of action for dealing with a practitione who does not meet its quality standards. **Element A: Actions Against Practitioners** The organization has policies and procedures for: 1. The range of actions available to organization.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	• Specify that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare. • Specify the range of actions that may be taken to improve practitioner performance before termination. • Specify that the organization reports its actions to the appropriate authorities. 2. Making the appeal process known to practitiones. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA ~~2020~~ CR 7) State Contract 6.5.4.2	**Element A: Review and Approval of Provider** The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. acceptable to Delegate, including which accrediting bodies are acceptable; 3. Conducts an onsite quality assessment is conducted if the provider is not accredited. by an accrediting body acceptable to Delegate, including which accredited bodies are acceptable; 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate; Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. **Element B: Medical Providers**	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Free-standing surgical centers. *Hospices. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA). *Comprehensive Rehabilitation Facilities (CORFs). *Outpatient Physical Therapy and Speech Pathology Providers. *Providers of end-stage renal disease services. *Providers of outpatient diabetes self-management training . *Portable X-Ray Suppliers. *Rural Health Clinic (RHCs). Federally Qualified Health Center (FQHCs). **Element C: Behavioral Healthcare Providers** The Delegate includes behavioral health care facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory. **Element D: Assessing Medical Providers** The Delegate assesses contracted medical health care providers. **Element E: Assessing Behavioral Healthcare Providers** The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA ~~2020~~ CR 8) State Contract 6.5.4.2	**Element A: Delegation Agreement** If the organization (Anthem) sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterlyreporting to Delegate	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its obligations, including revocation of the sub-delegation agreement. Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of Delegate's Credentialing Activities** For sub-delegation arrangements in effect for 12 months or longer, the Delegate: 1. Annually reviews its sub-delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. 3. Annually evaluates the Sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually. 4. Evaluates regular reports from Sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable	

Standard	Delegated Activities	Retained by L.A. Care
	If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre delegation audit reveals deficiencies identified that are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ~~2020~~ ME 1)	**~~Element B.~~ Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**~~Element A:~~ Rights and Responsibilites Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities 2. A right to be treated with respect and recognition of their dignity and right to privacy 3. A right to participate with practitioners in making decisions about their health care 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage 5. A right to voice complaints or appeals about the organization or the care it provides 6. A right to make recommendations regarding the organization's member rights and responsibilities policy 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ~~2020~~ ME 2)		**Element A: Subscriber Information** The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care. **Element B: Interpreter Services** Based on linguistic need of its subscribers, the organization provides interpreter or bilingual services in its Member Services department and telephone functions.

Standard	Delegated Activities	Retained by L.A. Care
		L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ~~2020~~ ME 3)		**Element A: Materials and Presentations** All organizational materials and presentations accurately describe the following information: 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures. **Element B: Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **Element C: Assessing Member Understanding** **The organization systematically takes the following steps:** 1. Assesses how well new members understand policies and procedures. 2. Implements procedures to maintain accuracy of marketing communication. 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA ~~2020~~ ME 4)	**Element B: Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. ~~5.~~ The date paid 5.	
Pharmacy Benefit Information (NCQA ~~2020~~ ME 5)	**Element A: Pharmacy Benefit Information-Website** Members can complete the following actions on the organization's website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Initiate the exceptions process 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. SB1052: Anthem shall post the formulary on its internet website and update that posting on a monthly basis. **Element B: Pharmacy Benefit Information Telephone** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes. **Element C: QI Process on Accuracy of Information** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **Element D: Pharmacy Benefit Updates** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA ~~2020~~ ME 6)	**Element A: Functionality – Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable **Element B: Functionality Telephone** To support financial decision making, members can complete each of the following	

Standard	Delegated Activities	Retained by L.A. Care
	activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Element C: Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information it provides to its members via the webs and telephone, by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **Element D: E-mail Response Evaluation** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience Applicable L.A. Care Policy: QI-0031 (NCQA ~~2020~~ ME 7)	~~**Element A:**~~ **Policies and Procedures for Complaints** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken. 2. Investigating of the substance of complaints 3. Notification to members of the resolution of complaint and, if there is an adverse decision, the right to appeal. 4. Standards for timeliness including standards for urgent situations.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. ~~**Element D:**~~ **Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which

Standard	Delegated Activities	Retained by L.A. Care
	5. Provision of language services for the complaint process. ~~**Element B:**~~ **Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals. 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate. 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. ~~**Element C:**~~ **Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. ~~**Element E:**~~ **Annual Assessment of Behavioral Healthcare and Services** Using valid Methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. ~~**Element F:**~~ **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2.Identifying opportunities for improvement. 3.Implementing interventions, if applicable. 4.Measuring effectiveness of interventions, if applicable.	opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from the Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.
Sub-Delegation of ME (NCQA ~~2020~~ ME 8)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon.~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization.~~

Standard	Delegated Activities	Retained by L.A. Care
	3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **Review of Performance** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.	~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested *~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation begins.~~ ~~**Element C: Review of Performance**~~ ~~For delegation arrangements in effect for 12 months or longer, the organization:~~ ~~1. Semiannually evaluates regular reports, as specified in Element A.~~ ~~2. Annually evaluates delegate performance against NCQA standards for delegated activities.~~ ~~**Element D: Opportunities for Improvement**~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that organization identified and followed up on opportunities for improvement, if applicable.~~ ~~** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*~~
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2 Knox-Keene 1348.8)	Plan shall provide telephone medical advice services to its enrollees and subscribers. The staff hold a valid California license as a registered nurse or a valid license in the state within which they provide telephone medical advice services as a physician and surgeon or physician assistant, and are operating in compliance with the laws governing their respective scopes of practice.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors (Knox-Keene, 1348.8; 1. Is available 24 hours a day, 7 days a week by telephone. (Title 28 CA Code of Regulations; 1300.67.2.2) 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. (Knox-Keene; 1367.04) 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. (1300.67.2.2) **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. ~~2.~~ Link member contacts to a contact history. **2.** **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone and website statistics at least quarterly. 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion (1300.67.2.2)** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Pan Partner Services Agreement	

Standard	Delegated Activities	Retained by L.A. Care
	and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
~~Quality Assurance Program~~ ~~(Title 28 California Code of Regulations Section 1300.70)~~	~~The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.~~ ~~The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.~~	~~L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.~~
Quality Improvement Performance DHCS APL 19-017 Applicable L.A. Care Policy: QI-008~~DHCS~~ APL ~~Supplement to All Plan Letter~~ 19-017 *	1. Annually measures performance and meets the NCQA 25th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 25th percentile is not met the plan will identify and follow up on opportunities for improvement. ~~* DHCS supplement to All Plan Letter (APL) 19-017 is to provide Medi-Cal managed care health plans (MCPs) with adjustments to quality and performance improvement requirements as a result of the current public health emergency resulting from COVID-19. These adjustments are consistent with recent allowances from the National Committee for Quality Assurance (NCQA).~~	L.A. Care will retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.

Standard	Delegated Activities	Retained by L.A. Care
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016. 2. Identify, on at least a quarterly basis (i.e. January-March, April-June, July-September, October-December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required, *L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

Standard	Delegated Activities	Retained by L.A. Care
	a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC SERVICES		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations. It must includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H)	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested,	

Standard	Delegated Activities	Retained by L.A. Care
Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. 2. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at	

Standard	Delegated Activities	Retained by L.A. Care
	physical location where the plan interacts with the public and on Plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory.	

Standard	Delegated Activities	Retained by L.A. Care
Federal Guidelines: OMH CLAS Standards, Standard 7	4. Plan annually assesses the provider network language capabilities to meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-8	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website. d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and 18 non-English required by DHCS to Member Informing Materials. Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean,	

Standard	Delegated Activities	Retained by L.A. Care
	Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis. c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters.	

Standard	Delegated Activities	Retained by L.A. Care
Federal Guidelines: OMH CLAS Standards, Standard 6	3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial and annual education/training on cultural and linguistic requirements to providers, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language. ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members.	

Standard	Delegated Activities	Retained by L.A. Care
	e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. b. Awareness that culture and cultural beliefs may influence health and health care delivery. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. d. Skills to communicate effectively with diverse populations e. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees.	

Standard	Delegated Activities	Retained by L.A. Care
9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422.	

Standard	Delegated Activities	Retained by L.A. Care
	b. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. c. Skills to communicate effectively with diverse populations. d. Language and literacy needs.	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	
Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services)	

Standard	Delegated Activities	Retained by L.A. Care
17-004DHCS All Plan Letter 21-004	2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. 3. Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	

CLAIMS PROCESSING REQUIREMENTS		
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims:** Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. c. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum of 95% of the time. **Accurate and Clear Written Explanation**	

	Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum of 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute.	

	b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy Reporting requirements for additional delegated activities 1. NCQA UM related [Part 1] a. **UM 4E:** Practitioner Review of Pharmacy Denials b. **UM 5:** Timeliness of Pharmacy UM Decision Making c. **UM 5C:**Notification of Pharmacy Decisions d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials 2. NCQA UM related [Part 2] a. **UM 7I:** Pharmacy Notice of Appeals Rights/Process b. **UM 9A** Preservice and Postservice Pharmacy Appeals c. **UM 9B:** Timeliness of the Pharmacy Appeal Process d. **UM 9C:** Pharmacy Appeal Reviewers e. **UM 9D:** Notification of Appeal Decision/Rights for Pharmacy f. **UM 12A:** UM Denial System Controls 3. NCQA UM related [Part 3] a. **UM 5G(factors5&6)**: UM Timeliness Report (Pharmacy) 4. DHCS Related a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA decisions within 24 hours of receipt/Total PAs .- includes approval and denials, <u>excludes all</u>	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) – Compliance Folder. Plan will also have the option to submit via email to remain compliant with due date.	1-3. L.A. Care Reporting Format with data elements as defined in the Anthem Pharmacy Report Templates workbook, and 4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

early close and administrative denials b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs .- includes approval and denials, excludes all early close and administrative denials 5. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded. b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded **c.** Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 6. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization.			
NCQA Pharmacy ME related reporting requirements 1. **ME:** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME:** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 - 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) – Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission

~~APPEALS & GRIEVANCES~~

~~**APPEALS & GRIEVANCES**~~ ~~Member complaints and Appeals Log~~	~~Monthly~~ ~~12th Calendar Day of Each Month~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) Compliance folder~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~Format as defined in the L.A. Care Technical Bulletin MS 005~~
~~**ME 7 A, B, C, E, F**~~ ~~1. **Analysis of Member Experience, if delegated, to include:** Policies and Procedures for Complaints~~ ~~2. Policies and Procedures for Appeals~~ ~~3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories along with oppurtunities for improvement:~~ ~~a. Quality of Care~~ ~~b. Access~~ ~~c. Attitude and Service~~ ~~d.~~ ~~e. Quality of Practitioner Office Site~~ ~~4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with oppurtunities for improvement:~~ ~~a. Quality of Care~~ ~~b. Access~~ ~~c. Attitude and Service~~ ~~d.~~ ~~e. Quality of Practitioner Office Site~~	~~Annually during PP audit~~	~~L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder /~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** 1. Assess the cultural, ethnic, racial and linguistic needs of its members 2. Adjust the availability of practitioners within its network, if necessary	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission

NET 1B **Availability of Practitioners, if delegated:** Formal assessment of primary care, behavioral healthcare and specialty care practitioners (SCP) availability to include: 1. Adjustment of practitioners availability within its network to meet the cultural, ethnic, racial and linguistic needs of its members 2. Quantifiable and Measurable Standards for the number of each type of practitioner providing primary care. 3. Quantifiable and Measurable Standards for Geographic Distribution of each type of practitioner providing primary care. 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 1C **Formal assessment of Practitioners Providing Specialty Care, if delegated, to include:** 1. Identification of High Volume Specialty Providers, one of which must be OB/GYN; and Identification of High Impact Specialty Providers, one of which must be Oncology 2. Quantifiable and Measurable Standards for the number of each type of high-volume specialists. 3. Quantifiable and Measurable Standards and Distribution by Geographic Distribution of High Volume SCPs and High Impact SCPs; and 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 1D **Assessment of Practitioners Providing Behavioral Healthcare, if delegated, to include:** 1. Identification of High-Volume behavioral healthcare practitioners 2. Quantifiable and Measurable Standards for the number of each type of High-Volume behavioral healthcare practitioner. 3. Quantifiable and Measurable Standards for the geographic distribution of each type of High-Volume behavioral healthcare practitioners. 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission

NET 2A **Access to Primary Care, if delegated:** Analysis of data that measures: 1. Regular and Routine Care Appointments 2. Urgent Care Appointments 3. After-Hours Care	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2B **Access to Behavioral Healthcare, if delegated:** Analysis of data that evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent Care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care within a time frame defined by the organization	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2C **Access to Specialty Care, if delegated:** Analysis of data that evaluate access to appointments for : 1. High-Volume specialty care. 2. High-Impact specialty care.	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3 **Assessment of Network Adequacy** 1. Assessment of Member Experience Accessing the Network by: a. Analyzing data from complaints and appeals about network adequacy for non-behavioral and behavioral healthcare services b. Using aspects of analysis from (b) to determine if there are issues specific to particular geographic areas or types of practitioners or providers 2. Analyze opportunities to improve access to non-behavioral healthcare services by: a. Prioritizing opportunities for improvement from analysis of availability, accessibility and	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date	Compliant with NCQA in accordance to Plan's accreditation submission

CAHPS survey results and member complaints and appeals b. Implement interventions on at least one opportunity, if applicable c. Measure the effectiveness of interventions, if applicable 3. Analyze opportunities to improve access to behavioral healthcare services by: a. Prioritizing improvement opportunities identified from analyses of availability, accessibility, complaints and appeals, or member experience b. Implementing interventions on at least on opportunity, if applicable c. Measures the effectiveness of the interventions, if applicable			
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ubcsc/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3A Identifying Opportunites **QI 3B** Acting on Opporunities **QI 3C** Measuring Effectiveness ~~**QI 3 A-C & 4 A-C Annual Assessment and Improvement Actions taken for Continuity and Coordination of Care across the health care network**~~ ~~1. Continuity and Coordination of Medical Care analysis~~ ~~2. Continuity and Coordination Between Medical Care and Behavioral Healthcare analysis.~~	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org ..	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activites **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder: home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org .	Compliant with NCQA in accordance to Plan's accreditation submission.

QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org .	Compliant with NCQA in accordance to Plan's accreditation submission.
Quality Improvement Quarterly reporting requirements 1. **QI Workplan Update** ~~1.~~ Workplan updates should goals, objectives, QI activities and responsible party related to the MCAS MPL measures. 2. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	1 – 2. Quarterly 1st Qtr – ~~April~~ June 30 2nd Qtr – ~~July 25~~Sep 30 3rd Qtr – ~~Oct 25~~Dec 30 4th Qtr – ~~Jan 25~~Mar 30 2.Quarterly PQI Report 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder home/ubcsc/infile/Quality Improvement/ ~~.~~ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org.	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Workplan *(if the activities are not included in the QI Workplan)*	1 – 4. Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org. The PHM reporting element is part of Anthem's UM operations – copy of its UM Workplan will be shared with LA Care's Quality Improvement Team during the annual PP audit.	Acceptable formats: • ICE Reporting Format

ME 1B: Distribution of Member Rights & Responsibilities Statement to New Practitioners	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 & Q2)	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org.	Mutually agreed upon format
PHM 1A~~:~~ ~~PHM Strategy~~ ~~Element A:~~ Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data integration **PHM 2B~~: Population Identification~~** ~~Element B:~~ Population Assessment **PHM 2C** Activites and Resources **PHM 2D** ~~Element D:~~ Segmentation	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant to quality@lacare.org	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A ~~: Population Health Management Impact~~ ~~Element A:~~ Measuring Effectiveness ~~**Element B**~~**PHM6B~~:~~** ~~-~~Improvement and Action	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org .~~-~~	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder	Compliant with NCQA in accordance to Plan's accreditation submission

PHM 7C Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement		home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org .	
Title 28 California Code of Regulations Section 1300.67.2.2 **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds 2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25 2. Annually during PP Audit	1. L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Regulatory Reports/ Plan will also have the option to submit via email to remain compliant with due date. 2. L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 25th percentile for the Managed Care Accountability Set and the 25th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities. ~~* DHCS supplement to All Plan Letter (APL) 19-017 is to provide Medi-Cal managed care health plans (MCPs) with adjustments to quality and performance improvement requirements as a result of the current public health emergency resulting from COVID-19. These adjustments are consistent with recent allowances from the National Committee for Quality Assurance (NCQA).~~	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/. Plan will also have the option to submit via email to remain compliant to quality@lacare.org	The PDSA tool provided by DHCS
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			

UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Annually during PP audit 2-3. May 31	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	1. Narrative 2. HICE Quarterly Reporting format 3. HICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Annual and Quarterly UM Activity (HICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Annual 2022 Evaluation and 2023 Work Plan – February 15, 2023 Quarterly 1st Qtr – May ~~31~~ 2nd Qtr – Aug ~~31~~ 3rd Qtr – Nov ~~30~~ 4th Qtr – Feb ~~28~~	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	ICE Quarterly Reporting Format
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	L.A. Care Quarterly Reporting Format

PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) (Compliance folder.) Plan will also have the option to submit via email to remain compliant with due date.	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly	Anthem supports its compliance via its encounter submission	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care--member transition to other care, **a.** When their benefits end. **b.** During transition from pediatric care to adult care. (MM 22 Element D)	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	L.A. Care TOC Reporting Document and COC Log Template Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to Credinfo@lacare.org to remain compliant with due date.	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (HICE Format)
DMHC Survey			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards	Annually - March	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	

b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards (if applicable) c. Exhibit A-3 Timely Access Monitoring Policies and Procedures related to subdivision (c)(5) d. Exhibit A-4 Timely Access Monitoring policies and Procedures related to all other standards e. Exhibit C-1 Methodology f. Exhibit C-2 Incidents of Non-Compliance with Rule 1300.67.2.2 g. Exhibit C-3 Patterns of Non-Compliance with rule 1300.67.2.2 h. Exhibit D-1 Methodology for Verification of Advanced Access Program (if applicable) i. Exhibit D-2 List of Advanced Access Providers (if applicable) j. Exhibit E-1 Triage k. Exhibit E-2 Telemedicine l. Exhibit E-3 Health I.T. m. Exhibit F-1 Provider Satisfaction Survey Methodology (a) Policy & Procedures n. Exhibit F-1 Provider Satisfaction Survey Methodology (b) Survey Tool o. Exhibit F-1 Provider Satisfaction Survey Methodology (c) Detailed Explanation p. Exhibit F-2 Provider Satisfaction Survey Results q. Exhibit F3- Enrollee Satisfaction Survey Methodology (a) Policy and Procedures r. Exhibit F3- Enrollee Satisfaction Survey Methodology (b) Survey Tool s. Exhibit F3- Enrollee Satisfaction Survey Methodology (c) Detailed Explanation t. Exhibit F4- Enrollee Satisfaction Survey Results u. Quality Assurance Report			

v. Annual Provider Network Report Forms i. PCP ii. Specialists iii. Other Contracted iv. Hospitals and Clinics v. Telehealth vi. Service and Enrollment vii. Mental Health viii. Grievances			
1. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) 274 folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	No specific template. All DHCS reports submitted to L.A. Care within the month must be listed and signed by Plan Partner President
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 75 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain	DHCS approved template

		compliant with due date.	
~~4.~~ AB1455 Quarterly Reporting: Claims Timeliness Reports ~~4.~~ Provider Dispute Resolution (PDR) Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to LA Care 45 calendar days after quarter *The effective date will be based on the last date signed by the parties to support the full execution of this delegation agreement.	~~L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports~~ Plan will also have the option to submit via email to remain compliant with due date.	~~DMHC~~ HICE approved template
5. Call Center Report Mandated by APL 14-012 *DHCS retired effective December 31, 2019. However, Anthem to continue its submission directly to LA Care.	Quarterly – Due 30 days after quarter end	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Compliance folder ~~Plan will also have the option to submit via email to remain compliant with due date.~~	DHCS approved templates
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7~~5~~ business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
8. Coordinated Care Initiative – Long-Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template

~~9. Encounter Data Letters – CAP response~~	~~Quarterly – Due to L.A. Care 30 business days after receipt of CAP request~~	~~L.A. Care Regulatory Reporting via email~~	~~No specific template~~
~~10. Grievance Report Mandated by APL 14-013~~	~~Quarterly – Due to L.A. Care 5 business days prior to submission to DHCS~~	~~L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~DHCS approved template~~
~~11.~~9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012~~APL 14-010~~	Quarterly - Due to L.A. Care ~~5~~7 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
~~12. Out-of-Network (OON) Report~~	~~Quarterly – Due to L.A. Care 5 business days prior to submission to DHCS~~	~~L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~DHCS approved template~~
~~13.~~10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually – contingent of DHCS notice	DHCS SFTP with copy to LA Care Medical Payment Systems and Services Reporting	DHCS approved template
~~14. Pharmacy Formulary Changes Reports~~	~~Annually – Due to L.A. Care 5 business days prior to submission to DHCS~~	~~L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~DHCS approved template~~

~~15.~~11. Health Homes Program DHCS Required Reporting **DHCS retired effective December 31, 2021*	Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
12. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
~~16.~~14. CBAS Monthly Wavier Report	Monthly -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
15. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
~~17.~~16. Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements

~~18.~~17. Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~19.~~18. Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~20.~~19. Prop 56 Directed Payments for Valued Base Payment Program (APL 20-014)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~21.~~20. Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~22.~~21. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain	DHCS Template based on APL reporting requirements

		compliant with due date.	
~~23.~~22. MMDR MER Exemption Review Denial Report	Monthly - Due to L.A. Care 5 business days prior to submission to DHCS This deliverable is contingent of receiving a member list from L.A Care to support monthly report.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Reporting template
~~24.~~23. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report***	Monthly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~25. Third Party Liability~~	~~Due 25 days from the date LA Care submits case file.~~	~~L.A. Care Regulatory via its Secure File Transfer Protocal (SFTP) TPL folder~~	~~DHCS approved templates~~

		~~Plan will also have the option to submit via email to remain compliant with due date.~~	
24. Acute Care at Home Hospital Report APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS Reporting Template
25. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Quarterly - Due to L.A. Care 45 days after the quarter ends	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements
26. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
27. Third Party Liability	Due 25 days from the date LA Care submits case file.	L.A. Care Regulatory via its Secure File Transfer Protocal (SFTP) TPL folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
28. ECM and Community Supports Quarterly Report	Report due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS Reporting Template
~~26.~~29. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS *The effective date will be based on the last date signed by the parties to support the full execution of this delegation agreement.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
~~27.~~30. Disaster and Recovery Plan / Test Results L.A. Care will communicate all data elements as outlined by DHCS due to an	~~Contingent of DHCS notice~~	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	~~DHCS template~~ Word Document, Non-Specific template

emergency declared by the Governor. below including but not limited to: LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc Contingent on government notice; Ad-hoc	Plan will also have the option to submit via secure email to remain compliant with due date. EnterpriseRiskManagement@lacare.org home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Template may change upon regulators request.
FINANCIAL COMPLIANCE			
1. PPG Solvency Report 627	Quarterly - Due to L.A. Care 75 calendar days after each quarter end	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via secure email to remain compliant with due date.	Excel/PDF
2. Annual Audit Report 628	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted in the reporting quarter	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via secure email to remain compliant with due date.	Excel/PDF
DELEGATION OVERSIGHT			
1. New Member Welcome Kit Mailing Reports	Due to L.A. Care by the 15th of each month	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	

CULTURAL & LINGUISTIC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	Plan Partner can submit their own format of C&L program description and work plan.
2. C&L Program Evaluation NCQA HE Standard 7	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	Plan Partner can submit their own format of C&L program evaluation
3. Bilingual Staff List NCQA HE Standard 7	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
4. Translated Documents / Alternative Formats Tracking Log NCQA HE Standard 7	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
5. Interpreting Utilization Report (Face-to-face and Telephonic interpreting) NCQA HE Standard 7	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
6. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter:	L.A. Care's Secure File Transfer Protocol (SFTP)	L.A. Care report template

	• Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	*OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	*OR* Mutually agreed upon report format

HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and jtWork Plan	Annually – due to L.A. Care January 31st of each year	Via email to designated Health Education contact	As appropriate per Plan Partner model.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023~~2~~

By: _____
~~Hector De La Torre~~Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: _____, 2023~~2~~

Blue Cross of California dba Anthem Blue Cross
A California health care services plan

By: _____
Les Ybarra
President,
Medicaid Health Plan for California

Date: _____, 2023~~2~~

Amendment No. 48
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 48 is effective as of July 1, 2021, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Shield of California Promise Health Plan***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq.*) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

I. Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 48 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023~~2~~

Blue Shield of California Promise Health Plan,
A California health care services plan

By: _____
Kristen Cerf
President and Chief Executive Officer

Date: _____, 2023~~2~~

By: _____
~~Hector De La Torre~~Alvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: _____, 2023~~2~~

II. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2021-June 30, 2022
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Blue Shield of California Promise Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, (vii) claims recovery., and (viii) claims processing. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Blue Shield of California Promise Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Blue Shield of California Promise Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Blue Shield of California Promise Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Blue Shield of California Promise Health Plan as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Blue Shield of California Promise Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Blue Shield of California Promise Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Blue Shield of California Promise Health Plan, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS starting January 1, 2022, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. *L.A. Care will provide* ***delegate with Member Experience data: complaints, CAHPS, survey results or other data collected on members' experience with the delegate's services. In addition, will also provide Clinical performance data: HEDIS measures, claims and other clinical data collected by the organization. L.A. Care may provide data feeds for relevant claims data or clinical performance measure results*** *when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's delegate Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption.*

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY MANAGEMENT AND IMPROVEMENT	
Program Structure and Operations: Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated physician in the QI program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates'

Standard	Delegated Activities	Retained by L.A. Care
(NCQA —QI 1)	4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership **Annual Work Plan** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of performance in the quality and safety of clinical care and quality of service 3. evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. **Promoting Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Health Services Contracting : Applicable L.A. Care Policy: QI-007	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs;

Standard	Delegated Activities	Retained by L.A. Care
(NCQA- QI 2)	2. Practitioners allow the organization to use their performance data. **Provider Contracts** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities. 2. Practitioners allow the organization to use their performance data.	including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Continuity and Coordination of Medical Care: Applicable L.A. Care Policy: QI-0026 (NCQA -QI 3)	**Identifying Opportunities** The organization annually identifies opportunities to improve continuity and coordination of medical care across the network by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement. 5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement. **Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity identified in Element A, factor 4-7 2. Acting on the second opportunity identified in Element A, factor 4-7 3. Acting on the third opportunity identified in Element A, factor 4-7. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B. 3. The third opportunity identified in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
	Transition to Other Care Refer to Utilization Management Delegated Activities Section	
Continuity and Coordination Between Medical Care and Behavioral Healthcare: Applicable L.A. Care Policy: QI-0026 (NCQA -QI 4)	**Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information. 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care. 3. Appropriate use of psychotropic medications. 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness. **Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners. 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A. 4. Identifying and selecting a second opportunity for Improvement from Element A. 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; d. Standards for the availability of medical records	

Standard	Delegated Activities	Retained by L.A. Care
Sub-Delegation of QI: Applicable L.A. Care Policy: QI-007 (NCQA QI 5)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA -PHM 1)	**Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus. 2. Programs or Services offered to members. 3. Activities that are not direct member interventions,	

Standard	Delegated Activities	Retained by L.A. Care
	4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services. 3. How to opt in or opt out of the program	
Population Identification (NCQA- PHM 2)	**Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claim (Jul 1, 2021-Dec 31,2021) ~~2.~~3. Physician Administered Drugs (PAD) claim ~~3.~~4. Laboratory results ~~4.~~5. Health appraisal results ~~5.~~6. Electronic health records ~~6.~~7. Health Services programs within the organization ~~7.~~8. Advanced data sources **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs.	

Standard	Delegated Activities	Retained by L.A. Care
	Segmentation 1. segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA- PHM 3)	**Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering certified shared-decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. One additional activity to support practitioners or providers in achieving PHM goals	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.
Wellness and Prevention (NCQA -PHM 4)	**Frequency of Health Appraisal Completion** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer ~~an~~a health appraisal (HA) annually. **Topics of Self-Management Tools** The organization offers self-management tools derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating. 5. Managing stress. 6. Avoiding at-risk drinking. 7. Identifying depressive symptoms.	

Standard	Delegated Activities	Retained by L.A. Care
Complex Case Management (NCQA PHM 5)	**Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **Case Management Systems** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of the individual ID and date and time of action on the case when interaction with the member occurred; and 3. Automated prompts for follow-up as required by the case management plan. **Case Management Process** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Initial assessment of life planning activities 7. Evaluation of cultural and linguistic needs, preferences or limitations 8. Evaluation of visual and hearing needs, preferences or limitations 9. Evaluation of caregiver resources and involvement 10. Evaluation of available benefits 11. Evaluation of community resources 12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	13. Identification of barriers to the member meeting goals or complying with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans. 17. A process to assess members' progress against case management plans for members. **Initial Assessment** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living (ADL) 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the plan 3. Development of a schedule for follow-up and communication with members.	

Standard	Delegated Activities	Retained by L.A. Care
	4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA -PHM 6)	**<u>Measuring Effectiveness</u>** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **<u>Improvement and Action</u>** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA PHM 7)	**<u>Sub-Delegation Agreement</u>** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested.	

Standard	Delegated Activities	Retained by L.A. Care
	6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA -NET 1)	**Cultural Needs and Preferences** The organization: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually. **Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measureable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measureable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against standards annually	

Standard	Delegated Activities	Retained by L.A. Care
Accessibility of Services (NCQA NET 2)	**<u>Access to Primary Care</u>** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments; 2. Urgent care appointments; 3. After-hours care **<u>Access to Behavioral Healthcare</u>** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care. **<u>Access to Specialty Care</u>** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Assessment of Network Adequacy (NCQA NET 3)	**<u>Assessment of Member Experience Accessing the Network</u>** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element C and Element E. 3. Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **<u>Opportunities to Improve Access to Nonbehavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **<u>Opportunities to Improve Access Behavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of the interventions, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
Continued Access to Care (NCQA- NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section ~~**The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.**~~ **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section ~~If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:~~ Note: Review process is managed by L.A. Care Utilization Management team. ~~1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.~~ ~~2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.~~	
Physician and Hospital Directories (NCQA NET 5)	**Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Board certification 7. Accepting new patients 8. Language spoken by the physician or clinical staff 9. Office locations and phone numbers **Physician Directory Updates**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **Assessment of Physician Directory Accuracy** Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers 2. Accuracy of hospital affiliations 3. Accuracy of accepting new patients 4. Awareness of physician office staff of physician's participation in the organization's networks. **Identifying and Acting on Opportunities** Based on results of the analysis performed in Element C, at least annually the organization: 1. Identifies opportunities to improve the accuracy of the information in its physician directories. 2. Takes action to improve the accuracy of the information in its physician directory. **Searchable Physician Web Based Directory** The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Accepting new patients 7. Languages spoken by the physician or clinical staff 8. Office locations **Hospital Directory Data** The organization has a web-based hospital directory that includes the following: 1. Hospital name 2. Hospital location and phone number 3. Hospital accreditation status 4. Hospital quality data from recognized sources **Hospital Directory Updates**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level 2. Intuitive content organization 3. Ease of navigation 4. Directories in additional languages, if applicable to the membership **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print 2. Telephone	
Sub-Delegation of NET (NCQA NET 6)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its	

Standard	Delegated Activities	Retained by L.A. Care
	obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4 and QI 3)	**Notification of Termination (NET4)** The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. **Continued Access to Practitioners** If a practitioner's contract is discontinued the organization allows affected members continued access to practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **Transition to Other Care**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**<u>Written Program Description</u>** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes used to make determinations of benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. **<u>Annual Evaluation</u>** The organization annually evaluates and updates the UM program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA UM 2)	**<u>UM Criteria</u>** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews UM criteria and the procedures for applying them based on individual needs and assessment of the local delivery system, and updating as necessary. **<u>Availability of Criteria</u>** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **<u>Consistency in Applying Criteria</u>** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	2. Acts on opportunities to improve consistency, if applicable.	
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA UM 4)	**Licensed health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training and professional experience in medical or clinical practice 2. A current license to practice or an administrative license to review UM cases without restriction. **Practitioner Review of Nonbehavioral healthcare Denials** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses that a physician or appropriate behavioral healthcare practitioner, to review any behavioral healthcare denial of care based on medical necessity. . **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist reviews pharmacy denials based on medical necessity.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **Use of Board Certified Consultants** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations	
Timeliness of UM Decisions* (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaidurgent preservice decisions, the organization gives electronic or written	

Standard	Delegated Activities	Retained by L.A. Care
	notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace) **Timeliness Report** The organization monitors and submits a report for timeliness of: 1. 1. Non-behavioral UM decision making 2. 2. Notification of non-behavioral UM decisions 3. 3.Behavioral UM decision making 4. 4.Notification of behavioral UM decisions 5. Pharmacy UM decision making 6. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	

