2014

MEDI-CAL DIRECT (MCLA),

PASC-SEIU,

AND

HEALTHY KIDS

PROVIDER MANUAL

Contents

1.0 L.A. CARE

GENERAL INTRODUCTION

Responsibility of Participating Providers

L.A. Care Health Plan (L.A. Care) requires that its contracted medical groups, hospitals, ancillary providers and other Participating Physician Groups (PPGs) fulfill specified responsibilities. There is a segment entitled "Responsibility of Participating Providers" at the beginning of most sections of this manual that clarifies what functions, if any, are the responsibility of L.A. Care's contracted providers. Please read each of these sections carefully in order to determine what functions are the responsibilities of L.A. Care, and which are the responsibility of PPGs, hospitals, ancillary providers, or other participating providers.

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

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

Traditional and Safety Net Providers

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

L.A. CARE ENROLLMENT ASSISTANCE LINE

If you have patients that you believe may be eligible for Medi-Cal, or Healthy Kids Programs, please refer them to L.A. Care at 1-888-4LA-CARE (1-888-452-2273). TTY/TDD users should call 1-866-LA-CARE1 (1-866-522-2731)

HEALTHY KIDS PROGRAM

Program Overview

The Healthy Kids program is offered by L.A. Care Health Plan and is sponsored by First 5 LA and the Children's Health Initiative of Greater Los Angeles. Healthy Kids is a low-cost health insurance program that offers comprehensive medical, dental, and vision coverage for children up to their 19th birthday. The Healthy Kids Program for children ages 0-5 is sponsored by First 5 LA. The Healthy Kids Program for children ages 6 through 18 is sponsored by the Children's Health Initiative of Greater Los Angeles.

Eligibility Criteria

Regardless of their immigration status, uninsured children who do not qualify for Medi-Cal or the program, and whose family income is below 300% of the Federal Poverty Level are eligible to enroll in the program. Children covered by employer sponsored insurance will not be eligible for Healthy Kids until they have been off of the employer sponsored health coverage for a minimum of three (3) months.

There are no pre-existing condition exclusions. Children accepted into the program are eligible for a full year of coverage. While Healthy Kids is subsidized by First 5 LA and Children's Health Initiative of Greater Los Angeles, families may have to pay a $4 or $6 premium, depending on family income. Families with more than two children in the program will only have to pay premium for a maximum of two children ($8 or $12 is the maximum a family would pay per month).

Healthy Kids is an extension of all L.A. Care's product lines. This allows families to choose L.A. Care Health Plan and have children in any of our product lines to continue receiving care with the same providers.

1.2. L.A. CARE DEPARTMENTAL CONTACT LIST

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

DEPARTMENT	NAME	EXTENSION
Capitation	Director	4236
Case Management	Case Management Nurse	Call: 1-877- 431-2273; Fax: 1-213-438-5034
Claims	Director For all claims for which L.A. Care is responsible, please mail to: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081	5727
Communications	Director	4142
Cultural & Linguistic Services	Director	4559
Eligibility Verification	Provider Information Line	1-866-LA-CARE6 1-866-522-2736
Encounter Data	Provider Information Line	1-866-LA-CARE6 1-866-522-2736
Health Education	Director	4559
Health Education	Manager	4524
Long Term Services and Supports	Provider Line	855-427-1223 OR 213-694-1250, ext. 5422 Fax: 213-438-4877
Medical Management	Senior Director, Medical Management	4427

Medical Management	Director, Medical Management	4650
Medical Management	Manager, Utilization Management	4649
Member Services	Member Service Department	1-888-839-9909
Network Operations	Sr. Director Provider Network Operations Manager Provider Relations	4036 4504
Pharmacy	Director	4251
Prior Authorizations/ Hospital Admissions	TOLL-FREE: 1-877-431-2273 FAX: (213) 438-5777 **PPGs not delegated for extended Medical Management/Concurrent Review -** L.A. Care Medical Management Department must be notified within 24 hours or the next business day following the admission. To obtain an Authorization: CALL TOLL-FREE: 1-877-HF1-CARE(431-2273) FAX: (213) 438-5777	
Provider Credentialing, Performance and Certification	Manager	4026
Provider Information/Data Issues	Provider Information Line	1-866-LA-CARE6 1-866-522-2736
Provider Network Research and Analysis	Manager	4263
Quality Improvement	Sr. Director	5744
Quality Improvement	Manager of Quality Improvement	4391
Quality Improvement	Manager of Disease Management	4768
Regulatory Affairs & Compliance	Compliance Officer	4292
Sales & Marketing	Director	4575

BH/Medi-Cal: Los Angeles County Department of Mental Health (LACDMH). Services from LACDMH can be provided with or without a referral. LACDMH may be reached toll-free at 1-800-854-7771.

Behavioral Health hotline (Healthy Kids) 1-877-344-2858

www.lacare.org/providers/resources/mentalhealth

L.A. Care Nurse Advice Line: 1-800-249-3619

24/7 Free Health Advice for MCLA, Healthy Kids

Well Child Assessment Forms: L.A. Care Website

www.lacare.org/providers/resources/stayinghealthyforms

Health Education Services: 1-855-856-6943

http://www.lacare.org/providers/resources/healtheducation

Case Management: 1-877-431-2273

www.lacare.org/providers/commonquestions

Disease Management Programs: 1-800 LA-CARE6 or 1-866-522-2736

www.lacare.org/providers/commonquestions/qualityimprovementprogram

Clinical Practice Guidelines: L.A. Care Website

www.lacare.org/providers/resources/clinicalguidelines

Preventive Health Guidelines: L.A. Care Website

www.lacare.org/providers/resources/clinicalguidelines

GLOSSARY OF TERMS

ACRONYM OR WORD(s)	DEFINITION
AAP	American Academy of Pediatrics
AIM	Access for Infants and Mothers Program
Ancillary Service	The following services are considered ancillary: ambulance transportation; durable medical equipment (DME) including but not limited to apnea monitor, artificial limbs, and hearing aids; home health care; prosthetic and orthodontic devices; and skilled nursing facilities.
BOG	Board of Governors
CAP	Corrective Action Plans
CBAS	Community Based Adult Services
CCS	California Children's Services – This program provides health care services to children with certain physical limitations and diseases whose families cannot afford all or part of the care.
CHDP	Child Health & Disability Prevention
CPSP	Comprehensive Perinatal Services Programs
DDS	Developmental Disability Services
DHS	Department of Health Services
DMHC	Department of Managed Health Care
DOFR	Division of Financial Responsibility
FSR	Facility Site Review
HEDIS	Healthcare Effectiveness Data and Information Set
IBNR	Incurred But Not Reported

GLOSSARY OF TEMS (CONTINUED)

ACRONYM OR WORD(s)	DEFINITION
PASC-SEIU	In Home Supportive Services
IPA	Independent Practice Association – In the L.A. Care Provider Manual, PPG will be referred to Participating Physician Groups
L.A. Care	L.A. Care Health Plan (Local Initiative Health Authority for Los Angeles County)
LTC	Long Term Care
LTSS	Long Term Services and Supports (a.k.a. Managed Long Term Supports and Services)
MOU	Memorandum of Understanding
MLTSS	Managed Long Term Services and Supports (a.k.a. Long Term Services and Supports)
MRMIB	Managed Risk Medical Insurance Board
MSSP	Multipurpose Senior Services Program
NCQA	National Committee for Quality Assurance
NAL	Nurse Advice Line
PCP	Primary Care Provider
PNRA	Provider Network Research & Analysis Unit
QIP	Quality Improvement Plan
SED	Severely Emotionally Disturbed
SNF	Skilled Nursing Facility
WIC	Women, Infant & Children's Program

Information Available to Providers on L.A. Care's Web site

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

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

If you would like paper copies of any of the information available on the website, please contact us at **1-866-LA-CARE6 (1-866-522-2736).**

NOTICE TO PROVIDERS

L.A. Care has recently amended practitioner and provider contracts to encourage practitioners to freely communicate with patients about their treatment, including medication treatment options, regardless of benefit coverage limitations; and to require that practitioners and facilities:

- Cooperate with L.A. Care's and Plan Partner Quality Improvement activities.
- Provide L.A. Care and Plan Partners access to practitioner or facility medical records, to the extent permitted by state and federal law.
- Maintain the confidentiality of member information and records.
- Provider groups and practitioners allow L.A. Care to use practitioner performance data, e.g. Quality Improvement Activities, public reporting to consumers, etc.

The contract amendment also requires specialists and specialty group practices to provide timely notification to L.A. Care's members who have been under the ongoing care of the terminating specialist or an entire specialty group. Our contracts with specialists and specialty group practices outline which party is responsible for notifying those members affected by the termination prior to the effective date of termination. L.A. Care holds responsibility for notifying members affected by a termination of a provider unless this function is delegated by contract. You can find additional information regarding notification of specialist termination on L.A. Care's website at www.lacare.org If you would like paper copies of any of the above information, please contact us at **1-866-LA-CARE6 (1-866-522-2736).**

2.0 MEMBERSHIP AND MEMBERSHIP SERVICES

This section covers membership and Member Services for L.A. Care Health Plan's direct product lines. Topics include eligibility, enrollment and disenrollment, primary care provider assignment, and member rights and responsibilities.

RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs) in L.A. Care are responsible for adhering to the Member Services provisions and guidelines specified in this section.

PROGRAM ELIGIBILITY

All subscribers who are determined eligible by the governing agency, such as the Department of Managed Health Care (DMHC) the Department of Health Care Services (DHCS) and Managed Risk Medical Insurance Board (MRMIB) of the particular product line can be enrolled in that program.

CONDITIONS OF ENROLLMENT

L.A. Care will enroll all subscribers referred by the program or program contractor on the specified date.

Through a new member Welcome Packet, L.A. Care Health Plan will notify the member of enrollment status and effective date of coverage with L.A. Care Health Plan.

MEMBER ENROLLMENT, ASSIGNMENT AND DISENROLLMENT

The following guidelines apply to Healthy Kids programs **only**. Medi-Cal guidelines to follow.

Healthy Kids Program

Individuals interested in applying for the Healthy Kids Program can apply at any DHCS/Healthy Kids contracted entity, or they may call **L.A. Care at 1-888-4LA-CARE (1-888-452-2273)**.

The Healthy Kids Program enrolls children on a rolling basis. An application that is approved before the 20th of each month will be active on the first day of the next consecutive month. All applications received after the 20th of the month will not be active until the following month.

Medi-Cal Guidelines

There are two types of Medi-Cal programs in Los Angeles County; "fee-for-service" and "managed care". Most Medi-Cal beneficiaries in this county are enrolled in "managed care." L.A. Care is a managed care health plan.

Medi-Cal beneficiaries, who are part of the "fee-for-service" program, are not enrolled in a managed care health plan and must find doctors and other providers who will accept payment directly from Medi-Cal.

Medi-Cal Expansion

Under the Affordable Care Act, Medicaid — or Medi-Cal in California — has been expanded to include low-income adults without children. Coverage under the expansion will begin January 1, 2014.

Medi-Cal currently provides health coverage for low-income individuals including families with children, seniors, people with disabilities, foster care youth, pregnant women and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS. The Medi-Cal Expansion program now covers low-income adults up to 138% of the federal poverty level, or $15,856 a year for a single individual.

In Los Angeles County, an estimated 300,000 adults currently enrolled in the Los Angeles County Low Income Health Program, also known as Healthy Way LA (HWLA), will be automatically transitioned into a Medi-Cal health plan on January 1, 2014. As one of two Medi-Cal health plans in Los Angeles County, L.A. Care

anticipates receiving approximately 153,000 of these members.

Mandatory Medi-Cal Managed Care beneficiaries
The Department of Health Care Services (DHCS) is in charge of the Medi-Cal Program and has designated Los Angeles County as a "mandatory managed care" county for most Medi-Cal beneficiaries.

A mandatory member may disenroll from Medi-Cal managed care only if the member: has a complex medical condition (such as HIV/AIDS or cancer) has been in Medi-Cal managed care less than 90 days is being treated by a doctor who does not work with any Medi-Cal managed care health plan.

Voluntary Medi-Cal Managed Care beneficiaries
Medi-Cal beneficiaries considered to be "voluntary" managed care enrollees can choose to enroll in a managed care health plan. A voluntary Medi-Cal beneficiary can choose to leave their managed care health plan and return to fee-for-service Medi-Cal at any time.

Voluntary beneficiaries include:

- American Indians and their household, and others who are eligible to get services from an
- Indian Health Center or Native American Health Clinic
- Children in foster care or the Adoption Assistance Program
- Members with HIV/AIDS diagnosis
- Dual eligible beneficiaries

Member Enrollment
DHCS conducts member enrollment and disenrollment into and out of L.A. Care Health Plan. This is accomplished through DHCS' contracted Health Care Options (HCO) Program. The current contractor is Maximus.

HCO enrolls Medi-Cal beneficiaries into L.A. Care Health Plan or the commercial plan of the Two-Plan Model. Individuals in mandatory aid codes who do not select L.A. Care Health Plan or the commercial plan will be defaulted into one of them using a special assignment algorithm. Beneficiaries may disenroll from L.A. Care Health Plan or the commercial plan and enroll in the other plan. HCO also disenrolls members from Medi-Cal managed care when their managed care eligibility is lost.

Selection, Assignment, and Change of Primary Care Physician Selection
The governing agencies will provide L.A. Care with the name of the subscriber's chosen PCP. L.A. Care will ensure that all subscribers are enrolled with a PCP by the effective date of coverage in the plan. L.A. Care will mail a Welcome Packet to each subscriber (one per household) who is enrolled.

Assignment to Primary Care Physician
If the member does not select a PCP, one will be chosen for the member. The assignment process will take into consideration the member's area of residence, the member's primary language, the member's age, the capacity of each PCP and the safety net status of the provider.

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

Member-Initiated Change
Members requesting to change to another PPG or PCP can do so by calling L.A. Care at 1888-839-9909.

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

Notification of Enrollment and Assignment
L.A. Care will mail a Welcome Packet to the member's upon enrollment. . The Welcome Packet includes a welcome letter, identification card, Provider Directory and the Evidence of Coverage (EOC)/Member Handbook. The Welcome Packet will be sent no later than the 7th day of the month that the member is effective for Healthy Kids and Medi-Cal programs.

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

A member will be disenrolled for the following reasons:

- If he/she is no longer eligible during the benefit year in accordance with the governing agency's eligibility requirements
- Requests disenrollment in writing
- Makes a false declaration in order to establish program eligibility

In addition to the disenrollment reasons listed above, members may be disenrolled from a program for reasons specific to the program as identified in this section.

The member is responsible for charges incurred after eligibility ends.

Healthy Kids Program
A member will be disenrolled from the Healthy Kids Program for the following reasons:

- Reaches the age of 19 (member will be disenrolled at the end of the month in which age 19 is reached). This is also known as "age-out"
- Moves out of the service area
- Fails to provide the necessary information to be re-qualified
- Requests to be disenrolled
- Failure to pay the monthly premium for sixty (60) days

After the member is disenrolled, he/she cannot re-enroll in the Healthy Kids program for six (6) months. Members may contact L.A. Care at **1-866-4LA-CARE** (1-866-452-2273) to discuss enrollment and disenrollment processes and options.

Medi-Cal Program
Members may disenroll from L.A. Care Health Plan at their discretion. Voluntary disenrollment for individuals in mandatory Medi-Cal aid codes will result in their subsequent enrollment in the commercial plan. Conversely, commercial plan members may disenroll and must then enroll in L.A. Care Health Plan.

To disenroll from L.A. Care, members can call Health Care Options at 1-800-430-4263. Health Care Options enrolls or disenrolls Medi-Cal beneficiaries in or out of a Medi-Cal managed care health plans. They will send the disenrollment form. Membership will end on the last day of the month in which Health Care Options approves the request. Disenrollment takes about 15 to 45 days. Members must continue to receive services through L.A. Care until they are disenrolled from L.A. Care.

Under certain circumstances, a member may be involuntary disenrolled from managed care. These include:

- Moving out of Los Angeles County permanently.
- Member is in a long-term care or intermediate care facility beyond the month of admission and the following month.
- Member requires medical health care services not provided by L.A. Care (for example, some major organ transplants, and chronic kidney dialysis).

- Member has other non-government or government sponsored health coverage.
- Member is in prison or jail.
- For cases in which a disenrolled member reverts back to fee-for-service Medi-Cal, the former member could feasibly continue to receive care from the same provider(s) on a fee-for-service basis.

MEMBER IDENTIFICATION CARD

The L.A. Care member identification card provides a member's program name, language, date of birth, PPG name and phone numbers, PCP name, phone number and address, and pharmacy claims information. See **Exhibit 1** of the services agreement.

ELIGIBILITY VERIFICATION

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

To verify member eligibility, providers can log on to L.A. Care Connect at www.lacare.org or call L.A. Care's Provider Information Line at 1-866-LA-CARE6 (1-866-522-2736).

EVIDENCE OF COVERAGE

An L.A. Care Evidence of Coverage (EOC)/Member Handbook is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and how to access such services. You can obtain a copy of the EOC by logging in to www.lacare.org or by calling L.A. Care Health Plan's Member Services Department at 1-888-839-9909.

CO-PAYMENTS FOR HEALTHY KIDS MEMBERS

There are member co-payments for most health care services and prescription drugs. For a complete listing, please refer to **Exhibit 2** for a matrix of co-payments. For purposes of tracking co-payments, L.A. Care suggests that members keep all their co-payment receipts.

Healthy Kids Program

- Age 0-5 pay $0 to $6 a month for each child, depending on family income (with maximum of $12); $5 co-payment for emergency services
- Age 6-18 pay $15 a month for each child, regardless of family income (with maximum of $45); $15 co-payment for emergency services
- Co-payment of $5 for most services and prescriptions
- Preventive services such as immunizations and regular checkups are covered at no charge to the member

Medi-Cal Program

No co-payments will be charged when receiving services covered by the Medi-Cal program.