Standard	Delegated Activities	Retained by L.A. Care
	Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards ~~Note: This only applies to pharmaceuticals covered under the medical benefit.~~	
Clinical Information* (NCQA UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices* (NCQA UM 7)	**Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. **Written Notification of Nonbehavioral healthcare Denials** The organization's written notification of each non-behavioral denials, provided to members and their treating practitioners contains the following information: 1. The specific reason for denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based	

	3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written non-behavioral denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the members' rights to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decisions with a physician appropriate behavioral healthcare reviewer or pharmacist reviewer. **Written Notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials that it provided to members and their treating practitioners contains: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request **Written Notification of Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials which it provides to members and their treating practitioners contains the following information:	

	1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including members' right to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **Discussing a Pharmacy Denial with a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist **Written Notifications of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand. 2. A reference to the benefit provision guidelines protocol or similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision guideline protocol or similar criterion on which the denial decision was based, upon request. **Pharmacy Notice of Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights including the member's right to submit written comments documents or other information relevant to the appeal. 2. An explanation of the appeal process including the member's right to representation and the appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	

Policies for Appeals (NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request. 7. The decision for a post-service appeal and notification to the member within 60 calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 8. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 9. Notification to the member about further appeal rights. 10. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based 11. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. 12. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. Allowing an authorized representative to act on behalf of the member 14. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 15. Continued coverage pending the outcome of an appeal.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Appropriate Handling of Appeals* (NCQA UM 9)	**Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frames: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **Appeal Reviewers** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to and copies of all documents free of charge upon request. 5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures. **Final Internal and External Appeal Files**	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022- and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA ~~2020~~ UM 11)	**Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures 4. A process to provide procedures to practitioners annually and when it makes changes. **Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet website and update that posting with changes on a monthly basis (SB1052)	

	2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The process for generic substitution, therapeutic interchange and step-therapy protocols. **Pharmaceutical Patient Safety Issues** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **Reviewing and Updating Procedures** With the participation of physicians and pharmacists the organization annually: 1. Reviews the procedures 2. Reviews the list of pharmaceuticals 3. Updates the procedures as appropriate 4. Updates the list of pharmaceuticals, as appropriate, and 5. Post the list with changes on its Internet website on a monthly basis. (SB1052) **Considering Exceptions** The organization has exceptions policies and procedures that describe the process for: 1. Making exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of request 5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	

UM System Controls* (NCQA UM 12)	**UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **UM Denial System Controls Oversight** **At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by:** **1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.** **2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.** **3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.**	
Sub-Delegation of UM (NCQA UM 13)	**Sub-Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when request.	

	6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. Annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement if applicable.	
	CREDENTIALING	
Credentialing Policies (NCQA ~~2022~~ CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners to provide care to its members by developing and implementing credentialing policies and procedures which specify: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing.	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its

	4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions within sixty (60) calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data including education training board certification and specialty. The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing or recredentialing application 2. The right of practitioners to correct erroneous information and:	Delegates adhere to the standards delegated by L.A. Care.

	• The timeframe for making corrections. • The format for submitting corrections. • The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. 5. How the organization monitors its compliance with the processes and procedures in factors 1–4 at least annually and takes appropriate action when applicable.	
(DHCS APL 19-004)	**Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for practitioners whose enrollment application is in process. 3. The process for monitoring between recredentialing cycles to validate continued enrollment. 4. Process for practitioners not currently enrolled in the Medi-Cal program. 5. Process for practitioners deactivated, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In	

	addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA ~~2022~~ CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee: a. Includes representation from a range of participating practitioners to provide advice and expertise for credentialing decisions. b. Has the opportunity to review the credentials of all practitioners being credentialed or re-credentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. c. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria.	

Credentialing Verification (NCQA ~~2022~~ CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the NCQA prescribed time limits, through primary or other NCQA-approved sources prior to credentialing and recredentialing by: Verifying that the following are within the prescribed time limits: 1. Current, valid license to practice (develop a process to ensure providers licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate. • 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. 3. Verification of the highest of the following three levels of education and training obtained by the practitioners as appropriate: • Board certification if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. • Completion of a residency program. • Graduation from medical or professional school. 4. Work history. 5. Current malpractice insurance coverage ($1 million/$3 million). 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 7. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 8. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 9. CLIA Certifications, if applicable. 10. NPI number. 11. Medi-Cal FFS enrollment.	

	All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA ~~2022~~ CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing. a. State sanctions, restrictions on licensure, or limitations on scope of practice. b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA ~~2022~~ CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice insurance coverage. f. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA ~~2022~~ CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	

CR Ongoing Monitoring and Interventions (NCQA ~~2022~~ CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. b. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes. c. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. d. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. e. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: • Requesting what action will be taken by the Delegate. • What type of monitoring is being performed.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate. b. What type of monitoring is being performed. c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network. d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care.

	• What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. • The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. 6. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network. 8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA ~~2022~~ CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify: a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. 2. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
CR Assessment of Organizational Providers (NCQA ~~2022~~ CR 7) DHCS, DMHC, CMS	The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment if the provider is not accredited.	

	4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs). The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers. The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA ~~2022~~ CR 8) DHCS, DMHC, CMS	If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: a. Is mutually agreed upon. b. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. c. Requires at least quarterly reporting to Delegate. d. Describes the process by which Delegate evaluates sub-delegate's performance. e. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. f. Describes the remedies available to Delegate if sub-delegate does not fulfill its obligations,	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

	including revocation of the delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures. b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable. If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate 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 score.	

MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization its services its practitioners and providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their right to privacy. 3. A right to participate with practitioners in making decisions about their health care. 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage. 5. A right to voice complaints or appeals about the organization or the care it provides. 6. A right to make recommendations regarding the organization's member rights and responsibilities policy. 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners. 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

		L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**Subscriber Information** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ME 3)		**Materials and Presentations** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **Assessing Member Understanding** 1. Assesses how well new members understand policies and procedures. The right to approve

		the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA ME 4)	**<u>Functionality-Website</u>** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid **<u>Functionality-Telephone Requests</u>** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Pharmacy Benefit Information (NCQA ~~2020~~ ME 5)	**<u>Pharmacy Benefit Information-Website</u>** Members can complete the following actions on the website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process 3. Order a refill for an existing, unexpired mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. *According to SB1052 Blue Shield shall post the formulary on its internet website and update that posting on a monthly basis. **<u>Pharmacy Benefit Information Telephone</u>** Members can complete the following actions via telephone in one attempt or contact:	

	1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 3. Order a refill for an existing, unexpired, mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes. **QI Process on Accuracy of Information** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **Pharmacy Benefit Updates** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA -ME 6)	**Functionality-Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **Functionality Telephone** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by:	

	1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **E-mail Response Evaluation** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience Applicable L.A. Care Policy: QI-031 (NCQA ME 7)	**Policies and Procedures for Complaints** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken. 2. Investigating of the substance of complaints and actions taken. 3. Notification to members of the resolution of complaints and, if there is an adverse decision, the right to appeal. . 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the complaint process. **Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. **Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals**	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. **Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

	Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. **Annual Assessment of Behavioral Healthcare and Services** Using valid methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2. Identifying opportunities for improvement. 3. Implementing interventions, if applicable. 4. Measuring effectiveness of interventions, if applicable.	
Sub-Delegation of ME (NCQA -ME 8)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **Review of Performance** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement.	

	2. Annually evaluates delegate performance against NCQA standards for delegated activities. **<u>Opportunities for Improvement</u>** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week, by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone statistics at least quarterly 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. **D. Policies and Procedures** 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

	Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Quality Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required Note: ~~*~~L.A. Care will send delegate CLPPB data when they receive from DHCS on a ~~monthly or~~ quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to

	d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ 11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	request Plan Partner assistance as needed.
CULTURAL & LINGUISTIC REQUIREMENTS		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.	

	2Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: 2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to	

	providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	

California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

	confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis. c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	

Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial and annual education/training on cultural and linguistic requirements to providers, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language,	

	age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. 4. a. Awareness that culture and cultural beliefs may influence health and health care delivery. b. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. c. Skills to communicate effectively with diverse populations d. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services	

	f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	

Authority: Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter 17-004DHCS All Plan Letter 21-004	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services) 2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral*** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. 3. Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	
CLAIMS PROCESSING REQUIREMENTS		

Claims Processing (Title 28 California Code of Regulations Section 1300.71) Blood Lead Screening of Young Children APL 20-016	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims**: Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation**	

	Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time.	

	a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
~~NCQA~~ Delegation Agreement
[Attachment B]

Plan's Reporting Requirements
(Pharmacy reporting requirements are only applicable from July 1, 2021 to December 31, 2021)

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy * Reporting requirements for additional delegated activities 1. NCQA UM related a. **UM 4E:** Practitioner Review of Pharmacy Denials	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1-3. L.A. Care Reporting Format with data elements as defined in the Blue Shield Pharmacy Report Templates workbook, and

b. **UM 5:** Timeliness of Pharmacy UM Decision Making**UM 5C:** Notification of Pharmacy Decisions c. **UM 5D (factors 5&6):** UM Timeliness Report (Pharmacy) d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials g. **UM 7I:** Pharmacy Notice of Appeals Rights/Process h. **UM 9A** Preservice and Postservice Pharmacy Appeals i. **UM 9B:** Timeliness of the Pharmacy Appeal Process j. **UM 9C**: Pharmacy Appeal Reviewers k. **UM 9D**: Notification of Appeal Decision/Rights for Pharmacy l. **UM 12A:**UM Denial System Controls **2. DHCS Related** a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA decisions within 24 hours of receipt/Total PAs. - includes approval and denials, <u>excludes all early close and administrative denials</u> b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs. - includes approval and denials, <u>excludes all early close and administrative denials</u> 3. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded.			4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded c. Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 4. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization			
NCQA ME Pharmacy related reporting requirements 1. **ME :** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME :** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 – 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare

QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Quality Improvement Quarterly reporting requirements 1. **QI Workplan Update** **2. Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	QI Workplan Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. Quarterly PQI Report 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format

	July 15th (Reporting period Q1 &Q2)		ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

PHM 7C Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement			
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds 2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18 2. Annually during PP Audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
UTILIZATION MANAGEMENT			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/grievance/	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories: a. Quality of Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission

b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue~~s~~ e. ~~e.~~ Quality of Practitioner Office Site			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1~~.~~ Delegation Oversight to review. Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	ICE Quarterly Reporting Format

NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care--member transition to other care, **a.** When their benefits end, if necessary **b.** During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care TOC Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name,	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)

First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name			
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards (if applicable) c. Exhibit A-3 Timely Access Monitoring Policies and Procedures related to subdivision (c)(5) d. Exhibit A-4 Timely Access Monitoring policies and Procedures related to all other standards e. Exhibit C-1 Methodology f. Exhibit C-2 Incidents of Non-Compliance with Rule 1300.67.2.2 g. Exhibit C-3 Patterns of Non-Compliance with rule 1300.67.2.2 h. Exhibit D-1 Methodology for Verification of Advanced Access Program (if applicable) i. Exhibit D-2 List of Advanced Access Providers (if applicable) j. Exhibit E-1 Triage k. Exhibit E-2 Telemedicine l. Exhibit E-3 Health I.T. m. Exhibit F-1 Provider Satisfaction Survey Methodology (a) Policy & Procedures n. Exhibit F-1 Provider Satisfaction Survey Methodology (b) Survey Tool o. Exhibit F-1 Provider Satisfaction Survey Methodology (c) Detailed Explanation ~~m.~~ ~~n.~~p. Exhibit F-2 Provider Satisfaction Survey Results	Annually - March	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	

q. Exhibit F3- Enrollee Satisfaction Survey Methodology (a) Policy and Procedures r. Exhibit F3- Enrollee Satisfaction Survey Methodology (b) Survey Tool s. Exhibit F3- Enrollee Satisfaction Survey Methodology (c) Detailed Explanation ~~o.~~ t. Exhibit F4- Enrollee Satisfaction Survey Results ~~p.~~u. Quality Assurance Report ~~q.~~v. Annual Provider Network Report Forms i. PCP ii. Specialists iii. Other Contracted iv. Hospitals and Clinics ~~v. Out of Network~~ ~~vi.~~v. Telehealth ~~vii.~~vi. Service and Enrollment ~~viii.~~vii. Mental Health ~~ix.~~viii. Grievances			
2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) /home/ucfst/infile/274	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign

			off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
4. **Health Industry Collaboration Effort** AB1455 Quarterly Reports M/Q Medi-Cal Claims Timeliness Report AB1455 Pharmacy Claims Timeliness Reports Quarterly Provider Dispute Resolution (PDR) Report Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September • Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates

7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
8. Coordinated Care Initiative – Long- Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
11. Health Homes Program DHCS Required Reporting (Sunset CY 2022)	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period

14. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
15. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
16. Prop 56 Directed Payment for Physician Services Mandated by APL 19-015	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Financial Compliance provided Template based on APL reporting requirements
17. Prop 56 Hyde Reimbursement Requirements for specific Services Mandated by APL 19-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Prop 56 Directed Payments for Developmental Screening Services Mandated by APL 19-016	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
Prop 56 Directed Payments for Valued Base Payment Program Mandated by APL 20-014	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
19. Prop 56 Directed Payments for Family Planning Mandated by APL 20-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
20. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services Mandated by AP-19-018	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements

21. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) Mandated by APL 20-017 The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements
22. Acute Care at Home Hospital Report Mandated by APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**DHCS Reporting Template**
23. Blood Lead Screening Mandated by APL 20-016	Quarterly - Due to L.A. Care 45 days after the quarter ends	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**Regulatory Reports provided Template based on APL reporting requirements**
24. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template

25. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
26. Third Party Liability	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
27. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
28. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; 29. L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Word Document, Non-Specific template Template may change upon regulators request.
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			
1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Claims Delegates' Quarterly Timeliness Reporting will be included in 1(a) above – Oversight	~~Quarterly – Due to L.A. Care 75 calendar days after each quarter end~~	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF

Report on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements) Note: *Delegates consist of PPGs and capitated hospitals.			
2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates*** Note:* Delegates consist of PPGs and capitated hospitals.	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates Note: *Delegates consist of PPGs and capitated hospitals.	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of fieldwork conducted by BSC PHP.	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			

1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	Via email to designated Health Education contact	As appropriate per Plan Partner model.
CULTURAL AND LINGUISTC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor**.**
2. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023~~2~~

By: _____
~~Hector De La Torre~~Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: _____, 2023~~2~~

Blue Shield of California Promise Health Plan
A California health care services plan

By: _____
Kristen Cerf
President and Chief Executive Officer

Date: _____, 2023~~2~~

~~NHao~~Amendment No. ~~36~~41
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Kaiser Foundation Health Plan, Inc.

This Amendment No. ~~36~~ 41 is effective as of July 1, 2021~~20202021~~ ~~20202020~~20210, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Kaiser Foundation Health Plan, Inc.,*** a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq.*) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

I. Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.

IN WITNESS WHEREOF, the parties have entered into this Amendment No. ~~36~~ 41 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: _____
John Baackes
Chief Executive Officer

Date: _____, 202~~1~~2

Kaiser Foundation Health Plan, Inc.,
A California health care services plan

By: _____
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market~~Region (Interim)~~

Date: _____, 202~~1~~2

By: _____
Hector De La Torre
Chairperson
L.A. Care Board of Governors

Date: _____, 202~~1~~2

II. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Kaiser Foundation Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management, (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, ~~and (vii) claims recovery~~, and (viii) claims processing.~~.~~ All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Kaiser Foundation Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Kaiser Foundation Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Kaiser Foundation Health Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Kaiser Foundation Health Plan as described elsewhere in the Services Agreement. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS ~~in 2021~~starting January 1,~~-~~2022 ~~2021~~, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. In the event deficiencies are identified through this oversight, Kaiser Foundation Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Kaiser Foundation Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Kaiser Foundation Health Plan, in whole or in part, in accordance with Exhibit 5, herein. L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business~~Business~~ Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY	
Program Structure and Operations (NCQA ~~2021~~0-2022~~2020~~ QI 1) QI	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated physician in the QI program 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	~~6. Objectives for serving a culturally and linguistically diverse membership~~ **Annual Work Plan** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: • 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • 2. Trending of measures of ~~to assess~~ performance in the quality and safety of clinical care and quality of service • 3. ~~Analysis and~~ evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate.	
Health Services Contracting (NCQA 2021~~0~~-2022~~2020~~ QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities; 2. Practitioners allow the organization to use their performance data. ~~**Provider Contracts**~~ ~~Contracts with organization providers specifically require that:~~ ~~1. Providers cooperate with QI activities;~~ ~~2. Providers allow the plan to use their performance data~~	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination of Medical Care (NCQA 2021~~0~~-2022~~2020~~ QI 3)	**Continuity and Coordination of Medical Care** The organization annually identifies opportunities to improve coordination of medical care by: 1. Collecting data on member movement between practitioners 2. Collecting data on member movement across settings 3. Conducting quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting one opportunity for improvement 5. Identifying and selecting a second opportunity for improvement 6. Identifying and selecting a third opportunity for improvement 7. Identifying and selecting a fourth opportunity for improvement **Acting of Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity identified in Element A, factors~~factor~~ 4-7 2. Acting on the second opportunity identified in Element A, factors~~factor~~ ~~5~~ 4-7 3. Acting on the third opportunity identified in Element A, factors~~factor~~ ~~6~~ 4-7 **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B. 3. The third opportunity in Element B. **Transition to other care** Refer to Utilization Management Delegated Activities Section	
Continuity and Coordination between Medical and Behavioral Healthcare (NCQA 2021~~0~~-2022~~2020~~ QI 4)	**Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: ~~4.~~1. Exchange of information ~~5.~~2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care ~~6.~~ Appropriate use of psychotropic medications 3.	

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. ~~7.~~ Primary or secondary preventive behavioral healthcare program implementation. 5. ~~2.~~6. Special needs of members with severe and persistent mental illness. **Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and ~~causal~~ qualitative analysis of data to identify improvement opportunities ~~3.~~ Identifying and selecting one opportunity for improvement from Element A 3. ~~1.~~4. Identifying and selecting a second opportunity for improvement from Element A ~~4.~~ Taking collaborative action to address one identified opportunities for improvement from Element A 5. ~~2.~~6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: ~~**III.**~~1. The first opportunity in Element B. ~~**IV.**~~2. The second opportunity in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed, and organized, and which permits effective and confidential patient care and quality review, including: ~~a.~~1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records b. Medical record documentation standards ~~a.~~i. Requirements for an organized medical record c. Standards for the availability of medical records	

Sub-~~Sub~~-delegation Delegation of QI (NCQA 2021~~0~~-2022~~2020~~ QI 5~~7~~	**Element A: Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity ~~3.~~ Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. ~~1.~~4. Describes the process by which the delegate evaluates the sub-delegated entity's performance ~~4.~~ Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 5. ~~2.~~6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of QI Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's QI program 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA 20210 2022~~2020~~ PHM 1)	**Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. ~~3.~~ Activities that are not direct member interventions, 3. ~~1.~~4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services 3. How to opt in or opt out of the program	

Population Identification (NCQA 20210-20222020 PHM 2)	**Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claims 3. Laboratory results 3. 1.4. Health appraisal results 4. Electronic health records 5. 2.6. Health Services programs within the organization 5.7. Advanced data sources **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population 2. Identifies and assesses the needs of relevant member subpopulations 3. Assesses the needs of child and adolescent members 2. 1.3. Assesses the needs of members with disabilities 4. Needs of members with serious and persistent mental illness (SPMI) 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member needs 3. Review and update activities or resources to address health care disparities for at least one identified populations. 2.4. Review community resources for integration into program offerings to address member needs **Segmentation** 1. At least annually, the organization segments or stratifies its entire population into subset for targeted intervention.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA 20210-20222020 PHM 3)	~~**Practitioner or Provider Support**~~ ~~The organization supports practitioners or providers in its network to achieve population health management goals by:~~ ~~1. Sharing Data~~ ~~2. Offering certified shared decision making aids~~ ~~3. Providing practice transformation support to primary care practitioners~~ ~~4. Providing comparative quality information on selected specialties~~ ~~5. Providing comparative pricing information for selected services~~ ~~6.~~ ~~1. Sharing data~~ ~~7. Offering certified shared decision making aids~~ ~~2. Providing practice transformation support to primary care practitioners~~ ~~1. Providing comparative quality information on selected specialties~~ ~~8. Providing comparative pricing information for selected services~~ ~~2. One additional activity to support practitioners or providers in achieving PHM goals~~ **Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering evidence-based or certified decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. Providing training on equity, cultural competency, bias, diversity and inclusion. 1.	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Standard	Delegated Activities	Retained by L.A. Care
Wellness and Prevention (NCQA 2020 PHM 4)	**Frequency of Health Appraisal Completion** The organization has the capability to administer an HA annually **Topics of Self-Management Tools** The organization offers self-management tools, derived from available evidence, that provides members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. ~~1.~~ Healthy eating. 4. ~~4.~~5. Managing stress. ~~2.~~ Avoiding at-risk drinking. 6. ~~5.~~7. Identifying depressive symptoms.	
Complex Case Management (NCQA 2020 PHM 5)	**Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: ~~a.~~1. Medical management program referral ~~b.~~2. Discharge planner referral ~~c.~~3. Member or caregiver referral ~~1.~~a. Practitioner referral. **Case Management Systems** The organization uses case management systems that support: ~~a.~~1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; ~~b.~~2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred ~~c.~~3. Automated prompts for follow-up, as required by the case management plan.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	Case Management Process The organization's complex case management procedures address the following: ~~a.~~1. Initial assessment of member health status, including condition-specific issues ~~b.~~2. Documentation of clinical history, including medications ~~c.~~3. Initial assessment of activities of daily living ~~1.~~a. Initial assessment of behavioral health status, including cognitive functions ~~d.~~4. Initial assessment of social determinants of health ~~2.~~b. Initial assessment of life planning activities ~~e.~~5. Evaluation of cultural and linguistic needs, preferences or limitations ~~f.~~6. Evaluation of visual and hearing needs, preferences or limitations ~~3.~~c. Evaluation of caregiver resources and involvement ~~g.~~7. Evaluation of available benefits ~~h.~~8. Evaluation of community resources ~~4.~~d. Development of an individualized case management plan, including prioritized goals that considers the member's and caregiver's goals, preferences and desired level of involvement in the case management plan ~~5.~~e. Identification of barriers to a member meeting goals or complying with the case management plan ~~6.~~f. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals ~~7.~~g. Development of a schedule for follow-up and communication with members ~~8.~~h. Development and communication of a member self-management plan ~~9.~~i. A process to assess member progress against case management plan **Initial Assessment** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for: ~~a)~~1. Initial assessment of members' health status, including condition-specific issues	

Standard	Delegated Activities	Retained by L.A. Care
	~~b)~~2. Documentation of clinical history, including medications ~~c)~~3. Initial assessment of activities of daily living ~~1.~~a) Initial assessment of mental health status, including cognitive functions ~~d)~~4. Initial assessment of social determinants of health ~~2.~~b) Evaluation of cultural and linguistic needs, preferences or limitations ~~e)~~5. Evaluation of visual and hearing needs, preferences or limitations ~~f)~~6. Evaluation of caregiver resources and involvement ~~3.~~c) Evaluation of available benefits ~~g)~~7. Evaluation of available community resources ~~4.~~d) Assessment of life planning activities. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: ~~a)~~1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program ~~b)~~2. Identification of barriers to meeting goals and complying with the plan ~~c)~~3. Development of a schedule for follow-up and communication with members. ~~2.~~a) Development and communication of member self-management plans; and ~~d)~~4. Assessment of progress against the case management plans and goals and modification as needed.	

Standard	Delegated Activities	Retained by L.A. Care
Population Health Management Impact (NCQA 2020 PHM 6)	**Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **Improvement and Action** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	

Standard	Delegated Activities	Retained by L.A. Care
Sub-delegation Delegation of PHM (NCQA 2021~~0~~-2022~~2020~~ PHM 7)	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon ~~2.~~ Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 2. ~~3.~~ Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. ~~1.~~4. Describes the process by which the delegate evaluates the sub-delegated entity's performance ~~4.~~ Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 5. ~~2.~~6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable ~~3.~~ Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. ~~1.~~4. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA 2021~~0~~-2022~~2020~~ NET 1)	**Cultural Needs and Preferences** The organization: ~~2.~~1. Assesses the cultural, ethnic, racial, and linguistic needs of its members ~~3.~~2. Adjusts the availability of practitioners within its network, if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics by: •1. Establishes measurable standards for the number of each type of practitioner providing primary care •2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care •3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care ~~1.~~• Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of practitioners who serve as high volume and high impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists ~~3.~~ Establishes measurable standards for the geographic distribution of each type of high-volume specialist 3. ~~1.~~4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist ~~4.~~5. Analyzes its performance against the established standards at least annually **Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization:	

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~**a.** Defines the types of high volume behavioral healthcare practitioners ~~2.~~**b.** Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner ~~3.~~**c.** Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner ~~4.~~**d.** Analyze performance against the standards at least annually	
Accessibility of Services (NCQA 2021~~0~~-2022~~2020~~ NET 2)	**Access to Primary Care** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: ~~2.~~1. Regular and routine care appointments ~~3.~~2. Urgent care appointments ~~4.~~3. After-hours care. **Access to Behavioral Healthcare:** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care **Access to Specialty Care** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Assessment of Network Adequacy (NCQA 2021~~0~~-2022~~2020~~ NET 3)	**Assessment of Member Experience Accessing the Network** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ~~Member Experience standards for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals and Nonbehavioral Opportunities for Improvement.~~ ME 7, Element C and Element D.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ~~the Member Experience standard for Annual Assessment of Behavioral Healthcare and Services.~~ ME 7, Element C and Element D. ~~3.~~ Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 3. ~~3.~~4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **Opportunities to Improve Access to Nonbehavioral Healthcare Services** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability, ~~accessibility and member experience accessing the network~~. **(NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).** 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: ~~1. Prioritizes improvement opportunities for improvement identified from analyses of availability, accessibility, and member experience accessing the network.~~ 1. 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable.	
Continued Access to Care	**Notification of Termination**	

Standard	Delegated Activities	Retained by L.A. Care
(NCQA 2020 NET 4)	Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section	
Physician and Hospital Directories (NCQA 2020 NET 5)	**Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: ~~a.~~1. Name ~~b.~~2. Gender ~~c.~~3. Specialty ~~1.~~a. Hospital affiliations ~~d.~~4. Medical group affiliations ~~2.~~b. Board certification ~~e.~~5. Accepting new patients ~~f.~~6. Language spoken by the physician or clinical staff ~~3.~~c. Office locations and phone numbers **Physician Directory Updates** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **Assessment of Physician Directory Accuracy** Using valid methodology, the organization performs an annual evaluation of its physician directories for: ~~a.~~1. Accuracy of office locations and phone numbers ~~b.~~2. Accuracy of hospital affiliations ~~c.~~3. Accuracy of accepting new patients ~~1.~~a. Awareness of physician office staff of physician's participation in the organization's network **Identifying and Acting on Opportunities** Based on results of the analysis performed in Element C, at least annually, the organization: ~~a.~~1. Identifies opportunities to improve the accuracy of the information in its physician directories ~~b.~~2. Takes action to improve the accuracy of the information in its physician directories	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Searchable Physician Web-Based Directory The organization's web-based physician directory includes search functions with instructions for finding the following physician information: ~~a.~~1. Name ~~b.~~2. Gender ~~c.~~3. Specialty ~~1.~~a. Hospital affiliations ~~d.~~4. Medical group affiliations ~~2.~~b. Accepting new patients ~~e.~~5. Languages spoken by the physician or clinical staff ~~f.~~6. Office locations **Hospital Directory Data** The organization has a web-based hospital directory that includes the following information: 1. Hospital name 2. Hospital location and phone number ~~3.~~ Hospital accreditation status 3. ~~1.~~4. Hospital quality data from recognized sources **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: ~~a.~~1. Reading level ~~b.~~2. Intuitive content organization ~~c.~~3. Ease of navigation	

Standard	Delegated Activities	Retained by L.A. Care
	~~4.~~a. Directories in additional languages, if applicable to membership **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: ~~a.~~1. Print ~~b.~~2. Telephone	
Sub-Delegation of NET (NCQA 2020 NET 67	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity ~~3.~~ Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance ~~4.~~ Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 5. ~~5.~~6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the organization: ~~I.~~ Annually reviews its sub-delegate's network management procedures 1. ~~II.~~2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities	

Standard	Delegated Activities	Retained by L.A. Care
	~~III.~~1. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA 2020 NET 4and QI 3)	**Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family, and internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helping the member select a new practitioner. **Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **Transition to Other Care** The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA 2020 UM 1)	**Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program ~~3.~~ Involvement of a designated senior-level physician in UM program implementation 3. ~~1.~~4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	~~4.~~ The program scope and processes to determine benefit coverage and medical necessity 5. ~~2.~~6. Information sources used to determine benefit coverage and medical necessity. **Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary.	
Clinical Criteria for UM Decisions (NCQA 2020 UM 2)	**UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs ~~3.~~ Has written policies for applying the criteria based on an assessment of the local delivery system 3. ~~1.~~4. Involves appropriate practitioners in developing, adopting, and reviewing criteria ~~4.~~5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA 2020 UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners including: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours	

Standard	Delegated Activities	Retained by L.A. Care
	3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals* (NCQA 2020 UM 4)	**Appropriate Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: ~~b.~~1. Education, training, or professional experience in medical or clinical practice ~~c.~~2. A current clinical license to practice or an administrative license to review UM cases **Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional, as appropriate, to review any non-behavioral healthcare denial based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician, appropriate behavioral healthcare practitioners, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity. **Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Timeliness of UM Decisions (NCQA 2020 UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. N/A (Marketplace) ~~1.~~2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request ~~2.~~ For Medicaid urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 3. ~~3.~~4. For Medicaid non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within fourteen (14) calendar days of the request ~~3.~~5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: ~~1.~~ N/A (Marketplace) 1. ~~1.~~2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request ~~2.~~ For Medicaid urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 3. ~~3.~~4. For Medicaid non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to	

Standard	Delegated Activities	Retained by L.A. Care
	practitioners and members within fourteen (14) calendar days of the request ~~3.~~5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within twenty-four (24) hours of the request 2. For Medicaid urgent preservice decisions, electronic or written notification of the decision to members and practitioners within seventy-two (72) hours of the request ~~3.~~ For Medicaid non-urgent pre-service decisions, electronic or written notification of the decision to members and practitioners within fifteen (15) calendar days of the request 3. ~~8.~~4. For Medicaid post service decisions, electronic or written notification of the decision to members and practitioners within thirty (30) calendar days of the request. ~~4.~~ N/A (Medicare and Marketplace) 5. ~~9.~~6. N/A (Medicare and Marketplace) ~~5.~~7. N/A (Medicare and Marketplace) **UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Non-behavioral UM decision making 2. Notification of non-behavioral UM decisions ~~3.~~ Behavioral UM decision making 3. ~~1.~~4. Notification of behavioral UM decisions ~~4.~~ Pharmacy UM decision making 5. ~~2.~~6. Notification of pharmacy UM decisions. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California***	

Standard	Delegated Activities	Retained by L.A. Care
	Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards	
Clinical Information (NCQA 2020 UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision-making. **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision-making.	
Denial Notices (NCQA 2020 UM 7)	**Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer **Written Notification of Nonbehavioral Healthcare Denials** The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written non-behavioral healthcare denial notifications to members and their treating practitioners contains the following information:	

Standard	Delegated Activities	Retained by L.A. Care
	1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer **Written notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains: ~~A.~~1. The specific reasons for the denial, in easily understandable language ~~A.~~2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based ~~A.~~3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information: ~~I.~~1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal ~~I.~~2. An explanation of the appeal process, including the right to member	

Standard	Delegated Activities	Retained by L.A. Care
	representation and time frames for deciding appeals ~~H.~~ A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 3. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Discussing a Pharmacy Denial With a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist. **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: ~~a.~~1. The specific reasons for the denial, in language that is easy to understand ~~b.~~2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. **Pharmacy Notice of Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: ~~2.~~1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal ~~3.~~2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals ~~4.~~3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials ~~5.~~4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care	

Standard	Delegated Activities	Retained by L.A. Care
Policies for Appeals (NCQA 2020 UM 8)	**Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals must follow all current regulations and include but not limited totoinclude the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 3. 1.4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 4. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 5. 2.6. Appointment of at least one person to review an appeal who is a practitioner in the same (defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems) specialty. 5.7. The decision for a pre-service appeal and notification to the member within thirty (30) calendar days of receipt of the request. 6. The decision for a post-service appeal and notification to the member within sixty (60) calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 8. 3.9. The decision for an expedited appeal and notification to the member within seventy-two (72) hours of receipt of the request 7. Notification to the member about further appeal rights 10.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. The Delegate will supply L.A. with requested documentation for processing and investigating appeals and grievances filed by the member. Timeframes for supplying the requested information will be 7 calendar days for standard appeals or grievances and 24 hour or less for expedited appeal or grievances. Part B appeals 24 hours. The Delegate will assist L.A. Care in remaining in compliance with all regulatory guidelines and requests. The Delegate will supply L.A. Care with any requested documentation required to conduct research for any Regulatory inquires made by our Regulators within 24 hours or less contingent upon the turnaround times established by the Regulator.