MEMBER'S RIGHTS AND RESPONSIBILITIES

L.A. Care members have specific rights and responsibilities that are fundamental to the provision and receipt of quality healthcare. Member rights and responsibilities are described in L.A. Care's Evidence of Coverage (EOC)/Member Handbook as well as listed below.

MEMBER RIGHTS

Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy from your health plan's providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care. You have the right to be free from restraint (including physical and mechanical restraints and drugs), used as a means of coercion, discipline, convenience or retaliation.

Privacy and confidentiality. You have the right to have a private relationship with your provider and to have your medical record kept confidential. You also have the right to receive a copy of, amend and request corrections to your medical record. If you are a minor, you have the right to certain services that do not need your parent's okay.

Choice and involvement in your care. You have the right to receive information about your health plan, its services, its doctors and other providers. You have the right to choose your Primary Care Physician (doctor) from the doctors and clinics listed in your health plan's provider directory. You also have the right to get appointments within a reasonable amount of time. You have the right to talk with your doctor about any care your doctor provides or recommends, discuss all treatment options, and participate in making decisions about your care. You have the right to a second opinion. You have the right to talk candidly to your doctor about appropriate or medically necessary treatment options for your condition, regardless of the cost or what your benefits are. You have the right to information about treatment regardless of the cost or what your benefits are. You have the right to say "no" to treatment. You have a right to decide in advance how you want to be cared for in case you have a life-threatening illness or injury.

Receive timely customer service. You have the right to wait no more than 10 minutes to speak to a customer service representative during L.A. Care's normal business hours.

Voice your concerns. You have the right to complain about L.A. Care, the health plans and providers we work with, or the care you get without fear of losing your benefits. L.A. Care will help you with the process. If you don't agree with a decision, you have the right to appeal, which is to ask for a review of the decision. You have the right to disenroll from your health plan whenever you want. As a Medi-Cal member, you have the right to request a State Fair Hearing.

Service outside of your health plan's provider network. You have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of your health plan's network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have the right to request an interpreter at no charge and not use a family member or a friend to translate for you. You have the right to get the Member Handbook and other information in another language or format.

Know your rights. You have the right to receive information about your rights and responsibilities. You have the right to make recommendations about these rights and responsibilities.

MEMBER RESPONSIBILITES

Act courteously and respectfully. You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.

Give up-to-date, accurate and complete information. You are responsible for giving correct information and as much information as you can to all of your providers, and to L.A. Care. You are responsible for getting regular checkups and telling your doctor about health problems before they become serious.

Follow your doctor's advice and take part in your care. You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.

Use the Emergency Room only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by your doctor.

Report wrong doing. You are responsible for reporting health care fraud and abuse or wrong doing to L.A. Care. You can do this without giving your name by calling the L.A. Care's Compliance Helpline toll-free at 1-800-400-4889 go to www.lacare.ethicspoint.com, or call the Department of Health Care Services (DHCS) Medi-Cal Fraud and Abuse Hotline toll-free at 1-800-822-6222.

NOTICE TO MEMBERS REGARDING CHANGE IN COVERED SERVICES

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

In the event that the change in covered services includes termination of a provider's contract; the member has a right to make an affirmative request for completion of services in the following situations:

- Acute condition (a serious and sudden condition that lasts a short time like a heart attack, pneumonia or appendicitis) — For the time the condition lasts.
- Serious chronic (long-term) condition — For a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider.
- Pregnancy — During the pregnancy and immediate postpartum care (six weeks after giving birth).
- Terminal illnesses/conditions — For the length of the illness.
- Children ages birth to 36 months — For up to 12 months.
- Surgery or other procedures authorized by L.A. Care as part of a documented course of treatment. This treatment was set to occur — within 180 days of the time the doctor or hospital stops working with L.A. Care or — within 180 days of the time coverage began with L. A. Care.

Some L.A. Care members have additional continuity of care rights based on the DHCS program requirements. An example, Members requesting a DHCS medical exemption from mandatory enrollment but are denied, Medi-Cal expansion enrollment, etc. See section on Continuity of Care.

MEMBER GRIEVANCES

A grievance is ***any*** expression of dissatisfaction by an L.A. Care member. Grievance that suggests a quality of care issue must be handled as a clinical grievance and will be referred to L.A. Care's Member Services Department immediately.

L.A. Care maintains a comprehensive grievance resolution system which includes tracking grievances by category and PPG. PPGs are required to respond to requests for information related to a grievance within five (5) business days. If a PPG fails to provide such medical records within five (5) business days, L.A. Care or the designated agent will be provided access to copy the appropriate medical records at the expense of the PPG.

PPGs that wish to obtain information on the details of this process are encouraged to contact L.A. Care's Member Appeals and Grievance Department.

Some examples are complaints about:

- The service or care received by the PCP or other providers
- The service or care received by the PCP doctor's medical group
- The service or care received by the pharmacy
- The service or care received by the hospital
- The service or care received by L.A. Care

Members can file grievances by doing any of the following:

Write, visit or call L.A. Care

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
1-888-839-9909
213-438-5748 (fax)

Medi-Cal Program Members may also

Ask for a State Fair Hearing by calling toll-free 1-800-952-5253 (English and Spanish), or by writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

A State Fair Hearing can be requested before, during or after filing a grievance with the health plan. Members can file a grievance with the health plan and ask for a State Fair Hearing at the same time.

Complaints to the Department of Managed Health Care (DMHC)

If you or your members have a grievance against L.A. Care, you need to contact L.A. Care and follow its internal grievance process.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-839-9909 and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance

procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The DMHC also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877688-9891) for the hearing and speech impaired. The DMHC's internet website, http://www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

Maintenance of Member Grievance Records

L.A. Care will maintain all records related to member grievances for up to five (5) years after the active record has been closed.

3.0 ACCESS TO CARE

This section summarizes the access to care requirements for L.A. Care Participating Physician Groups (PPGs).

RESPONSIBILITY OF PARTICIPATING PROVIDERS

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

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

L.A. CARE/PARTICIPATING PHYSICIAN GROUP ACCESS REQUIREMENTS

Accessibility Standards		
L.A. Care	**Member Services Department Call Service:** **a.** Speed of Telephone Answer: The maximum length of time for Member Service Department staff to answer the telephone. **b.** Call Abandonment Rate	 • 90% of calls within 30 seconds Not to exceed 3% in a calendar month
Primary Care Appt. Wait Times	**Preventive Exams:** A periodic health evaluation for a member with no acute medical problem, including: • Initial Health Assessment and Individual Health Education Behavioral Assessment (IHEBA) "Staying Healthy" • First Prenatal Visit • Routine preventive health examination*	 ≤ 90 calendar days from when the member becomes eligible. Members <18 months of age ≤ 60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less • ≤14 calendar days of request • • ≤ 10 business days of request, not to exceed 30 calendar days
	• EPSDT/CHDP*	• ≤ 10 business days of request, not to exceed 30 calendar days

	Routine Primary Care (non-urgent): Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	• ≤ 10 business days of request
Accessibility Standards		
Urgent Care	**Urgent Care:** Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	• ≤ 48 hours of request if no authorization is required • ≤ 96 hours if prior authorization is required
Emergency Care	**Emergency:** Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	• Immediate, 24 hours a day, 7 days per week
Office Wait Times	**Office Waiting Room Time:** The time after a scheduled medical appointment a patient is waiting to see a practitioner once in the office.	• Within 45 minutes of arrival
Speed to Answer (Practitioner Office)	**Speed of Telephone Answer (Practitioner's Office):** The maximum length of time for practitioner office staff to answer the phone.	• ≤ 30 seconds

After Hours	**After Hours Calls:**	• Automated systems must provide emergency 911 instructions; and • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, covering practitioner or offer a call-back from the PCP or covering practitioner within 30 minutes. • If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls. • Professional Marketplace staff: o Must have access to practitioner for both urgent and non-urgent calls.
Call Return Time (Physician)	**Call Return Time:** The maximum length of time for PCP or on-call practitioner to return a call after hours.	• ≤ 30 minutes
SCP Care	**Routine Specialty Care:**	• Within 15 business days of request, not to exceed 30 calendar days*
SCP: Urgent Care:	**Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.**	• ≤ 48 hours of request if no authorization is required • ≤ 96 hours if prior authorization is required
Accessibility Standards		
Ancillary Care	**Non-Emergent Ancillary Services**	• ≤ 15 business days of request
Behavioral Health Care*	**Routine Behavioral Health Care**	• < 10 business days of request, not to exceed 30 calendar days*
	Urgent Care	• < 48 hours of request
	Non-life-threatening emergency	• < 6 hours of request

	Emergency: Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	• Immediate, 24 hours a day, 7 days per week
	Behavioral Health Telephone Responsiveness • Quarterly average speed of answer for screening and triage calls. • Quarterly average abandonment rate for screening and triage calls.	• < 30 seconds • NTE 3%
Availability Standards		
Ratio of providers to members	**Physician to Enrollee Ratio**	• 1:1200
	PCP to member ratio **Provider to Extender Ratio*** • Nurse Practitioners • Physicians Assistants *L.A. Care allows a provider an additional 1,000 members per extender up to a maximum of 5,000 members per PCP.	• 1:2000 • 1:4 • 1:4
	SCP to member ratio	• Annually, L.A. Care identifies and assesses the OBG network along with the top four specialties based on number of encounters for the 12 month period from October 1st through September 30th of the measurement year. Standards for provider to member ratio are determined based on utilization, need and trended data.
	Ancillary Providers* ***Hospitals, Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgical Centers, Radiology Centers an Dialysis Centers**	• 1:5000