Standard	Delegated Activities	Retained by L.A. Care
	4.11. Referencing the benefit provision guideline, protocol or other similar criterion on which the appeal decision is based 8. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request 12. 5. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. 6. Allowing an authorized representative to act on behalf of the member 14. 7. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner 15. 8.16. Continued coverage pending the outcome of an appeal	
Appropriate Handling of Appeals (NCQA 2020 UM 9)	**Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documentation of the substance of appeals 2. Investigation of appeals 3. Appropriate response to the substance of the appeal. **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice, and expedited appeal process is within the specified time frames: a.1. The organization resolves preservice appeals within thirty (30) calendar days of receipt of the request b.2. The organization resolves postservice appeals within thirty (30) calendar days of receipt of the request c.3. The organization resolves expedited appeals within seventy-two (72) hours of receipt of the request **Appeal Reviewers** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **Notification of Appeal Decision/Rights**	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	An NCQA review of the organization's internal appeal files indicates notification to members of the following: ~~A.~~1. Specific reasons for the appeal decision, in easily understandable language ~~A.~~2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based ~~B.~~ Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request 3. ~~1.~~4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request ~~A.~~ A list of titles and qualifications, including specialties, of individuals participating in the appeal review 5. ~~2.~~6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA 2020 UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, pharmaceuticals, and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state

Standard	Delegated Activities	Retained by L.A. Care
		mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures ~~Procedures for Pharmaceutical Management (NCQA 2020 UM 11)~~	~~**Pharmaceutical Management Procedures**~~ ~~The organization's policies and procedures for pharmaceutical management include the following:~~ ~~a) The criteria used to adopt pharmaceutical management procedures~~ ~~b) A process that uses clinical evidence from appropriate external organizations~~ ~~c) A process to include pharmacists and appropriate practitioners in the development of procedures~~ ~~9. A process to provide procedures to practitioners annually and when it makes changes.~~ ~~**Pharmaceutical Restrictions/Preferences**~~ ~~Annually, and after updates, the organization communicates to members and prescribing practitioners:~~ ~~a) A list of pharmaceuticals including restrictions and preferences to post on its Internet website on a monthly basis. (SB1052)~~ ~~b) How to use the pharmaceutical management procedures~~ ~~c) An explanation of limits or quotas~~ ~~1. How prescribing practitioners must provide information to support an exception request~~ ~~d) The organization's process for generic substitution, therapeutic interchange, and step therapy protocols.~~ ~~**Pharmaceutical Patient Safety Issues**~~ ~~The organization's pharmaceutical procedures include:~~ ~~a. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification~~ ~~b. An expedited process for prompt identification and notification of members~~	

Standard	Delegated Activities	Retained by L.A. Care
	~~and prescribing practitioners affected by a Class I recall.~~ ~~**Reviewing and Updating Procedures**~~ ~~With the participation of physicians and pharmacists, the organization annually:~~ ~~1. Reviews the procedures~~ ~~2. Reviews the list of pharmaceuticals~~ ~~3. Updates the procedures as appropriate~~ ~~5. Updates the list of pharmaceuticals as appropriate~~ ~~4. Posts the list with changes on its Internet website on a monthly basis. (SB1052)~~ ~~**Considering Exceptions**~~ ~~The organization has exceptions policies and procedures that describe the process for:~~ ~~2. Making an exception request based on medical necessity~~ ~~3. Obtaining medical necessity information from prescribing practitioners~~ ~~4. Using appropriate pharmacists and practitioners to consider exception requests~~ ~~1. Timely handling of exception requests~~ 5. ~~Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request~~.	
UM System Controls (NCQA 2020 UM 12)	**<u>UM Denial System Controls</u>** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **<u>UM Appeal System Controls</u>**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6.	
Sub-Delegation of UM (NCQA 2020 UM 13)	**Sub-Delegation Agreement** A written sub-delegation agreement: ~~d)~~a. Is mutually agreed upon ~~e)~~b. Describes the sub-delegated activities and responsibilities of Delegate and Sub-delegated entity ~~f)~~c. Requires at least semiannual reporting from Sub-delegate to Delegate ~~g)~~d. Describes the process by which Delegate evaluates Sub-delegate's performance ~~h)~~e. Describes the process for providing member experience and clinical performance data to its delegates when requested ~~i)~~f. Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Pre-delegation Evaluation** For new delegation agreements initiated in the look-back period, the delegate evaluated sub-delegate capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its Sub-delegate's UM program 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities	

Standard	Delegated Activities	Retained by L.A. Care
	4. Semiannually evaluates regular reports as specified in the sub-delegation agreement 5. Annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. ~~4.~~ **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed-up on opportunities for improvement, if applicable.	
	CREDENTIALING	
Credentialing Policies (NCQA ~~2020~~ 2022 CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners to provide care to its members. The organization specifies: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval	L.A. Care retains the right, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the organization does not base credentialing and recredentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process for notifying practitioners of the credentialing and recredentialing decisions within sixty (60) calendar days of the committee's decision 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification, and specialty. ~~**Medi-Cal FFS Enrollment**~~ ~~Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to:~~ ~~1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.~~ ~~2. The process for ensuring and verifying Medi-Cal enrollment.~~ ~~3. The process for practitioners whose enrollment application is in process.~~ ~~4. The process for monitoring between recredentialing cycles to validate continued enrollment.~~	

Standard	Delegated Activities	Retained by L.A. Care
	~~5. Process for practitioners not currently enrolled in the Medi-Cal program.~~ ~~6. Process for practitioners deactivated or suspended from the Medi-Cal program.~~ The organization notifies practitioners about: ~~their right to:~~ ~~4.~~ The right of practitioners to review information submitted to support their credentialing application ~~5.~~a. The right of practitioners to correct erroneous information: • i. The timeframe for making corrections. • ii. The format for submitting corrections. • iii. The person to whom the corrections must be submitted. ~~6.~~b. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. ~~1.~~2. How modified information is tracked and dated from its initial verification. ~~2.~~ Titles or roles of s~~S~~taff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 3. ~~2.~~4. The security controls in place to protect the information from unauthorized modification ~~1.~~5. How the organization monitors its compliance with ~~audits~~ the processes and procedures in factors 1–4~~.~~at least annually and takes appropriate action when applicable. At least annually, the organization demonstrates that it monitors compliance with its CR controls by: 1. Identifying all modifications to credentialing and recredentialing	

Standard	Delegated Activities	Retained by L.A. Care
(DHCS APL 19-004)	information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement from one finding over three consecutive quarters. ~~During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their process does not match their policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.~~ **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 1. ~~The~~ process for ensuring and verifying Medi-Cal enrollment. The process for practitioners whose enrollment application is in process. 2. ~~The~~ process for monitoring between recredentialing cycles to validate continued enrollment. 3. Process for practitioners not currently enrolled in the Medi-Cal program. 4. Process for practitioners deactivated or suspended from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their process does not match their policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	

Standard	Delegated Activities	Retained by L.A. Care
Credentialing Committee (NCQA ~~2020~~ 2022 CR 2) DMHC, DHCS, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and re-credentialing decisions such that the organization's Credentialing Committee: 1. Includes representation from a range of participating practitioners, and provides advice and expertise for credentialing decisions 2. Has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. 3. The Medical Director, designated physician or ~~equally qualified individual~~ credentialing committee reviews and approves files that meet the Delegate's established criteria.	
Credentialing Verification (NCQA ~~2020~~ 2022 CR 3) DMHC, DHCS, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, prior to credentialing and recredentialing The organization verifies that the following are within the prescribed time limits: 1. Current, valid license to practice (Develop a process to ensure providers' licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: ~~a.~~• Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate ~~b.~~• Requiring an explanation from a qualified practitioner who does not prescribe medications and provides arrangements for the practitioner's patients who need prescriptions for medications. 3. Verification of the highest of the following three levels of education and training obtained by the practitioner as appropriate: • Board certified if practitioner stated on the application that he/she is board certified, as well as expiration date of certification.	

Standard	Delegated Activities	Retained by L.A. Care
	• Completion of a residency program. • Graduation from medical or professional school. 4. Work history. 5. Current malpractice insurance coverage ($1 million/$3 million). 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 7. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 8. Current, valid FSR/MRR of primary care physician offices within 3 years prior to credentialing decision. 9. CLIA Certifications, if applicable. 10. NPI number. 11. Medi-Cal FFS enrollment All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA ~~2020~~2022 CR 3) DMHC, DHCS, CMS	The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, or limitations on scope of practice. 2. Medicare and Medicaid sanctions. ~~3.~~ *Medicare Opt-out. ~~2.~~3. SAM. 4. CMS Preclusion The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA ~~2020~~2022 CR 3) DMHC, DHCS, CMS	Applications for credentialing and recredentialing include the following: 1. Reasons for inability to perform the essential functions of the position, with or without accommodation 2. Lack of present illegal drug use ~~3.~~ History of loss of license and felony convictions 3.	

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~4. History of loss or limitation of privileges or disciplinary action ~~4.~~ Current malpractice insurance coverage 5. ~~2.~~6. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA ~~2020~~2022 CR 4) DMHC, DHCS, CMS	The length of the recredentialing cycle is within the required 36-month time frame. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA ~~2020~~2022 CR 5) DMHC, DHCS, CMS	Developing and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: •1. Collecting and reviewing Medicare and Medicaid sanctions. •2. Collecting and reviewing sanctions or limitations on licensure. •3. Collecting and reviewing complaints. ~~1.~~• Collecting and reviewing information from identified adverse events. •4. Implementing appropriate interventions when Delegate identifies instances of poor quality. ~~a.~~ 5. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring ~~1.~~a. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes ~~2.~~b. The Delegate's credentialing committee can: •1. 6. Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. ~~1.~~ Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate b. What type of monitoring is being performed c. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to Plan to ensure Plan's members receive the highest level of quality care.

Standard	Delegated Activities	Retained by L.A. Care
	• 7. Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. ~~3.~~ 8. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in Plan's policies and procedures ~~b.~~ 9. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: •1. Requesting what action will be taken by the Delegate. •2. What type of monitoring is being performed. •3. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. •4. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. ~~f.~~a. In the event that the Delegate fails to respond as required, the Plan will perform the oversight functions of the Adverse Event and the Delegate will be subject to Plan's credentialing committee's outcome of the adverse events. ~~g.~~b. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network ~~h.~~c. The above are samples, but not limited to, the steps the Delegate can take.	
Credentialing: Notification to Authorities and Practitioner Appeal Rights (NCQA ~~2020~~2022 CR 6) DMHC, DHCS, CMS	The Delegate uses objective evidence and patient care consideration when deciding on a course of action for dealing with a practitioner who does not meet its quality standards. The organization has policies and procedures specify for: ~~a.~~1. The range of actions available to Delegate ~~b.~~2. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. ~~c.~~3. The range of actions that may be taken to improve practitioner performance before termination. ~~1.~~a. That the Delegate reports its actions to the appropriate authorities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review ~~and~~ or more frequently, as required, per changes in contract, Federal and State regulatory guidelines, and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	~~d.~~4. Making the appeal process known to practitioners. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA ~~2020~~2022 CR 7) DMHC, DHCS, CMS	The delegate's organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider organization is in good standing with state and federal regulatory bodies. 2. Confirms that the provider organization has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment is conducted if the provider organization is not accredited by an accrediting body acceptable to Delegate, including which accredited bodies are acceptable. 4. At least every three years that the provider organization continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The organization includes at least the following medical providers in its assessment: ~~c.~~1. Hospitals. ~~d.~~2. Home health agencies. ~~e.~~ Skilled nursing facilities. 3. ~~5.~~4. Freestanding surgical centers. ~~f.~~ *Hospices. 5. 6. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA).	

Standard	Delegated Activities	Retained by L.A. Care
	~~g.~~7. *Comprehensive Rehabilitation Facilities (CORFs). ~~h.~~ *Outpatient Physical Therapy and Speech Pathology Providers. 8. ~~7.~~9. *Providers of end-stage renal disease services. ~~i.~~ *Providers of outpatient diabetes self-management training. 10. ~~8.~~11. *Portable X-Ray Suppliers. ~~j.~~ *Rural Health Clinic (RHCs). 12. ~~9.~~13. Federally Qualified Health Center (FQHCs). The organization includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory. The delegate assesses contracted medical health care providers. The delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA ~~2020~~2022 CR 8) DMHC, DHCS, CMS	If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including the written sub-delegation agreement that: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. ~~3.~~ Requires at least quarterly reporting to Delegate. 3. 4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. ~~4.~~ Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 5. ~~5.~~6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	obligations including revocation of the sub-delegation agreement. Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. For new sub-delegation agreements initiated in the look-back period, the delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. For sub-delegation arrangements in effect for 12 months or longer, the Delegate: 1. Annually reviews its sub-delegate's credentialing policies and procedures. ~~1.~~ 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. ~~2.~~ 3. Annually evaluates the sub-delegate's performance against relevant regulatory requirements, NCQA standards, and Delegate's expectations annually. 4. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. 5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	

Standard	Delegated Activities	Retained by L.A. Care
	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate 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 score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA 2020 ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities ~~1.~~2. A right to be treated with respect and recognition of their dignity and right to privacy ~~2.~~3. A right to participate with practitioners in making decisions about their health care ~~1.~~ 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage ~~3.~~5. A right to voice complaints or appeals about the organization or the care it provides ~~2.~~ 6. A right to make recommendations regarding the organization's member rights and responsibilities policy ~~4.~~ 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care ~~5.~~8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners ~~3.~~ 9. A responsibility to understand their health problems and

Standard	Delegated Activities	Retained by L.A. Care
		participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA 2020 ME 2)		**Subscriber Information:** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA 2020 ME 3)		**Materials and Presentations** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: ~~1.~~ 1. In routine notification of privacy practices ~~2.~~ 2. The right to approve the release of information (use of authorizations) ~~3.~~ 3. Access to Medical Records ~~1.~~ 4. Protection of oral, written, and electronic information across the organization ~~4.~~ 5. Information for employers **Assessing Member Understanding** ~~1.~~ 1. Assesses how well new members understand policies and procedures. The right to

Standard	Delegated Activities	Retained by L.A. Care
		approve the release of information (use of authorizations) ~~2.~~ 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization ~~3.~~ 3. Information for employers
Functionality of Claims Processing (NCQA 2020 ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. ~~1.~~2. The amount approved. ~~2.~~ The amount paid. 3. 4. Member cost. ~~1.~~5. The date paid **Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. ~~1.~~2. The amount approved. ~~2.~~ The amount paid. 3. 4. Member cost. ~~1.~~5. The date paid	
Pharmacy Benefit Information (NCQA 2020 ME 5)	**Pharmacy Benefit Information-Website** Members can complete the following actions on the website in one attempt or contact: ~~a.~~ Determine their financial responsibility for a drug, based on the pharmacy benefit. 1. ~~b.~~ Initiate the exceptions process 2. ~~c.~~3. Order a refill for an existing, unexpired mail-order prescription. ~~1.~~ Find the location of an in-network pharmacy. 4. ~~d.~~5. Conduct a pharmacy proximity search based on zip code. ~~2.~~a. Determine the availability of generic substitutes.	

Standard	Delegated Activities	Retained by L.A. Care
	*According to SB1052 Kaiser shall post the formulary on its internet website and update that posting on a monthly basis. **Pharmacy Benefit Information Telephone** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. ~~1.~~2. Initiate the exceptions process. ~~2.~~ Order a refill for an existing, unexpired, mail-order prescription. 3. ~~1.~~4. Find the location of an in-network pharmacy. ~~1.~~ Conduct a proximity search based on zip code. 5. ~~2.~~6. Determine the availability of generic substitutes. **QI Process on Accuracy of Information** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. ~~1.~~2. Analyze data results. ~~1.~~3. Act to improve identified deficiencies. **Pharmacy Benefit Updates** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA 2020 ME 6)	**Personalized Information on Health Plan Services** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. ~~1.~~2. Determine how and when to obtain referrals and authorizations for specific services, as applicable ~~1.~~3. N/A **Functionality Telephone**	

Standard	Delegated Activities	Retained by L.A. Care
	To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. ~~1.~~2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. ~~1.~~2. Analyzing data against standards or goals. ~~2.~~ Determining causes of deficiencies, as applicable. 3. ~~2.~~4. Acting to improve identified deficiencies, as applicable. **E-mail Response Evaluation** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. ~~1.~~2. Has a process for annually evaluating the quality of e-mail responses. ~~2.~~ Annually collects data on email turnaround time. 3. ~~2.~~4. Annually collects data on the quality of email responses. ~~1.~~ Annually analyzes data. 5. ~~3.~~6. Annually act to improve identified deficiencies**.**	
Member Experience (NCQA 20210-20222020 ME 7)	**Policies and Procedures for Complaints** The organization has policies and procedures for registering and responding to oral and written complaints that include: ~~a)~~1. Documenting the substance of complaints and actions taken. ~~a)~~2. Investigating of the substance of complaints and actions taken. ~~a)~~3. Notification to members of the disposition of complaints, including any aspect of clinical care involved.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~ a) Standards for timeliness including standards for clinically urgent situations. ~~a)~~4. Provision of language services for the complaint process. **Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: ~~a)~~1. Documentation of the substance of the appeals and actions taken. ~~a)~~2. Investigation of the substance of the appeals, including any aspects of clinical care involved ~~a)~~3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate ~~1.~~ a) Standards for timeliness including standards for clinically urgent situations. ~~a)~~4. Provision of language services for the appeal process. **Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. **Annual Assessment of Behavioral Healthcare and Services** Using valid methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2. Identifying opportunities for improvement. 3. Implementing interventions, if applicable. 4. Measuring effectiveness of interventions, if applicable.	prior notice of Plan's intent to sub-delegate. **Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from the Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

Standard	Delegated Activities	Retained by L.A. Care
Sub-Delegation of RRME (NCQA RR 52020 ME 8	**Element A: Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity ~~3.~~ Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance ~~4.~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested ~~5.~~ 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of Performance** For sub-delegation arrangements in effect for 12 months or longer, the delegate: ~~1.~~ 1. Semiannually evaluates regular reports, as specified in the sub-delegation agreement ~~2.~~ 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities **Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2; California Health and Safety Code Section 1348.8)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	3. Provides interpretation services for members by telephone. ~~1.~~4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: ~~2.~~1. Track telephone and website statistics at least quarterly. ~~3.~~2. Track member use of the nurse advice line at least quarterly. ~~4.~~ Evaluate member satisfaction with the nurse advice line at least annually. 3. ~~1.~~4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. D. **Policies and Procedures** ~~1.~~ 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. E. **Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. ~~1.~~2. In the form of, but not limited to: ~~a)~~ Flyers a. ~~c.~~b. Informational mailers ~~a)~~ ID Cards c. d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract,

Standard	Delegated Activities	Retained by L.A. Care
	The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	Federal and State regulatory guidelines and accreditation standards.
HEDIS Performance Benchmark APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening test as required ~~1.~~	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
CLAIMS PROCESSING REQUIRMENTS		
Claims Processing (Title 28 California Code of Regulations Section 1300.71)~~Blood Lead Screening of Young Children APL 20-016~~	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late.	~~Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening~~

Standard	Delegated Activities	Retained by L.A. Care
	b. **All other service claims:** Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. c. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records**	

Standard	Delegated Activities	Retained by L.A. Care
	1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated. ~~Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016~~ ~~Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening test as required~~ 3.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination	

Standard	Delegated Activities	Retained by L.A. Care
	Accurate Provider Dispute Payments 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy* Reporting requirements for additional delegated activities 2. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication **d.** Summary Report of L.A. Care member Prescription Utilization	1. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Pharmacy/	Pharmacy* 1. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements
NCQA ME Pharmacy reporting requirements 1. **ME:** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME:** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 – 2: Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Pharmacy/	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission
APPEALS & GRIEVANCES **Appeal & Grievance Logs to include raw data on all A&G cases received (example: case type category, case sub-classification, alleged provider information, provider information, MD reviewer information, dates/times received, resolution date/times, resolution decision, AOR information, withdrawal information, dismissal information, effectuation date/times, etc.) This data should be provided in the requested format defined by LA Care on a monthly basis. Delegate must do root cause analysis and remediation for all missed regulatory metrics. Delegate will provide data as requested for all regulatory inquiries.**			
MEMBER SERVICES			
Member Services Member complaints and Appeals Log	Monthly 12th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Member Services/	Format as defined in the L.A. Care Technical Bulletin MS 005
QUALITY IMPROVEMENT			

NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare ~~1. Assess the cultural, ethnic, racial and linguistic needs of its members~~ ~~2. Adjust the availability of practitioners within its network, if necessary~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
~~**NET 1B**~~ ~~**Availability of Practitioners, if delegated:**~~ ~~Formal assessment of primary care, behavioral healthcare, and specialty care practitioners' (SCP) availability to include:~~ ~~1. Adjustment of practitioners' availability within its network to meet the cultural, ethnic, racial, and linguistic needs of its members~~ ~~2. Quantifiable and Measurable Standards for the number of each type of practitioner providing primary care.~~ ~~3. Quantifiable and Measurable Standards for Geographic Distribution of each type of practitioner providing primary care.~~ ~~4. Analysis of Performance against Standards~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
~~**NET 1C**~~ ~~**Formal assessment of Practitioners Providing Specialty Care, if delegated, to include:**~~ ~~1. Identification of High Volume Specialty Providers, one of which must be OB/GYN; and Identification of High Impact Specialty Providers, one of which must be Oncology.~~ ~~2. Quantifiable and Measurable Standards for the number of each type of high-volume specialist.~~ ~~3. Quantifiable and Measurable Standards and Distribution by Geographic Distribution of High Volume SCPs and High Impact SCPs; and~~ ~~4. Analysis of Performance against Standards~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~

~~**NET 1D**~~ ~~**Assessment of Practitioners Providing Behavioral Healthcare, if delegated, to include:**~~ ~~1. Identification of High-Volume behavioral healthcare practitioners~~ ~~2. Quantifiable and Measurable Standards for the number of each type of High-Volume behavioral healthcare practitioner.~~ ~~3. Quantifiable and Measurable Standards for the geographic distribution of each type of High-Volume behavioral healthcare practitioner.~~ ~~4. Analysis of Performance against Standards~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care **, ~~if delegated:~~** ~~Analysis~~Analysis~~A~~ A analysis~~Analysis of data that measures:~~ ~~1. Regular and Routine Care Appointments~~ ~~2. Urgent Care Appointments~~ ~~3. After Hours Care~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
~~**NET 2B**~~ ~~**Access to Behavioral Healthcare, if delegated:**~~ ~~Analysis~~Analysis~~A~~ A analysis~~Analysis of data that evaluate access to appointments for behavioral healthcare for:~~ ~~1. Care for a non-life-threatening emergency within 6 hours~~ ~~2. Urgent Care within 48 hours~~ ~~3. Initial visit for routine care within 10 business days~~ ~~4.~~1. ~~Follow-up routine care within a time frame defined by the organization~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
~~**NET 2C**~~ ~~**Access to Specialty Care, if delegated:**~~ ~~Analysis~~Analysis~~A~~ a analysis~~Analysis of data that evaluate access to appointments for:~~ ~~3. High-Volume specialty care.~~ ~~4. High-Impact specialty care.~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~

NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services ~~3~~ ~~**Assessment of Network Adequacy**~~ ~~3. Assessment of Member Experience Accessing the Network by:~~ ~~a. Analyzing data from complaints and appeals about network adequacy for non-behavioral and behavioral healthcare services~~ ~~b. Using aspects of analysis from (b) to determine if there are issues specific to particular geographic areas or types of practitioners or providers~~ ~~4. AnalyzeAnalyzeAnalyzieAnalyze opportunities to improve access to non-behavioral healthcare services by:~~ ~~a. Prioritizing opportunities for improvement from analysis of availability, accessibility and CAHPS survey results and member complaints and appeals~~ ~~a. Implement interventions on at least one opportunity, if applicable~~ ~~b. Measure the effectiveness of interventions, if applicable~~ ~~5. Analyze opportunities to improve access to behavioral healthcare services by:~~ ~~b. Prioritizing improvement opportunities identified from analyses of availability, accessibility, complaints and appeals, or member experience~~ ~~a. Implementing interventions on at least on opportunity, if applicable~~ ~~b. Measures the effectiveness of the interventions, if applicable~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
-**ME 7C** Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP)	Compliant with NCQA in accordance to Plan's accreditation submission

ME 7E Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities for Improvement ~~7~~ **~~A, B, C, E, F~~** **~~Analysis of Member Experience, if delegated, to include:~~** ~~1. Policies and Procedures for Complaints~~ ~~2. Policies and Procedures for Appeals~~ ~~3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories along with opportunities for improvement:~~ ~~a. Quality of Care~~ ~~b. Access~~ ~~c. Attitude and Service~~ ~~d. Billing and Financial Issues~~ ~~e. Quality of Practitioner Office Site~~ ~~4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement:~~ ~~a. Quality of Care~~ ~~b. Access~~ ~~c. Attitude and Service~~ ~~d. Billing and Financial Issues~~ ~~e. Quality of Practitioner Office Site~~		home/ukais-cr/infile/Member Services/	
QI 2A Practitioner Contracts	Annually during PP audit	~~L.A. Care's Secure File Transfer Protocol (SFTP)~~ home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

QI 3 A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness ~~**C & 4 A C**~~ ~~**Annual Assessment and Improvement Actions taken for Continuity and Coordination of Care across the health care network**~~ ~~1. Continuity and Coordination of Medical Care analysis~~ ~~2. Continuity and Coordination Between Medical Care and Behavioral HealthCare analysis.~~ **1.**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Annual data collection analysis that identifies and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	~~L.A. Care's Secure File Transfer Protocol (SFTP)~~ home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Quality Improvement Quarterly reporting requirements 1. **QI Workplan Update(s))** 2. **Clinical Strategic Goals (CSG)** with MCAS Measures: 3. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months	1. Annually during PP audit 2. Quarterly Clinical Strategic goals 3. Quarterly PQI Report 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25	2-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	2-3. Acceptable formats: • Clinical Strategic Goals (CSG) Report with L.A. Care member rates included.

~~**Quality Improvement Quarterly reporting requirements**~~ ~~1. **QI Workplan Update(s)**~~ ~~1. Asthma Report~~ ~~2. Diabetes Report~~ ~~3. Clinical Strategic Goals (CSG)~~ ~~2. **Potential Quality of Care Issues (PQIs)**~~ ~~a. Number of PQIs~~ ~~b. Number of closed PQIs~~ ~~c. Number of closed PQIs within 6 months~~ ~~d. PQI Detail Report with final PQI severity level~~	4th Qtr – Feb 25 ~~1. 2. Quarterly~~ ~~1st Qtr May 25 April 25~~ ~~2nd Qtr Aug 25 July 25~~ ~~3rd Qtr Nov 25 Oct 25~~ ~~4th Qtr Feb 25 Jan 25~~	~~1. 2. L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	• Potential Quality of Care Issues (PQIs) ~~1. 2. Acceptable formats:~~ ~~QI Workplan Update(s)~~ ~~1. Clinical Strategic Goals (CSG) Report~~ ~~Potential Quality of Care Issues (PQIs)~~ ~~2. Quarterly Workplan Updates~~
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the annual QI Workplan)	~~1. 4.~~ Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Acceptable formats: • Quarterly •
ME 1B: Distribution of Member Rights & Responsibilities Statement 1. KP will randomly select 20 providers for each Reporting period and will complete the New Provider Training Tracking Sheet for the selected physicians each Reporting period.	Semi-Annually: **Jan 15th (Reporting period Q3 & Q4)** **July 15th (Reporting period Q1 & Q2)** KP to submit the New Provider Training Tracking Sheet to LA Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	New Provider Training Tracking Sheet (KP document) ME 1B_Distribution of Rights Statement
PHM 1A Strategy Description **PHM 1B** Informing Members ~~**PHM 1:** PHM Strategy Strategy Description~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation ~~**PHM 2:** Population Identification~~ ~~1. Population Assessment~~ ~~Segmentation.~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action ~~**6:** Population Health Management Impact~~ ~~1. Measuring Effectiveness~~ ~~Improvement and Action~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** ~~3.~~1. Nurse Advice Line monitoring for:	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Health Education/	Mutually agreed upon format

a. Telephone statistics at least quarterly ~~1.~~ Average abandonment rate within 5 percent ~~(goal)~~ ~~2.~~ Average speed of answer within 30 seconds ~~(goal)~~ ~~4.~~2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	2. Annually during PP Audit	Plan will also have the option to submit via email to remain compliant with due date.	
HEDIS Performance Benchmark A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after final validated HEDIS results are available.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ukais-cr/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
Blood Lead Screening of Young Children APL 20-016	1. Quarterly 1st Qtr – April 13 2nd Qtr – July 13 3rd Qtr – Oct 13 4th Qtr – Jan 13	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Data template provided by QI
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1.Delegation Oversight to review Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** ~~2.~~ 1. UM Summary – Inpatient Activity ~~1.~~a. Average monthly membership	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	ICE Quarterly Reporting Format

2.b. Acute Admissions/K 3.c. Acute Bed days/K a.d. Acute LOS 4.e. Acute Readmits/K 5.f. SNF Admissions/K 6.g. SNF Bed days/K b. 2. SNF LOS 7. a) SNF Readmits/K 3. 3. UM Activities Summary 1.a) Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) 2.b) Referral Denial Rate 3.c) Appeals/K 4.d) Overturn Rate 4.2. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	4th Qtr – Feb 28		
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 3.b. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition 4.c. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases CCM for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly 15th of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care--member transition to other care, a. a. When their benefits end.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care TOC Reporting Format
CREDENTIALING			

~~3.~~1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. ~~4.~~2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. ~~5.~~3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. ~~6.~~4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Credentialing/~~ credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
4. . AB1455 Claims Timeliness Reports a) AB1455 PDR Timeliness Reports ~~4.~~ b) ~~AB1455 Pharmacy Claims Timeliness Reports~~ ~~5.~~ c) Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DMHC approved templates

~~6.~~5. Call Center Report	Quarterly- – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September Q4 – October, November, and December~~Quarterly~~	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Format as specified by L.A. Care
~~7.~~6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~8.~~7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~9.~~8. Coordinated Care Initiative – Long- Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~10. Encounter Data Letters – CAP response~~	~~Quarterly – Due to L.A. Care 30 business days after receipt of CAP~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~Word Document, Non-Specific template~~
~~11. Grievance Report Mandated by APL 14-013~~	~~Quarterly – Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved templates~~

~~12.~~9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 14-010	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~13. Out-of-Network (OON) Report~~	~~Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved templates~~
~~14.~~10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~15. Pharmacy Formulary Changes Reports~~	~~Annually - Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved templates~~
~~16. Health Homes Program DHCS Required Reporting~~	~~Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care Regulatory / Secure File Transfer Protocol (SFTP)~~ ~~home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period~~
11. Enhanced Care Management DHCS Required Reporting	Quarterly~~, Bi-Annually, & Annually~~, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/~~ucfst~~ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Community Supports DHCS Required Reporting	Quarterly~~, Bi-Annually, & Annually~~, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/~~ucfst~~ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
~~17.~~13. CBAS Monthly Wavier Report	Monthly -Due to L.A. Care on the specified dates stated below:	L.A. Care Regulatory	DHCS approved template

	January 5 February 3 March 2 April 2 May 3 June 2 July 2 August 3 September 2 October 4 November 2 December 2	/ Secure File Transfer Protocol (SFTP) home/ ukais-cr /infile/Regulatory Reports	
~~18.~~14. Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
~~19.~~15. Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
~~20.~~16. Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
~~21. Prop 56 Directed Payments for Valued Base Payment Program (APL 20-014014)~~	~~Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS~~	~~LA Care Regulatory/Secure File Transfer Protocol (sFTP)~~ ~~home/ ukais-cr /infile/Regulatory~~	~~Regulatory Reports provided Template based on APL reporting requirements~~
~~22.~~17. Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
~~23.~~18. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP)	Regulatory Reports provided Template based on APL reporting requirements

		home/ ukais-cr /infile/Regulatory	
~~24. MER Exemption Review Report (MMDR)~~	~~Monthly – Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ ukais-cr /infile/Regulatory Reports/~~	~~DHCS Reporting template~~
~~25.~~19. Third Party Liability (TPL)	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocoal~~Protocal~~ (SFTP) – home/ ukais-cr /infile/Regulatory Reports/	DHCS approved templates
~~26.~~20. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***	Monthly - Due to L.A. Care every 4th day of the month ~~Monthly – Due per timeline mutually agreed upon by KP and LA Care~~ ~~FEB~~ ~~MCPD: February 15~~ ~~MAR~~ ~~PCPA: March 5~~ ~~MCPD: March 8~~ ~~APR~~ ~~PCPA: April 6~~ ~~MCPD: April 7~~ ~~MAY~~ ~~PCPA: May 6~~ ~~MCPD: May 6~~ ~~JUN~~ ~~PCPA: June 4~~ ~~MCPD: June 7~~ ~~JUL~~ ~~PCPA: July 6~~ ~~MCPD: July 7~~ ~~AUG~~ ~~PCPA: Aug 6~~ ~~MCPD: Aug 6~~ ~~SEPT~~ ~~PCPA: September 3~~ ~~MCPD: September 8~~ ~~OCT~~	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

	~~PCPA: Oct 6~~ ~~MCPD: Oct 6~~ ~~NOV~~ ~~PCPA: Nov 5~~ ~~MCPD: Nov 5~~ ~~DEC~~ ~~PCPA: Dec 6~~ ~~MCPD: Dec 7~~		
~~27.~~21. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DMHC approved templates
22. APL 20-021 Acute Care at Home Hospital Report	Monthly – Due to LA Care the last day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Reporting Template
23. APL 20-016 Blood Lead Screening~~Screening~~	Monthly – Due to LA Care the first Friday of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements
24. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: 1. LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/ukais-cr/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Word Document, Non-Specific template Template may change upon regulators request.