	Behavioral Health: • Psychiatrists/Behavioral Healthcare • Outpatient Mental Health Providers (Licensed Clinical Social Workers, Marriage and Family Therapists, etc.) • Psychologists • Inpatient Psychiatric Facilities and Residential Treatment Centers • Inpatient Substance Abuse Facilities and Residential Treatment Centers **Ambulatory Facilities**	 • 1:5000 • 1:2000 • 1:2000 • 1:5000 • 1:10000 • 1:10000
Drive Distance	**Drive distance: PCP**	95% of members have access to 1 PCP within 10 miles of their residence.
	Drive Distance: SCP	90% of members have access to one SCP of each type within 15 miles of residence
	Drive Distance: Behavioral Health • Psychiatrists/Behavioral Healthcare • Outpatient Mental Health Providers (Licensed Clinical Social Workers, Marriage and Family Therapists, etc.) • Psychologists • Inpatient Psychiatric Facilities and Residential Treatment Centers • Inpatient Substance Abuse Facilities and Residential Treatment Centers **Ambulatory Facilities**	 • Within 10 miles/20 minutes of member residence • 2 providers with 15 miles of member residence • • 2 providers with 30 miles of member residence • • 1 provider within 30 miles • 1 provider within 30 miles • • 2 providers within 15 miles

	Drive Distance: Ancillary Providers* *Hospitals, Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgical Centers, Radiology Centers an Dialysis Centers	• • • Within 15 miles/30 minutes of member residence
	Drive Distance: Pharmacies	• 95%of members have access to one pharmacy within 15 miles of residence

PCP MINIMUM SITE HOUR REQUIREMENTS

- PCP MUST BE PHYSICALLY ON SITE EIGHT (8) HOURS PER WEEK PER SITE WITH A MAXIMUM OF FOUR (4) SITES
- EACH SITE MUST BE AVAILABLE A MINIMUM OF SIXTEEN (16) HOURS PER WEEK TO SEE L.A. CARE MEMBERS.

4.0 SCOPE OF BENEFITS

HEALTH BENEFITS

Member Handbooks (Evidence of Coverage) for Medi-Cal Direct and Healthy Kids are maintained by Product Management and are provided annually to each member. The Benefits Section of the handbooks describe in detail the covered and non-covered services, procedures, and medical equipment for the line of business.

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

Healthy Kids benefits are developed by First 5 L.A and L.A. Care. A listing of the benefits for Healthy Kids may be found in the most recent version of the Evidence of Coverage.

PPGs may access health benefit information or obtain a copy of any of the L.A. Care's products Evidence of Coverage at the L.A. Care Website at www.lacare.org.

NURSE ADVICE LINE (1-800-249-3619)

L.A. Care provides, free of charge, a 24/7 nurse advice line (NAL). Providers are encouraged to share this number with these patients. The NAL is intended to assist provide general health advice and information understand health concerns, understand medicines and health test results, and seek the appropriate level of care. The line is staffed with RNs who follow MD reviewed algorithms when triaging symptomatic calls. An audio library of more than 1,000 easy to follow health topics is also provided through this service.

Other Important Numbers

Hearing- or speech- impaired members can contact L.A. Care Nurse Advice Line through the California Telecommunications Relay Service at 1-866-735-2929 (TTY) or 1-800-854-7784 (speech-to-speech).

How to access Non Emergency Transportation:

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

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

Press 1 for Ambulatory/Wheelchair Reservations

Press 2 for Ambulatory/Wheelchair "Where is my ride?" (Scheduling a Return Ride)

Press 3 for Gurney/Ambulance

Press 8 for Information in Spanish or dial 866-529-2142

NOTE: Medi-Cal patients are required to have a certificate of medical necessity on file. If you have questions about completing the form or need a copy of the form, you may contact LogistiCare's Utilization Review Department at **866-666-8645**.

5.0 UTILIZATION MANAGEMENT (The following UM processes apply to L.A. Care's Direct Lines of Business: MCLA, Healthy Kids, & PASC-SEIU Workers)

This section summarizes L.A. Care Health Plan's (L.A. Care) Utilization Management (UM) Processes for direct contract Participating Physician Groups (PPGs). UM functions/activities vary depending on specific contractual agreements with each contracted PPG, provider, and hospital. Please check your contract Division of Financial Responsibility (DOFR), or contact L.A. Care's Provider Information Line at 1-866-LA-CARE6 or Utilization Management at 1-877-431-2273.

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

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

- Benefit clarification
- Referral management
- Coordination of care and services for linked programs (CCS, DDS, Early Intervention, Local Education Agency Services Mental Health, etc.)
- Coordination of End Stage Renal Disease benefit
- Targeted (comprehensive and catastrophic) case management
- Complex Case Management
- Education of PPG/providers on policies, procedures and legislative updates

GOAL AND OBJECTIVES

Goal

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

Objectives

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

- Managing, evaluating, and monitoring the provision of healthcare services rendered to L.A. Care members to enhance access to, and provision of, appropriate services.
- Facilitating communication and developing partnerships between Plan Partners, Participating Provider Groups, Providers, Practitioners, Members, and L.A. Care.
- Developing and implementing programs to encourage preventive health behaviors which can ultimately improve quality outcomes.
- Assisting PPGs, Providers, and Practitioners in providing ongoing medical care for members with chronic or catastrophic illness.
- Developing and maintaining effective relationships with linked and carved-out service providers available to L.A. Care members through County, State, Federal, and other community based programs to ensure optimal care coordination and service delivery.
- Facilitating and ensuring continuity of care for L.A. Care members within and outside of L.A. Care's network.

- Integration with Quality Improvement
  - The UM Program has a variety of quality operations processes in place to ensure quality of care service-oriented interventions are initiated and carried out. Linkage between the UM Program and the Quality Improvement (QI) Program is supported through committee representation by UM Program management and by presenting executive level summary of pertinent UM documents to the L.A. Care QOC Committee.
  - Additionally, UM integration with quality operations supports activities to capture utilization trends or patterns and is measured by, but not limited to:
    - IRR,
    - Satisfaction with UM
    - Sentinel or adverse event reporting...
    - Referral of identified potential quality issues for review to the QI Department for follow-up in accordance with established procedures
- Referral of identified potential quality issues for review to the QI Department for follow-up in accordance with established procedures Ensuring a process for UM that is effective and coordinated through Committees, work groups and task forces with the involvement and cooperation of experts in all fields of medicine, management, patient advocacy and other relevant fields.
- Providing leadership to PPGs, Providers, and Practitioners by developing and recommending changes and improvements in programs and processes resulting from collection and analysis of utilization data.
- Ensuring that UM decisions are made independent of financial incentives or obligations.
- Monitoring the provision of health assessments and basic medical case management to all members, PPGs, Providers, and Practitioners.

SCOPE OF SERVICE

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

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

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

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

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

At a minimum the UM Program includes the following:

- Assures that services which are medically necessary are delivered at the appropriate level of care, including inpatient, outpatient, and the emergency room.
- Assures that authorized services are consistent with the benefits provided by the Plan.
- Provides a comprehensive analysis of care by identifying under- and over-utilization patterns by physicians and within the Plan.

- Reviews care and identifies trends that positively and negatively impact the quality of care provided to the members.
- Defines, monitors, and trends medical practice patterns impacting members' care.
- Ensures that appropriate medical review guidelines are available and used by UM personnel.
- Identifies, develops, revises, and implements appropriate policies, procedures, processes, and mechanisms for UM that can be used to evaluate medical necessity for requested services on a timely and regular basis.
- Instructs all institutions, physicians, and other health care clinicians regarding the criteria used, the information sources employed, and the methods utilized in the approval and review processes.
- Provides the health plan network with information related to effective mandated information system and communications for the monitoring, management, and planning of medical services.
- Ensures that network institutions, physicians, and other health care clinicians provide services unless otherwise mandated by regulatory standards.
- Determines if illness or injury is covered under other programs including third-party payers, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP) or Mental Health Services.
- Ensures that guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate.
- Facilitates consistent practice patterns among institutions, physicians, and other health care clinicians with L. A. Care Health Plan by offering feedback to the PPGs/Providers to assist in optimizing appropriate medical practice patterns.
- Provides case management services to ensure cost effective ongoing care at the appropriate level.
- Utilizes information in member and physician satisfaction surveys to develop quality improvement activities as appropriate.
- Conducts inter-rater reliability of physician and non-physician reviewers to assess determinations made as part of the UM process.
- Provides required reports.
- Ensures coordination and continuity of care for members receiving linked and carved out services.