DELEGATION OVERSIGHT			
~~1.~~ New Member Welcome Kit Mailing Reports	Quarterly Jan 15 April 15 July 15 October 15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Delegation Oversight	Format as specified by L.A. Care
CULTURAL AND LINGUISTC SERVICES			
C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

~~[Signature block is on the following page]~~

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2022~~1~~

Kaiser Foundation Health Plan
A California health care services plan

By: _____
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market~~Region (Interim)~~

Date: _____, 2022~~1~~

By: _____
Hector De La Torre
Chairperson,
L.A. Care Board of Governors

Date: _____, 2022~~1~~

Amendment No. 48
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 48 is effective as of July 1, 2021, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Shield of California Promise Health Plan***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq.*) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

I. <u>Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.</u>

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 48 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: DocuSigned by: John Baackes 70A86CF78A8F458...
John Baackes
Chief Executive Officer

Date: _____, 2023

By: 4/3/2023 | 5:42 PM PDT
Alvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: _____, 2023

Blue Shield of California Promise Health Plan,
A California health care services plan

By: DocuSigned by: kristen Cerf 9AE0D7770A434C7...
Kristen Cerf
President and Chief Executive Officer

Date: 3/31/2023 | 11:06 AM PDT, 2023

II. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2021-June 30, 2022
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Blue Shield of California Promise Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, (vii) claims recovery., and (viii) claims processing. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Blue Shield of California Promise Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Blue Shield of California Promise Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Blue Shield of California Promise Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Blue Shield of California Promise Health Plan as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Blue Shield of California Promise Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Blue Shield of California Promise Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Blue Shield of California Promise Health Plan, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS starting January 1, 2022, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. *L.A. Care will provide* ***delegate with Member Experience data: complaints, CAHPS, survey results or other data collected on members' experience with the delegate's services. In addition, will also provide Clinical performance data: HEDIS measures, claims and other clinical data collected by the organization. L.A. Care may provide data feeds for relevant claims data or clinical performance measure results*** *when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's delegate Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption.*

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY MANAGEMENT AND IMPROVEMENT	
Program Structure and Operations: Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated physician in the QI program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates'

Standard	Delegated Activities	Retained by L.A. Care
(NCQA QI 1)	4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership **Annual Work Plan** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of performance in the quality and safety of clinical care and quality of service 3. evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. **Promoting Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Health Services Contracting : Applicable L.A. Care Policy: QI-007 (NCQA QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities 2. Practitioners allow the organization to use their performance data.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and

Standard	Delegated Activities	Retained by L.A. Care
	Provider Contracts This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities. 2. Practitioners allow the organization to use their performance data.	approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Continuity and Coordination of Medical Care: Applicable L.A. Care Policy: QI-0026 (NCQA QI 3)	**Identifying Opportunities** The organization annually identifies opportunities to improve continuity and coordination of medical care across the network by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement. 5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement. **Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity identified in Element A, factor 4-7 2. Acting on the second opportunity identified in Element A, factor 4-7 3. Acting on the third opportunity identified in Element A, factor 4-7. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B. 3. The third opportunity identified in Element B. **Transition to Other Care** Refer to Utilization Management Delegated Activities Section	

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination Between Medical Care and Behavioral Healthcare: Applicable L.A. Care Policy: QI-0026 (NCQA QI 4)	**Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information. 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care. 3. Appropriate use of psychotropic medications. 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness. **Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners. 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A. 4. Identifying and selecting a second opportunity for Improvement from Element A. 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; d. Standards for the availability of medical records	

Standard	Delegated Activities	Retained by L.A. Care
Sub-Delegation of QI: Applicable L.A. Care Policy: QI-007 (NCQA QI 5)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA PHM 1)	**Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus. 2. Programs or Services offered to members. 3. Activities that are not direct member interventions,	

Standard	Delegated Activities	Retained by L.A. Care
	4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services. 3. How to opt in or opt out of the program	
Population Identification (NCQA PHM 2)	**Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claim (Jul 1, 2021-Dec 31,2021) 3. Physician Administered Drugs (PAD) claim 4. Laboratory results 5. Health appraisal results 6. Electronic health records 7. Health Services programs within the organization 8. Advanced data sources **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs.	

Standard	Delegated Activities	Retained by L.A. Care
	Segmentation 1. segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA PHM 3)	**Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering certified shared-decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. One additional activity to support practitioners or providers in achieving PHM goals	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.
Wellness and Prevention (NCQA PHM 4)	**Frequency of Health Appraisal Completion** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer a health appraisal (HA) annually. **Topics of Self-Management Tools** The organization offers self-management tools derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating. 5. Managing stress. 6. Avoiding at-risk drinking. 7. Identifying depressive symptoms.	
Complex Case Management (NCQA PHM 5)	**Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **Case Management Systems**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of the individual ID and date and time of action on the case when interaction with the member occurred; and 3. Automated prompts for follow-up as required by the case management plan. **<u>Case Management Process</u>** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Initial assessment of life planning activities 7. Evaluation of cultural and linguistic needs, preferences or limitations 8. Evaluation of visual and hearing needs, preferences or limitations 9. Evaluation of caregiver resources and involvement 10. Evaluation of available benefits 11. Evaluation of community resources 12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan 13. Identification of barriers to the member meeting goals or complying with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans.	

Standard	Delegated Activities	Retained by L.A. Care
	17. A process to assess members' progress against case management plans for members. **<u>Initial Assessment</u>** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living (ADL) 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **<u>Case Management Ongoing Management</u>** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals and modification as needed.	

Standard	Delegated Activities	Retained by L.A. Care
Population Health Management Impact (NCQA PHM 6)	**<u>Measuring Effectiveness</u>** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **<u>Improvement and Action</u>** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA PHM 7)	**<u>Sub-Delegation Agreement</u>** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **<u>Predelegation Evaluation</u>** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **<u>Review of PHM Program</u>** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities	

Standard	Delegated Activities	Retained by L.A. Care
	4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually.	

Standard	Delegated Activities	Retained by L.A. Care
	Practitioners Providing Behavioral Healthcare To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measureable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measureable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against standards annually	
Accessibility of Services (NCQA NET 2)	**Access to Primary Care** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments; 2. Urgent care appointments; 3. After-hours care **Access to Behavioral Healthcare** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care. **Access to Specialty Care** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Assessment of Network Adequacy (NCQA NET 3)	**<u>Assessment of Member Experience Accessing the Network</u>** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element C and Element E. 3. Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **<u>Opportunities to Improve Access to Nonbehavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **<u>Opportunities to Improve Access Behavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of the interventions, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
Continued Access to Care (NCQA NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section Note: Review process is managed by L.A. Care Utilization Management team.	
Physician and Hospital Directories (NCQA NET 5)	**<u>Physician Directory Data</u>** The organization has a web-based physician directory that includes the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Board certification 7. Accepting new patients 8. Language spoken by the physician or clinical staff 9. Office locations and phone numbers **<u>Physician Directory Updates</u>** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **<u>Assessment of Physician Directory Accuracy</u>** Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers 2. Accuracy of hospital affiliations 3. Accuracy of accepting new patients 4. Awareness of physician office staff of physician's participation in the organization's networks. **<u>Identifying and Acting on Opportunities</u>** Based on results of the analysis performed in Element C, at least annually the organization: 1. Identifies opportunities to improve the accuracy of the information in its physician directories. 2. Takes action to improve the accuracy of the information in its physician directory.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Searchable Physician Web Based Directory The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Accepting new patients 7. Languages spoken by the physician or clinical staff 8. Office locations **Hospital Directory Data** The organization has a web-based hospital directory that includes the following: 1. Hospital name 2. Hospital location and phone number 3. Hospital accreditation status 4. Hospital quality data from recognized sources **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level 2. Intuitive content organization 3. Ease of navigation 4. Directories in additional languages, if applicable to the membership	

Standard	Delegated Activities	Retained by L.A. Care
	Availability of Directories The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print 2. Telephone	
Sub-Delegation of NET (NCQA NET 6)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4 and QI 3)	**Notification of Termination (NET4)** The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. **Continued Access to Practitioners** If a practitioner's contract is discontinued the organization allows affected members continued access to practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **Transition to Other Care** The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes used to make determinations of benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. **Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA UM 2)	**UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates'

Standard	Delegated Activities	Retained by L.A. Care
	3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews UM criteria and the procedures for applying them based on individual needs and assessment of the local delivery system, and updating as necessary. **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA UM 4)	**Licensed health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training and professional experience in medical or clinical practice	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	2. A current license to practice or an administrative license to review UM cases without restriction. **Practitioner Review of Nonbehavioral healthcare Denials** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses that a physician or appropriate behavioral healthcare practitioner, to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist reviews pharmacy denials based on medical necessity. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **Use of Board Certified Consultants** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations	
Timeliness of UM Decisions (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaidurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace) **Timeliness Report** The organization monitors and submits a report for timeliness of: 1. 1. Non-behavioral UM decision making 2. 2. Notification of non-behavioral UM decisions 3. 3.Behavioral UM decision making 4. 4.Notification of behavioral UM decisions 5. Pharmacy UM decision making 6. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards***	
Clinical Information (NCQA UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices (NCQA UM 7)	**Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial	

	decisions with a physician or other appropriate reviewer. **Written Notification of Nonbehavioral healthcare Denials** The organization's written notification of each non-behavioral denials, provided to members and their treating practitioners contains the following information: 1. The specific reason for denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written non-behavioral denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the members' rights to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decisions with a physician appropriate behavioral healthcare reviewer or pharmacist reviewer. **Written Notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials that it provided to members and their treating practitioners contains: 1. The specific reasons for the denial, in easily understandable language.	

	2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request **Written Notification of Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials which it provides to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including members' right to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **Discussing a Pharmacy Denial with a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist **Written Notifications of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand. 2. A reference to the benefit provision guidelines protocol or similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision guideline protocol or similar criterion on which the denial decision was based, upon request. **Pharmacy Notice of Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights including the member's right to submit written comments documents or other information relevant to the appeal.	

	2. An explanation of the appeal process including the member's right to representation and the appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Policies for Appeals (NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request. 7. The decision for a post-service appeal and notification to the member within 60 calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 8. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 9. Notification to the member about further appeal rights. 10. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based 11. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	12. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. Allowing an authorized representative to act on behalf of the member 14. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 15. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA UM 9)	**Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frames: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **Appeal Reviewers** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	4. Notification that the member is entitled to receive reasonable access to and copies of all documents free of charge upon request. 5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022 and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA UM 11)	**Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures	

	4. A process to provide procedures to practitioners annually and when it makes changes. **<u>Pharmaceutical Restrictions/Preferences</u>** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet website and update that posting with changes on a monthly basis (SB1052) 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The process for generic substitution, therapeutic interchange and step-therapy protocols. **<u>Pharmaceutical Patient Safety Issues</u>** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **<u>Reviewing and Updating Procedures</u>** With the participation of physicians and pharmacists the organization annually: 1. Reviews the procedures 2. Reviews the list of pharmaceuticals 3. Updates the procedures as appropriate 4. Updates the list of pharmaceuticals, as appropriate, and 5. Post the list with changes on its Internet website on a monthly basis. (SB1052) **<u>Considering Exceptions</u>** The organization has exceptions policies and procedures that describe the process for: 1. Making exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of request	

	5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
UM System Controls (NCQA UM 12)	**<u>UM Denial System Controls</u>** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **UM Denial System Controls Oversight** **At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by:** **1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.** **2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.** **3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.**	
Sub-Delegation of UM (NCQA UM 13)	**<u>Sub-Delegation Agreement</u>** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity.	

	3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when request. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. Annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement if applicable.	
	CREDENTIALING	

Credentialing Policies (NCQA CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners to provide care to its members by developing and implementing credentialing policies and procedures which specify: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions within sixty (60) calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program.	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	10. The process for securing the confidentiality of all information obtained in the credentialing process except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data including education training board certification and specialty. The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing or recredentialing application 2. The right of practitioners to correct erroneous information and: • The timeframe for making corrections. • The format for submitting corrections. • The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 4. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 5. The security controls in place to protect the information from unauthorized modification. 6. How the organization monitors its compliance with the processes and procedures in factors 1–4 at least annually and takes appropriate action when applicable.	
(DHCS APL 19-004)	**Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to:	

	1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for practitioners whose enrollment application is in process. 3. The process for monitoring between recredentialing cycles to validate continued enrollment. 4. Process for practitioners not currently enrolled in the Medi-Cal program. 5. Process for practitioners deactivated, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee: a. Includes representation from a range of participating practitioners to provide advice and expertise for credentialing decisions. b. Has the opportunity to review the credentials of all practitioners being credentialed or re-credentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. c. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria.	
Credentialing Verification (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the NCQA prescribed time limits, through primary or other NCQA-approved sources prior to credentialing and recredentialing by: Verifying that the following are within the prescribed time limits: 1. Current, valid license to practice (develop a process to ensure providers licenses are kept current at all times).	

	2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate. • 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. 3. Verification of the highest of the following three levels of education and training obtained by the practitioners as appropriate: • Board certification if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. • Completion of a residency program. • Graduation from medical or professional school. 4. Work history. 5. Current malpractice insurance coverage ($1 million/$3 million). 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 7. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 8. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 9. CLIA Certifications, if applicable. 10. NPI number. 11. Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing.	

	a. State sanctions, restrictions on licensure, or limitations on scope of practice. b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice insurance coverage. f. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. b. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate. b. What type of monitoring is being performed. c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network. d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care.

	c. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. d. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. e. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: • Requesting what action will be taken by the Delegate. • What type of monitoring is being performed. • What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. • The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. 6. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network. 8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify:	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per

	a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. 2. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	changes in contract, Federal and State regulatory guidelines and accreditation standards.
CR Assessment of Organizational Providers (NCQA CR 7) DHCS, DMHC, CMS	The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs).	

	The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers. The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DHCS, DMHC, CMS	If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: a. Is mutually agreed upon. b. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. c. Requires at least quarterly reporting to Delegate. d. Describes the process by which Delegate evaluates sub-delegate's performance. e. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. f. Describes the remedies available to Delegate if sub-delegate does not fulfill its obligations, including revocation of the delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures. b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

	requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable. If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate 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 score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**<u>Distribution of Rights Statement</u>** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**<u>Rights and Responsibilities Statement</u>** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization its services its practitioners and providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their right to privacy. 3. A right to participate with practitioners in making decisions about their health care. 4. A right to a candid discussion of appropriate or medically

		necessary treatment options for their conditions regardless of cost or benefit coverage. 5. A right to voice complaints or appeals about the organization or the care it provides. 6. A right to make recommendations regarding the organization's member rights and responsibilities policy. 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners. 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**<u>Subscriber Information</u>** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **<u>Interpreter Services</u>** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ME 3)		**<u>Materials and Presentations</u>** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures.

		L.A. Care adheres to the most current NCQA standards to comply with these requirements. **<u>Communicating with Prospective Members</u>** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **<u>Assessing Member Understanding</u>** 1. Assesses how well new members understand policies and procedures. The right to approve the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA ME 4)	**<u>Functionality-Website</u>** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid **<u>Functionality-Telephone Requests</u>** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact:	

	1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Pharmacy Benefit Information (NCQA ME 5)	**<u>Pharmacy Benefit Information-Website</u>** Members can complete the following actions on the website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process 3. Order a refill for an existing, unexpired mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. *According to SB1052 Blue Shield shall post the formulary on its internet website and update that posting on a monthly basis. **<u>Pharmacy Benefit Information Telephone</u>** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 3. Order a refill for an existing, unexpired, mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes. **<u>QI Process on Accuracy of Information</u>** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **<u>Pharmacy Benefit Updates</u>** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	

Personalized Information on Health Plan Services (NCQA ME 6)	**<u>Functionality-Website</u>** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **<u>Functionality Telephone</u>** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **<u>Quality and Accuracy of Information</u>** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **<u>E-mail Response Evaluation</u>** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience Applicable L.A. Care Policy: QI-031 (NCQA ME 7)	**<u>Policies and Procedures for Complaints</u>** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-

	2. Investigating of the substance of complaints and actions taken. 3. Notification to members of the resolution of complaints and, if there is an adverse decision, the right to appeal. . 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the complaint process. **Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. **Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. **Annual Assessment of Behavioral Healthcare and Services** Using valid methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2. Identifying opportunities for improvement. 3. Implementing interventions, if applicable. 4. Measuring effectiveness of interventions, if applicable.	delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. **Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

Sub-Delegation of ME (NCQA ME 8)	**<u>Sub-Delegation Agreement</u>** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **<u>Predelegation Evaluation</u>** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **<u>Review of Performance</u>** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. **<u>Opportunities for Improvement</u>** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week, by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

	condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone statistics at least quarterly 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. **D. Policies and Procedures** 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Quality Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.

	When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

	the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ 11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC REQUIREMENTS		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines:	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services.	

OMH CLAS Standards, Standard 5-7	c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: 2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for	

Federal Guidelines: OMH CLAS Standards, Standards - 7	ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

	Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis.	

	c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial and annual education/training on cultural and linguistic requirements to providers, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc.	

	b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. 4. a. Awareness that culture and cultural beliefs may influence health and health care delivery. b. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. c. Skills to communicate effectively with diverse populations d. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A,	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L	

Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system.	

	d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	
Authority: Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter 17-004DHCS All Plan Letter 21-004	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services) 2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations	

	that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral*** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. 3. Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	
CLAIMS PROCESSING REQUIREMENTS		
Claims Processing (Title 28 California Code of Regulations Section 1300.71) Blood Lead Screening of Young Children APL 20-016	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims**: Late payments on a complete claim will automatically include	

	interest at a 15% rate per annum applied to the payment amount for the time period payment is late. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by	

	all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing	

	deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
Delegation Agreement
[Attachment B]

Plan's Reporting Requirements
(Pharmacy reporting requirements are only applicable from July 1, 2021 to December 31, 2021)

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy Reporting requirements for additional delegated activities 1. NCQA UM related a. **UM 4E:** Practitioner Review of Pharmacy Denials b. **UM 5:** Timeliness of Pharmacy UM Decision Making**UM 5C:** Notification of Pharmacy Decisions c. **UM 5D (factors 5&6):** UM Timeliness Report (Pharmacy) d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials g. **UM 7I:** Pharmacy Notice of Appeals Rights/Process h. **UM 9A** Preservice and Postservice Pharmacy Appeals i. **UM 9B:** Timeliness of the Pharmacy Appeal Process j. **UM 9C**: Pharmacy Appeal Reviewers k. **UM 9D**: Notification of Appeal Decision/Rights for Pharmacy l. **UM 12A:**UM Denial System Controls **2. DHCS Related** a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1-3. L.A. Care Reporting Format with data elements as defined in the Blue Shield Pharmacy Report Templates workbook, and 4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

decisions within 24 hours of receipt/Total PAs. - includes approval and denials, excludes all early close and administrative denials b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs. - includes approval and denials, excludes all early close and administrative denials 3. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded. b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded c. Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 4. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization			
NCQA ME Pharmacy related reporting requirements 1. **ME :** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME :** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 – 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission

QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare

QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly reporting requirements</u> 1. **QI Workplan Update** **2. Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	QI Workplan Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. Quarterly PQI Report 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
<u>Quality Improvement Annual reporting requirements</u> 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format

4. PHM Work plan (if the activities are not included in the QI Workplan)			
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 &Q2)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format  ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement			
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds 2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18 2. Annually during PP Audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
UTILIZATION MANAGEMENT			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/grievance/	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories: a. Quality of Care b. Access c. Attitude and Service	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission

d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue e. Quality of Practitioner Office Site			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Delegation Oversight to review. Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	ICE Quarterly Reporting Format

NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care--member transition to other care, **a.** When their benefits end, if necessary **b.** During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care TOC Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name,	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)

First Name, MI, Title, Address, City, State, Zip, Group Name			
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards (if applicable) c. Exhibit A-3 Timely Access Monitoring Policies and Procedures related to subdivision (c)(5) d. Exhibit A-4 Timely Access Monitoring policies and Procedures related to all other standards e. Exhibit C-1 Methodology f. Exhibit C-2 Incidents of Non-Compliance with Rule 1300.67.2.2 g. Exhibit C-3 Patterns of Non-Compliance with rule 1300.67.2.2 h. Exhibit D-1 Methodology for Verification of Advanced Access Program (if applicable) i. Exhibit D-2 List of Advanced Access Providers (if applicable) j. Exhibit E-1 Triage k. Exhibit E-2 Telemedicine l. Exhibit E-3 Health I.T. m. Exhibit F-1 Provider Satisfaction Survey Methodology (a) Policy & Procedures n. Exhibit F-1 Provider Satisfaction Survey Methodology (b) Survey Tool o. Exhibit F-1 Provider Satisfaction Survey Methodology (c) Detailed Explanation p. Exhibit F-2 Provider Satisfaction Survey Results	Annually - March	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	

q. Exhibit F3- Enrollee Satisfaction Survey Methodology (a) Policy and Procedures r. Exhibit F3- Enrollee Satisfaction Survey Methodology (b) Survey Tool s. Exhibit F3- Enrollee Satisfaction Survey Methodology (c) Detailed Explanation t. Exhibit F4- Enrollee Satisfaction Survey Results u. Quality Assurance Report v. Annual Provider Network Report Forms i. PCP ii. Specialists iii. Other Contracted iv. Hospitals and Clinics v. Telehealth vi. Service and Enrollment vii. Mental Health viii. Grievances			
2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) /home/ucfst/infile/274	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template

4. **Health Industry Collaboration Effort** AB1455 Quarterly Reports M/Q Medi-Cal Claims Timeliness Report AB1455 Pharmacy Claims Timeliness Reports Quarterly Provider Dispute Resolution (PDR) Report Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September • Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
8. Coordinated Care Initiative – Long- Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or	DHCS approved templates

		Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	
11. Health Homes Program DHCS Required Reporting (Sunset CY 2022)	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
14. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
15. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
16. Prop 56 Directed Payment for Physician Services Mandated by APL 19-015	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Financial Compliance provided Template based on APL reporting requirements

17. Prop 56 Hyde Reimbursement Requirements for specific Services Mandated by APL 19-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Prop 56 Directed Payments for Developmental Screening Services Mandated by APL 19-016	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
Prop 56 Directed Payments for Valued Base Payment Program Mandated by APL 20-014	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
19. Prop 56 Directed Payments for Family Planning Mandated by APL 20-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
20. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services Mandated by AP-19-018	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
21. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) Mandated by APL 20-017 The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)***	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

• Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***			
22. Acute Care at Home Hospital Report Mandated by APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**DHCS Reporting Template**
23. Blood Lead Screening Mandated by APL 20-016	Quarterly - Due to L.A. Care 45 days after the quarter ends	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**Regulatory Reports provided Template based on APL reporting requirements**
24. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
25. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
26. Third Party Liability	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
27. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
28. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to:	Annually during PP audit and ad-hoc;	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org	Word Document, Non-Specific template

LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; 29. L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Ad-Hoc	home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Template may change upon regulators request.
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			
1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Claims Delegates' Quarterly Timeliness Reporting will be included in 1(a) above – Oversight Report on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements) Note: Delegates consist of PPGs and capitated hospitals.		L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF
2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates*** Note: Delegates consist of PPGs and capitated hospitals.	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance	Excel/PDF

Note: Delegates consist of PPGs and capitated hospitals.	fieldwork conducted by BSC PHP.	Plan will also have the option to submit via email to remain compliant	
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	Via email to designated Health Education contact	As appropriate per Plan Partner model.
CULTURAL AND LINGUISTC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated

			Subcontractor**.**
2. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: DocuSigned by: John Baackes 70A86CE78A8F458...
John Baackes
Chief Executive Officer

Date: 4/3/2023 | 5:42 PM PDT, 2023

By: DocuSigned by: F6C72AC0AC4149C...
Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: 4/4/2023 | 7:36 AM PDT, 2023

Blue Shield of California Promise Health Plan
A California health care services plan

By: DocuSigned by: kristen Cerf 9AE0D7770A434C7...
Kristen Cerf
President and Chief Executive Officer

Date: 4/3/2023 | 4:28 PM PDT, 2023

Board of Governors
MOTION SUMMARY

Date: April 26, 2023 **Motion No. EXE 102.0523**

Committee: Executive **Chairperson:** Al Ballesteros, MBA

Issue: Establish the Provider Relations Advisory Committee

Background: At the April 6 Board Meeting, Board Member and Los Angeles County Supervisor Hilda Solis requested that the Board direct staff to review the process and requirements for the Board to establish the "Provider Relations Advisory Committee". She suggested that the Committee's purposes would include:

- identifying and informing the Board of the challenges affecting providers in Los Angeles County,
- considering opportunities to mitigate those challenges, and
- making recommendations to the Board.

Board Member Supervisor Solis requested that staff review and make recommendations concerning the potential appointment of Board Member George Greene as Chair of the Committee, and appointing other potential members to include other board members, Los Angeles County providers and other individuals, as appropriate. Staff recommendations should also include any other issues as designated in L.A. Care's bylaws and other applicable governing sources or law. Board Member Greene accepted the role of Chairperson of this Committee.

Suggestions at the meeting included:

- that this Committee would report to the Board on a regular basis in the same manner as other committees report at the Board meetings, and there will be a routine item on the Agenda,
- that the new Committee could provide specific suggestions on the dashboard metrics to align the measurements with the needs of providers, although some things may be considered proprietary and consideration will be made for L.A. Care's capacity to provide some metrics. The dashboards will be developed to recognize the nuances of the issues that individual providers and hospitals may have, keeping the beneficiaries at the center of discussions to determine opportunities for improvement in the delivery and quality of health care,
- that staff make a recommendation about the resources that may be needed to support the work of the Committee,
- that L.A. Care has a role in fostering collaboration across the spectrum of providers that serve L.A. Care's members, including Plan Partners.

Member Impact: The PRAC will advise the Board on potential actions that L.A. Care can take to improve services to members by developing deeper understanding and stronger relationships with all providers.

Budget Impact: No Budget impact.

Board of Governors
MOTION SUMMARY

Motion:

To establish a Provider Relations Advisory Committee ("Committee") to function as a committee of the Board of Governors ("Board") with its first regular meeting to be held in June 2023 or as soon thereafter as possible. The Committee will develop a Committee Charter that includes, but is not limited to:

- **identifying and informing the Board of challenges affecting providers in Los Angeles County**
- **recommending opportunities to mitigate those challenges,**
- **reporting to the Board regularly on progress made toward achieving its objectives,**
- **recommending to the Board the number and qualifications of Committee members, scope of matters on which Committee will review,**
- **recommending parameters for the conduct of proceedings, and**
- **Board Member George Greene shall serve as founding Chairperson.**

Founding Committee members may include Board members, Los Angeles County providers and others. Committee members will be recommended by John Baackes, *Chief Executive Officer,* and Committee Chairperson Greene, and shall be appointed by the Chairperson of the Board.

April 17, 2023

To: John Baackes, CEO

From: Augustavia Haydel, Esq., *General Counsel*
Linda Merkens, *Senior Manager, Board Services*

Subject: Establishing a Provider Relations Advisory Committee

Background

This memo is in response to a request from the Board on April 6, 2023 to:

- Review the process and requirements for the Board to establish the Provider Relations Advisory Committee (PRAC).
- Review and make recommendations concerning the potential appointment of George Greene as Chairperson of the Committee, and appointing other potential members to include other board members, Los Angeles County providers and other individuals, as appropriate, and
- Review and make recommendations concerning any other issues as designated in L.A. Care's bylaws and other applicable governing sources or law.

Below is a list of the categories of provider stakeholders in L.A. Care's enabling legislation to be included on the L.A. Care Board of Governors and other L.A. Care committees, to provide ideas for the stakeholders that might be included in the Committee.

Recommended Next Steps

Board Member Supervisor Solis made a motion at the April 6 L.A. Care Board of Governors' meeting. Below are recommended next steps to implement Board Supervisor Solis' proposed action, which was endorsed by Board Members:

1. Staff will place an item on the April 26 Executive Committee meeting Agenda.
2. The Executive Committee can discuss the proposal and approve a motion that will then be placed on the Agenda for the May Board of Governors meeting (a draft motion is attached).
3. Staff will prepare for the first meeting of the Committee to be held in June, once the Board action to create the Committee is completed.
4. Mr. Baackes and PRAC Chairperson Board Member Greene will solicit and recommend members of the Committee for appointment by the Chairperson of the Board of Governors. The PRAC member appointments will be made by the Chairperson, in accordance with the Bylaws. The appointment of individuals to the PRAC do not need any further action by the Board of Governors.
5. Meetings will be conducted in accordance with L.A. Care's Bylaws and applicable law. At its first meeting, the PRAC shall establish:
   a. Meeting schedule and location (schedule will then be approved by the Board),

b. Draft purpose and goals to be achieved by the Committee in accordance with the board's direction in its motion to establish the Committee,
c. Guidance for metrics to determine progress in the goals to be achieved.

6. Board Services will support the meetings of the PRAC in the same way as all Board committees are supported, which includes maintaining a schedule of meetings, planning the agenda, a roster of members, notice of the meetings to participants, agendas, meeting summaries, and logistics for the meetings.

Attached is a draft motion to establish a Provider Relations Advisory Committee for consideration by the Executive Committee on April 26: The draft motion includes the initial scope that was set out in the motion. Here is the motion recorded in the April 6 Board meeting minutes (there was no action on this proposed motion language):

Motion

> It is moved that the L.A. Care Board of Governors establish an advisory committee designated as the "Provider Relations Advisory Committee" for the purposes of identifying and informing the Board of the challenges affecting providers in Los Angeles County, considering opportunities to mitigate those challenges, and making recommendations to the Board. It is further moved that the initial Chair of the Committee shall be George Greene and that membership of the Committee shall consist of Board members, Los Angeles County providers and others, as deemed appropriate by this Board.

Provider stakeholders on L.A. Care Board and Committees

Board of Governors

One Los Angeles County Supervisor, three members with experience as a health care administrator or as a health care provider, a children's health care provider, health plan or health insurance expertise, community clinics and health centers, federally qualified health centers, private hospitals that have Medi-Cal disproportionate share (DSH) status, or if such status no longer exists, that serve an equivalent patient population, private hospitals (non-DSH), physician representative, a L.A. Care member, a L.A. Care member advocate.

Children's Health Consultant Advisory Committee

Children and family services, maternal and child health care, obstetrics, pediatrics, mental health, dental care, school-based care, health advocacy, community-based services, Los Angeles County/Department of Health Services (LAC/DHS) maternal and children's health programs and other experts and stakeholders in children's health care

Technical Advisory Committee

A medical school representative, an epidemiologist, a pharmacist, a nursing association representative, a home health care representative, a long-term care provider, a mental health care provider, a medical rehabilitation provider, an expert on health care quality, or, in the alternative, other persons with health care expertise.

Authority to form the committee and appoint members is in the L.A. Care Bylaws:

L.A. Care Bylaws

Section 6.4 Additional Advisory Groups or Committees

The Board may, as it deems necessary, establish additional advisory groups or committees, including, without limitation, one or more "peer review bodies" in accordance with W&I Code Section

14087.38(n). A resolution of the Board establishing any additional advisory group or committee may specify the number and qualifications of members, scope of matters on which such group or committee will provide review and recommendations, parameters for the conduct of proceedings, and conditions and procedures for dissolution of the advisory group or committee. The membership of the advisory groups or committees described in this Article VI, including, without limitation, the Technical Advisory Committee and the Community Advisory Committees specified in Sections 6.1 and 6.2 above, may include Board Members; provided that all of the members of such committees and subcommittees shall serve at the pleasure of the Board. The Board may adopt rules for the conduct of proceedings for any such advisory group or committee.

While there is no specific mention about forming committees in L.A. Care's enabling legislation, the following authority applies to the Committee's meetings:
California Code, Welfare and Institutions Code - WIC § 14087.963
(a) The governing body of the commission shall establish rules for its proceedings. There shall be at least six meetings per year.