Policy Prohibiting Financial Incentives for Utilization Management Decision-makers
Utilization Management decisions are based only on appropriateness of care and service and the existence of coverage. There are no rewards or incentives for practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for Utilization Management decision-makers to encourage decisions that would result in underutilization.

Required Reporting from UM
PPG UM Departments shall monitor, report, and address the following services to the appropriate committee structures. The services include, but at not limited to:

- Potentially fraudulent or abusive practices are referred to Regulatory Affairs and Compliance.
- Potential under and over utilization are referred to the UM Director.
- Coordination of care for results or facilitation are referred to the UM Director.
- Opportunities for improvement are referred to the UM Director.
- Breaches of adherence to confidentiality and HIPAA policies are referred to the HIPAA Compliance Officer.
- Potential quality issues identified through UM activities are referred to the Quality Improvement department

- Barriers to accessibility and availability of services are referred to Provider Network Operations and Quality Improvement Departments, as appropriate.

DELEGATION OF UTILIZATION MANAGEMENT

L.A. Care has a formal process by which specific Utilization Management functions are delegated to other organizations including PPGs, and ancillary vendors **(See PPGs Service Agreement — Delegation of UM Functions by NCQA UM Standards).**

L.A. Care evaluates all proposed delegates using a formal process that assesses the organization's systems, processes and capabilities according to defined criteria. Utilization Management is not delegated until L.A. Care determines, in its sole judgment, that the delegate is capable of performing the delegated functions in a manner acceptable to L.A. Care. L.A. Care's UM Delegation Standards and Oversight Monitoring Activities are described more fully in Addendum C.

The scope of delegation for each delegate is defined in a written delegation agreement. UM Delegation is defined in terms of:

- Standard Delegation
- Extended Delegation

Standard is defined as delegation to perform UM activities defined in the delegation agreement and noted in the PPG DOFR as "PPG Risk". Extended delegation is defined as delegation to perform activities defined in the delegation agreement and noted in the PPG DOFR as "PPG Risk" and "Hospital Shared Risk Pool".

The agreement also defines the oversight process and delegate reporting requirements. Delegates are not permitted to sub-delegate any functions without L.A. Care's consent.

The ability for an organization to maintain its status as a delegate depends solely on the organization's capacity, in L.A. Care's judgment, to continue to perform in a manner consistent with the defined criteria.

Oversight of delegation includes periodic assessments throughout the year by designated staff based, in part, on review of required reports submitted by the delegate.

All delegates are formally reevaluated annually. The scope of the reevaluation may depend on the organization's Knox-Keene or other regulatory status and NCQA accreditation or certification status and includes conducting oversight activities, reporting results, developing corrective action plans and monitoring progress in implementation of the corrective action plans.

L.A. Care is responsible for making sure that the delegated activities are performed in a manner consistent with the delegation agreement, L.A. Care criteria, and applicable regulatory requirements and accreditation standards. L.A. Care provides ongoing assistance, guidance, and oversight in furtherance of this goal. Should L.A. Care determine that an organization is not performing any portion of the delegated functions in a manner consistent with the delegation agreement, L.A. Care criteria, applicable regulatory requirements, or applicable accreditation standards L.A. Care may institute corrective action or revoke the delegation in whole or in part.

Non-compliance issues will be brought to the attention of the Compliance Officer for recommended actions. Non-compliance issues directly impacting member care will be brought to the attention of the Chief Medical Officer for recommendations which could include suspension of membership, up to and including immediate contract termination.

If L.A. Care Health Plan withholds or withdraws delegated status for Utilization Management from a PPG,

L.A. Care Health Plan's Utilization Management department shall assume the level of UM activity appropriate to the new non-delegated PPG. L.A. Care Health Plan reserves the right to continue to delegate Utilization Management to the PPGs if they meet L.A. Care Health Plan's standards for delegation. L.A. Care Health Plan's Utilization Management department will provide consultation to the PPG and may actively participate with the PPG to assist the PPG to come into compliance with a UM delegated function prior to L.A. Care Health Plan's revocation of a UM delegated status.

UM DELEGATION STATUS

PPGs audited for UM delegation will be designated a delegation status after the due diligence review, annually and as a result of a supplemental or focused audit findings. Delegation status includes standard and extended delegation.

Standard is defined as delegation to perform UM activities defined in the delegation agreement and noted in the PPG DOFR as "PPG Risk". Extended delegation is defined as delegation to perform activities defined in the delegation agreement and noted in the PPG DOFR as "PPG Risk" and "Hospital Shared Risk Pool".

PPG delegation status may be impacted by PPGs contractual relationship with L.A. Care. All PPGs will be audited for compliance with the UM related regulatory requirements. Non-compliance may result in supplemental audits or focused audits to ensure compliance.

UM DELEGATION MONITORING AND OVERSIGHT

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

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

UM REPORTS

PPGs will submit utilization reports as defined in the delegation agreements, by secured portal exchange, e-mail or fax, from encounter data, claims data or department logs. A copy of the reporting requirements can be found in the PPG Contract.

L.A. Care Health Plan will utilize encounter data, summary reports, and supplemental reports provided by PPGs to track, trend, and report UM activities as required by the State. These reports, combined with information obtained via site visits and audits, will be used to accomplish the UM oversight functions required by regulation and/or contract requirement. Some oversight reporting requires additional information be sent to the Delegation Oversight Unit for ongoing monitoring. L.A. Care reviews PPGs UM decision-making by auditing denial determinations on a periodic basis. Modification and Denial Notice of Action letters and medical records utilized in the modification or denial determination must be sent to the L.A. Care UM Department as defined in the PPG delegation agreements.

L.A. Care Health Plan will analyze the reports and present the results to the PPGs via the quarterly Oversight Response Communication. The goal of performing plan and group specific analysis is to monitor utilization activities, member access to care, and to validate and compare to community norms/ benchmarks. Any variance(s) or trends will be reviewed and discussed at the Utilization Management sub-committee and Committee meetings, and periodically at the Quality of Care and Internal Compliance Committees for recommendations.

UM DELEGATION OVERSIGHT AUDITS

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

- Annual approved Utilization Management Program, Work Plan, and Evaluation
- UM Policies/Procedures/Processes
- UM Administrative capacity, staffing resources
- UM Over/Under Utilization
- UM referral management
- UM Criteria and consistency of application of criteria
- Emergency Services and After Hours Authorizations
- UM sub-delegation activities
- UM Case Management, for Members identified by the HRA or CM program as "low" or "moderate" risk
- UM Care Coordination for in and out of network referrals/hospitals
- UM Care Coordination for Linked and Carved Out Services

SUPPLEMENTAL AUDITS

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

A sampling methodology, used to select member records, ensures a representative sample from the delegated entity for the supplemental audit.

Supplemental audit tools are scored according to the methodology approved by the UM Committee.

The supplemental audit may address any Utilization Management and coordination of care category

as identified by L.A. Care Health Plan UM Program.

CONTINUOUS MONITORING ACTIVITIES

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

- Referral Management – Timeliness and Clinical Decision Making
- Case Coordination Review for in and out of network referrals and hospitals
- Care Coordination for Linked and Carved Out Services Delegation Oversight Review
- Care Coordination for HRAs and care management services for low and moderate risk acuity levels

Continuous monitoring of unappealed denials

The L.A. Care UM Department reviews denials issued and submitted by the delegates. Delegated PPGs are required to submit all denial letters with any supporting documentation current to the denial or on schedule defined in L.A Care's Delegation Oversight Monitoring Policy

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

- Timeliness of the decision-making and notification process
- Physician involvement in the decision making
- Clear and concise denial reason
- Appropriate information available for decision-making
- Documentation of criteria for medical necessity denials or benefit reference
- Appeal rights and process ***(NOTE: Appeals process differs for members based on lines of business)***
- Appropriate template

If deficiencies are found in the initial review, the Plan or delegated PPGs are notified of the areas of deficiencies for immediate correction. Continued non-compliance issues are reported to the Internal Compliance Committee (ICC) for recommendations in corrective action planning or disciplinary action. Delegated Physician Group letters are also audited during the annual oversight audits. Corrective action plans are required for those PPGs with less than 90% compliance.

- PPGs with deficiencies or corrective action plans will be monitored according to L.A. Care policy.
- If a PPG remains non-compliant, the findings will be reported to the Delegation Oversight Committee for a decision regarding continued delegation.

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

BENEFITS

The State of California, Department of Health Care Services (DHCS) mandates benefits for Medi-Cal Members.

Healthy Kids benefits are developed by First 5 L.A and L.A. Care.

PASC-SEIU Workers benefits are developed by PASC-SEIU Workers benefits are developed by SEIU.

Member Handbooks for Medi-Cal, Healthy Kids, and PASC-SEIU Workers are maintained by Product Management and are provided annually to each member. The Benefits Section of the handbook describe in detail the covered and non-covered services, procedures, and medical equipment for the line of business.

TRANSITION TO OTHER CARE WHEN BENEFITS END

L.A. Care assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

NEW MEDICAL TECHNOLOGY

L.A. Care evaluates the inclusion of new technologies and new applications of existing technologies in the benefit plans. The Pharmacy and Therapeutics Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee and to the Quality Oversight Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices.

Members and providers may ask L.A. Care to review new technology. To request a new technology review or new use of an existing technology, the PPG may contact the UM Medical Director or UM Director at (877) 431-2273.

RESPONSIBILITY OF PARTICIPATING PROVIDERS

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

The PPG is responsible for notifying and obtaining authorization from L.A. Care's UM department for services in the hospital shared risk pool, for which L.A. Care has financial responsibility or as defined by the PPGs delegation agreement. Please refer to the contract DOFR. Certain PPGs may have delegation for extended UM activities which extends to the PPG the authority to review, authorize and coordinate services that a L.A. Care's financial responsibility. Please review your PPGs delegation status prior to making UM determinations.

The PPG agrees and is required to:

- Provide supportive care management/care coordination activities for the PCPs
- Make available to L.A. Care any requested data, documents and reports.
- Allow site visits, periodic attendance at UM meetings, evaluation and audits by L.A. Care or other agencies authorized by L.A. Care to conduct evaluations.
- Have representation and involvement in L.A. Care's UM committee meetings and other activities scheduled to enhance and/or improve the quality of health care services provided to L.A. Care's

members.

AFTER HOURS AUTHORIZATION

PPGs must have a system in place for members to contact their Primary Care Physician, or a physician delegated to provide medical advice, after hours (24 hours, 7 days a week). This includes contacting the delegated UM Staff or physician covering for the PCP or PPG for hospital notifications.

PPGs are required to have 24 hours/7 days per week telephone access to utilization management professionals to:

- Review and provide
  - Instructions for Medical Necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary
  - Response to these requests is required within 30 minutes or the service is deemed approved in accordance with state regulations.
  - Coordination of professional services for hospital admissions or transfers
- Review and provide instructions for non-urgent care following an exam in the emergency room
  - Response to these requests is required within 30 minutes or the service is deemed approved in accordance with DHCS contractual regulations.
- Respond to expedited requests for;
  - Referrals due within a 72 hour (from the time of the receipt) period
  - Assistance in the resolution for appeals of denied services
  - Assistance in the resolution of clinical grievances
  - Assistance in the resolution of requests for information from regulatory agencies

How to Communicate with UM Staff and Instructions for Triaging Inbound Calls Specific to UM Cases/Issues:

L.A. Care Health Plan provides members and practitioners access to UM staff when they are seeking information regarding the Utilization Management process and the authorization of care.

- UM Staff members are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
  - The toll free UM number at L.A. Care is (877) 431-2273.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff members identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- For telephone calls from Members and Providers regarding UM issues:
  - For Members: L.A. Care will accept collect calls from members and also provides the following toll free numbers (L.A. Care product specific member 800 toll free numbers)
    - TDD/TTY services for members who need them.
    - Language assistance for members to discuss UM issues.
  - For Practitioners: L.A Care provides a Toll-free telephone number/L.A. Care's UM toll free provider "800" authorization line: 1-877- 431-2273

- L.A. Care's Web Sites for members and providers provides the following information.
  - L.A. Care's processes for UM communication services that include:
    - Business hours during which UM staff are available.
    - Instructions on how to give and get specific information regarding a UM request.
    - Instructions for faxing or leaving a voice mail message outside of business hours, which also prompts members and practitioners to provide their contact information so that UM staff can respond back to them on a timely basis as appropriate
    - How to access language services
    - Resources for providers to download and use in their practice such as a C&L Provider Toolkit, interpreter request/refusal labels, patient language identification labels, translated signage, and the Employee Language Skills Self-Assessment Form.

Additional instructions on how to obtain authorizations and communicate with UM staff are listed below.

UM REFERRAL MANAGEMENT REVIEW PROCESSES

PPG contract status impacts how the PPG will coordinate UM referral activities with L.A Care. Currently, L.A. Care contract models include:

- Fee For Service (FFS)
- Shared Risk (SR)
- Dual Risk (DR)
- Full Risk (FR)
- Capitated

PPGs with FFS contracts are capitated for primary care services. Non-primary care related request for services (referrals) that are not considered exemptions from prior authorization or auto-authorization must be referred to L.A. Care UM Department for UM decision making.

PPGs with SR contracts are capitated for primary care and some diagnostic procedures. PPG may make medical necessity decisions on outpatient services noted as "hospital shared risk" WHEN services are provided at a L.A. Care contracted facility. PPG must notify L.A. Care at the time of the decision via the standard L.A. Care Referral Request form of the decision and the facility utilized. PPG is responsible for notification to the Member, the Requesting Provider, the Rendering Provider and the PCP. PPG must refer all inpatient, acute or sub-acute, settings to L.A. Care.

PPGs with DR contracts maintain a hospital and PPG risk arrangement; L.A Care delegates UM activities to the PPG. The PPG and the hospital have arrangements defining responsible parties for UM activities. PPG is responsible for maintaining UM referral management activities and ensuring communication and notifications to the Member, the Requesting Provider, the Rendering Provider and the PCP.

PPGs with FR contracts have Knox Keene or limited Knox Keene licensure and maintain a hospital and PPG risk arrangement; L.A Care delegates UM activities to the PPG. The PPG and the hospital have arrangements defining responsible parties for UM activities. PPG is responsible for maintaining UM referral management activities and ensuring communication and notifications to the Member, the Requesting Provider, the Rendering Provider and the PCP.

Capitated contracts are usually specialty health plans or services providers and are fully at risk for contracted services; L.A Care delegates UM activities to the provider. The provider may be responsible for maintaining UM referral management activities and ensuring communication and notifications to the Member, the

Requesting Provider, the Rendering Provider and the PCP based on the terms of the delegation agreement.

Services Exempt from (Not Requiring) Prior Authorization (Pre-service Review)

- PPGs must provide, arrange for, or otherwise facilitate the following services, including appropriate coverage of costs without prior authorization as described in corresponding policies and procedures.
    - Emergency services (medical screening and stabilization) where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed and when an authorized representative, acting for L.A. Care, has authorized the provision of emergency services.
    - Preventive health services for all ages including immunizations.
    - Family Planning Services including outpatient abortions through any family planning provider.
    - Basic in-network prenatal care, including OB/GYN in-network referrals and consults.
    - Sensitive and confidential services and treatment, including but not limited to, services relating to sexual assault, pregnancy and pregnancy related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment).
    - Sexually Transmitted Disease (STD) treatment services both in and out of network including follow-up care.
    - Confidential HIV counseling and testing services both in network and through out-of-network local health departments and family planning providers.

SERVICES REQUIRING PRIOR AUTHORIZATION

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

There are services for which the PPG must submit a request/referral to L.A. Care for prior authorization, or notification concurrently with or retrospective of the services for authorization by L.A. Care. All authorization requests submitted to L.A. Care will be responded to within the defined timeframes as follows:

- Routine – 5 working days from receipt of the information
- Expedited – 72 hours from the receipt of the request for service

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

- Certain pharmaceuticals (the pharmacy prior-authorization process can be found in the Pharmacy Manual)
- Durable Medical Equipment (DME)
- Home Health Services
- Hospice
- Non-Emergent/Non-Urgent Hospital or Skilled Nursing Facility admissions (see DOFR)
- Medical Supplies (not provided in physicians' offices)
- Most elective surgical and invasive diagnostic procedures (inpatient or outpatient facility component) (see DOFR)
- Orthotics & Prosthetics
- Physical/Occupational & Speech therapies (see DOFR)
- Rehabilitation services

- Transplant evaluation

UM SERVICES NOT DELEGATED TO PPGS:

Referrals for:

- Power Wheelchairs
- Coagulation Factors (see pharmacy list)
- EPSDT Supplemental Services – In Home Shift Nursing Care/Private Duty Nursing *(See Section: EPSDT Supplemental Services)*
- Medical Long Term Services and Supports

REFERRAL MANAGEMENT PROCESSES:

- Pre-Service Review (also called Prior Authorization, Pre-certification)
- Concurrent Review
- Post Service Review (service provided but no claim has been submitted)
- Retrospective Claim Review
- Second Opinion Review
- Reconsideration Review (Peer review between physicians for a second review within 24 hours of the initial decision); **NOT the CMS definition of a UM appeal.**
- Independent Medical Review

NOTE: Referral requests submitted as expedited/urgent must meet the regulatory definition for urgent care. The Health and Safety code defines urgent services as:

- Expedited (urgent) request means any request for medical care or treatment with respect to which the application of the time periods for making non urgent care determinations:
    - Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
    - In the opinion of a practitioner with knowledge of the members medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Referrals submitted as such will be reviewed by L.A. Care clinical staff to ensure the service requested meets this definition. Referrals that DO NOT met the definition will be modified to the appropriate determination status, i.e. routine, and processed accordingly. The modification will be referred to a L.A Care medical director to ensure the Member's condition is not such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process and would be detrimental to the Member's life or health or could jeopardize the Member's ability to regain maximum function

The requestor will receive notification of the modification and given an opportunity to submit a reconsideration of the determination.

COORDINATION OF MEDICALLY NECESSARY SERVICES

The PCP is responsible for providing members with routine medical care and serves as the medical case manager within each managed care system. Referrals are made when services are medically necessary, outside the PCP's scope of practice, or when members are unresponsive to treatments, develop complications, or

specialty services are needed. The PCP is responsible for making referrals and coordinating all medically necessary services required by the member. Pertinent summaries of the member's record should be transferred to the specialist by the PCP. Authorization flow charts are provided at the end of this section.

Outpatient Referrals and Specialty Referral Tracking

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

- Submit a referral request to the PPG or the designated hospital physician to obtain authorization for those services.
- The PPG will process the request or contact the L.A. Care UM department to obtain authorization for the facility component of services needed, as appropriate.
- After obtaining the authorization(s),
    - PCP/PPG is responsible for notifying and referring the member to the appropriate specialist or facility.
    - The PCP, office staff, or member may arrange the referral appointment.
    - Note the referral in the member's medical record and attach any authorization paperwork.
    - Discuss the case with the member and the referral provider.
    - Receive reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider, or facility the member was referred to.)
    - Discuss the results of the referral, any plan for further treatment, and care coordination with the member, if needed.

Referrals should be tracked by the PCP's office and authorizing PPG for follow-up through a tickler file, log or computerized tracking system. The log or tracking mechanism should note, at a minimum, the following for each referral:

- Member name and identification number
- Diagnosis
- Date of authorization request
- Date of authorization
- Date of appointment
- Date consult report received

Receipt of Specialist's Report

The PCP must ensure timely receipt of the specialist's report (e.g., use of tickler file). Reports for specialty consultations or procedures should be in the member's chart within a given timeframe, usually two (2) weeks. If the PCP has not received the specialist's report within the determined timeframe, the PCP should contact the specialist to obtain the report. For urgent and emergent cases, the specialist should initiate a telephone report to the PCP as soon as possible, and a written report should be received within two (2) weeks.

Member Eligibility Verification

Member eligibility and covered benefits should be verified prior to UM decisions

Minimum Clinical Information for Review of UM Requests for Authorization

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure.

When making a determination of coverage based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs as necessary.

Clinical information for making determinations of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:

- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

Referrals submitted to L.A. Care UM Department for a clinical determination must contain the information to assess for medical necessity of the service. Missing information provided by PPGs or PCPs delay the services and may result in referrals returned to the requestor

Timeliness Standards
Timeliness standards for decisions and notification of UM decisions are described for each line of business in the most current UM policies and procedures. . Please contact LA Care for the most recent version of the policies and matrix.

For operational purposes, L.A. Care's timeliness standards for the initial start date of a referral are:

- Routine requests
    - Day of receipt of the request as "Day 0"
    - Day following receipt of the request as "Day 1"
- Expedited or Urgent requests (within 72 hours)
    - 24 hours is equivalent to one calendar day
    - 72 hours is considered as 3 calendar days.

  NOTE: For Medicare enrollment, see the L.A. Care Medicare Provider Manual, Section - Medicare UM Timeliness Standards

Utilization Management Criteria
Approved UM Criteria are utilized for modifying, deferring, or denying requested services. PPGs are required to utilize evidence based criteria when making UM determinations.

L.A. Care requires that PPG UM Criteria be:

- Evidence based

- Reviewed or developed, and adopted, with involvement from actively practicing health care providers.
- Consistent with sound clinical principles and processes.
- Evaluated at least annually and updated as necessary.

L.A. Care adopts and maintains approved UM Criteria. UM criteria are used to determine medical necessity in the referral management Treatment Authorization Request (TAR) review process.

L.A. Care Approved Criteria and Application of UM Criteria

- UM Criteria used when determining medical necessity for a utilization review request in the following hierarchy order are:

  - Auto Auth Criteria as approved by the UM Committee; if Auto Auth Criteria do not apply; then

  - Other Utilization Management Committee Approved Criteria such as, but not limited to Synagis Criteria, Medical/Nutritional Criteria, Pharmacy Therapeutics & New Technology Approved Criteria, etc; If other approved criteria do not apply, then

  - For MCLA: UM Medi-Cal Criteria are to be used first for MCLA members, as available and updated on Department of Health Care Services (DHCS) Web Site (as applicable)

  - For HK, and PASC-SEIU & MCLA or when DHCS Medi-Cal Criteria not available:
    - The following evidence based criteria are to be used first for Healthy Kids, & PASC-SEIU members and for MCLA members when DHCS Web Site criteria are not applicable:
      - MCG Criteria (formally called Milliman Care Guidelines)
      - Apollo UM Criteria
      - Uptodate.com

  However, in situations where two or more decision making criteria as listed above are available, MCG Criteria will be utilized as first choice. MCG Criteria are also to be used as the first choice in Appeals and other requested Clinical reviews.

- **Definition of Medical Necessity (**Product Line specific when the above criteria do not apply to a specific request for a UM decision) **Medically Necessary or Medical Necessity** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:
  - Consistent with nationally accepted standards of medical practice:
  - "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

- For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
- For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
- When determining the medical necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "medical necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

- **Because nationally developed procedures for applying criteria, particularly those for lengths of hospital stay, are often designed for "uncomplicated" patients and for a complete delivery system, they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care**. Therefore, L.A. Care considers at least the following when applying criteria to a given individual:

  - age
  - comorbidities
  - complications
  - progress of treatment
  - psychosocial needs
  - home environment, when applicable

- **L.A. Care also considers characteristics of the local delivery system available for specific members, such as, but not limited to:**

  - availability of contracted hospitals within the network and other hospitals out of network
  - availability of contracted specialists and specialty centers
  - availability of non-contracted specialists and specialty centers which may be contracted through a one-time MOU for a specific member for unusual specialty services
  - availability of skilled nursing facilities, sub-acute care facilities or home care in the service area to support the patient after hospital discharge
  - coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed
  - local hospital's ability to provide all recommended services within the estimated length of stay.

- **If none of the approved UM Criteria meet the member's medically necessary services needs, even when considering the member's individual needs, and/or the characteristics of the local delivery system, then the physician reviewer considers other alternatives, such as:**

  - approving higher levels of care within the local area

- making arrangements to send the member out-of-the local network or out-of-Plan for the needed services
- arranging for case discussion with a local physician consultant or a physician consultant from the contracted vendor
- assembling a panel of independent experts to identify other possible alternatives

- Ultimately the physician reviewer makes a UM decision in a timely manner that will meet the member's individual medically necessary needs. In these instances, the physician reviewer makes the determination in a manner which is consistent with L.A. Care's Utilization Management Principles.

PPG UM Criteria

- PPGs may choose to review or adopt specific evidence based UM criteria to be used for decision making.

  L.A. Care reserves the right to review the PPGs criteria on an annual basis to ensure that PPGs are using evidence based criteria and the most current available versions of the evidence based criteria.

Criteria for use in L.A. Care review of Appeals and other requested Clinical Reviews (e.g. Clinical Grievance Review, PQIs, etc

- MCG Criteria are used by L.A. Care as the first choice in review of Appeals and other requested Clinical reviews (e.g. Clinical Grievance Review, PQIs, etc.).
- Assessment of Consistency of UM Decisions
- PPGs are required to ensure that UM criteria be applied in a consistent and appropriate manner by physician and non-physician UM staff based on available medical information and the needs of individual Members.

- L.A. Care's requirements for PPG Inter-rater Reliability (IRR)

  At least annually, PPGs are required to ensure that consistency and appropriateness with which health care professionals involved in utilization review apply criteria in decision making is evaluated and reported.

  The assessment of IRRs applies only to determinations made as part of a UM process. A primary care practitioner's referral of a member to a specialist, when the referral does not require prior authorization, is not considered a UM determination.

  Opportunities to improve consistency in the application of criteria are acted upon, as appropriate.

  Require IRR Methodologies use Statistically Valid Samples (see most recent copy of L.A. Care policy):

  - 5 percent or 50 of its UM determination files, whichever is less; or
  - NCQA "8/30 methodology" or a valid sampling of hypothetical cases

- L.A. Care reserves the right to review the PPGs IRR on an annual basis to ensure that PPGs are using required IRR Methodology with statistically valid samples.

Access to and Disclosure of UM Criteria and UM Policies/Procedures and Processes
UM criteria and UM procedures and processes are available to L.A. Care practitioners, providers, members and their representatives, and the public upon request. To obtain a copy of any L.A. Care UM criteria, UM policies/procedure and UM processes, practitioners, providers, members and their representatives, and the public may contact the L.A. Care Member Services Department at **1-888-839-9909,** or the L.A. Care UM Department at **1-877-431-2273** and ask to speak with the UM Director or UM Manager to make the request.

PPGs shall make information available so that practitioners, providers, members, member representatives, and the public know how to request the PPG's UM criteria, UM policies/procedures and UM processes.

PPGs shall maintain a log for requests of UM Criteria, and report the number and types of UM Criteria requests annually to their UM Committees.

Use of Board Certified Consultant to assist in making UM Decisions based on Medical Necessity and covered Medical Benefits

- L.A. Care provides a description of guidelines for the use of Board Certified Consultants to assist in making UM decisions based on medical necessity, covered medical benefits as defined in the member's Evidence of Coverage (EOC), and care or services that could be considered either covered or non-covered, depending on the circumstances.

- L.A. Care has access to a broad range of contracted medical, pharmaceutical, and behavioral health practitioners in various specialties and subspecialties in Los Angeles County available for verbal and written consultation.

- L.A. Care also maintains a contract with an outside vendor for various services, including use of Board Certified Consultants, who are available for review upon request.
    - If the Board Certified Consultant is from the contracted vendor that L.A. Care uses to obtain the services of a Board Certified Consultants (i.e. non-L.A. Care physician/peer reviewer), the consultant shall provide advice that the UM Medical Director/peer reviewer considers in making his/her UM decision.
    - Non-L.A. Care consultants cannot make a denial decision

Requests for Authorization (Referrals) to L.A. Care's UM Department
Requests for Authorization (Referrals) may be submitted on paper, by phone, or electronically. All requests must be submitted on a L.A. Care Referral Form and include the following information:

- Requesting provider
- Patient's name, date of birth, address, phone number, and social security number
- Confirmation of current L.A. Care eligibility
- Patient's diagnosis and medical history supportive to the service requested
- Supportive medical records needed to make a determination
- Appropriate coding (using current CPT-4, ICD-9 procedure, and/or HCPCS codes), and identification of services requested
- Identification of requested provider of service, including name, type of provider, location and provider's phone number

Notification Process for UM Decisions *(See L.A. Care UM Timeliness Matrix)*
Notifications of UM decisions are made in accordance with all current regulatory requirements as described for

each line of business in the most current UM Policies and Procedures. For PPGs delegated to perform UM functions, the PPG is responsible for member and provider notifications.

PPGs are required to notify members and providers of UM determinations related to approvals, modifications, deferrals (pended) or denials.

Providers should be notified of determinations by phone within 24 hours of the determination. The written determination must be mailed to the Member and Provider within two (2) business days of the determination.

For services that are the financially responsibility of the PPGs hospital shared risk pool or L.A. Care:

- PPGS with Standard Delegation
    - PPG managing an outpatient referral and using a contracted L.A. Care facility, PPG UM Department is responsible for notifying the member, the requesting provider, the rendering provider and the PCP.

    - When PPG must utilize a non-L.A. Care facility, PPG will pend the determination and route the request to L.A. Care's UM Department for review/determination. **NOTE:** Decision-making timeframe is within the 5 business days of receipt of the information necessary to make the information:
        - Upon final determination, L.A. Care will notify the PPG UM Department, of the determination and
        - PPG UM Department is responsible for notifying the member, the requesting provider, the rendering provider and the PCP.
    - For requests with insufficient information to make the determination AND additional information is necessary to make an appropriate determination, the PPG will issue a deferral notification. The deferral must be communicated, completed before the 5th calendar day of receipt of the request and approved by the Member and Provider; the notification must include the reason for the delay and a date the request will be completed (must be within the 14 calendar days of the request), the L.A. Care UM Department will notify the PPG UM Department and the member.
- PPGs with Extended Delegation
    - PPG is responsible for processing the request, notifying the appropriate providers and documentation of notification to the providers and members as defined in the **L.A. Care UM Timeliness matrix**
    - PPG will notify LA Care as defined in the PPG contract agreements (i.e. electronic file exchange or Excel file logs).

L.A. Care's CAP Deduct Process for PPGs:

Should a PPG authorize a service that is L.A. Care's financial responsibility according to the DOFR, L.A. Care will honor the authorization request and pay the claim, but as defined in the PPG Service Agreement, services are subject to capitation deduction from the PPG's monthly capitation (See PPG contract Section 1.22 E). L.A. Care will notify the PPG and L.A. Care's Provider Network Operations Department when determination is made that a service is eligible for CAP deduct.

Rescission or Modification of an Authorization after a Service has been provided is not allowed

PPG shall not rescind or modify an authorization after the provider renders the health care service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract, or when the PPG did not make an accurate determination of the member's eligibility.

Delay, Denial, Modification, and Termination Determinations/Notice of Action Letters
PPGs are required to utilize the most recent version of the UM Notice of Action Letters (NOA's) specific to the product line. Copies of the template letters are provided to the PPGs, or may be obtained by contacting the L.A. Care UM Department.

Reference to Basis of UM Determination
The following are included in a UM Notice of Action Letter:

- Clear documentation and communication of the reasons for the determination, so that Members and Practitioners receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.
- A reference to the UM Criteria, citation (when applicable), or benefit provision on which the decision is based.
- Information about how the member, upon request, can obtain a copy of the actual UM Criteria or benefit provision on which the decision was based.

Contacting the Peer Reviewer (Reconsideration)
All UM Notice of Action correspondences sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer in order to allow the requesting practitioner the opportunity to discuss issues or concerns regarding the decision.

A requesting practitioner may call L.A. Care to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer, or may write to supply additional information for the physician (or peer) reviewer.

To file a reconsideration of a UM determination, the reconsideration must be filed by the requesting practitioner within 24 hours of the notice of action.

If a requesting practitioner would like to discuss L.A. Care denials/modifications decisions with the physician (or peer) reviewer, please call L.A. Care's UM Department at **1-877-431-2273**.

- L.A. Care's UM Department responds to reconsideration requests within one (1) business day of the receipt of the requesting practitioner telephone call or written request.
- If the physician (or peer) reviewer reverses the original UM determination based on the discussion with, or additional information provided by the requesting practitioner, the case will be closed.
- If reconsideration does not resolve a difference of opinion, and the previous UM determination remains or a modification results, or the requesting practitioner does not request reconsideration, the requesting practitioner may submit a request for review through the appropriate practitioner dispute processes or may appeal on behalf of the member, if appropriate.

Practitioner Appeal Processes--How to Dispute an Adverse Determination Process for Filing a Formal Appeal

If a requesting practitioner believes that a determination is not correct, he/she has the right to appeal the decision on behalf of the member by filing a grievance with L.A. Care Health Plan. The requesting practitioner should submit a copy of the member's denial notice and a brief explanation of his/her concern with any other relevant information to the address below:

L.A. Care Health Plan
Attn: Appeals and Grievance Unit
P.O. Box 811610
Los Angeles, CA 90081
1-888-839-9909
FAX 1-213-438-5748

Pre-service Review (Prior Authorization)

Pre-service Review or Prior Authorization, the formal process requiring a health care provider to obtain advance approval for coverage of specific services or procedures, allows for benefit determination, determination of medical necessity and clinical appropriateness, level of care assessment, assignment of the length of stay for inpatient admissions, appropriate facility placement prior to the delivery of service, and identification of the intensity of case management that may be needed for optimal patient outcomes.

- **24 hour Access to Pre-service Review (Prior Authorization)**
  A Physician with an active unrestricted California license is available 24 hours a day to review requests for post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department, if necessary.
- **Services Requiring Pre-service Review (Prior Authorization)**
  L.A. Care develops, reviews, and approves at least annually, lists of auto pay and auto authorization. Any procedure, treatment, or service not on these lists requires prior authorization. L.A. Care communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.
- **Prior Authorization Specialty Referral Tracking Systems**
  PPGs are required to maintain a system to track and monitor specialty referrals requiring prior authorization. The system tracks the decision (authorization, denial, deferral, modification, and termination) and the timeliness of the decision. L.A Care ensures that all contracting health care practitioners are aware of the referral processes and tracking procedures.

- UM Services Types include:
  - **Pre-service – Urgent** is an expedited authorization in which the provider indicates or determines that following the standard timeframe could jeopardize the member's life or health or ability to attain, maintain or regain maximum function. These determinations are made as expeditiously as the member's health condition requires and not more than within 72 hours after receipt of the request for the service
    - **NOTE:** Service types identified by the PPG Staff as Pre-Service Urgent may be reviewed for appropriateness by the L.A. Care UM Medical Director. PPG will be contacted if a request is determined by the Medical Director not to meet the definition of urgent, and advised that the requested service will be revised to reflect a routine request. Providers who disagree with the revision may contact L.A. Care at (877) 431-2273.

        - **Pre-service – Routine** is a standard request for services not otherwise exempt or expedited.
        - **Concurrent review of authorization** is: an authorization for treatment regimen already in place, reviewed within five working days or less, and is consistent with urgency of the member's medical condition
            - **NOTE:** This does not include inpatient concurrent review; pre-service inpatient concurrent review of service must be responded to within 24 hours of the request
        - **Post Service** – service has occurred without prior authorization; determination within 30 calendar days of the request
        - **Retrospective Claim review**– service has occurred without prior authorization and request is submitted with a claim; determination is made within 30 calendar days of the request or the regulatory requirement for claims processing.
    - UM determinations are made in accordance with the standard regulatory requirements for referral management and include:
        - Approved
        - Modified
        - Denial
        - Pended (Delayed)

Concurrent Review/In-patient Hospital Care
Concurrent Review is the assessment used to determine medical necessity or clinical appropriateness of services as the services are being rendered. Concurrent review is used for the assessment of the need for continued inpatient or ongoing ambulatory care. Concurrent review is generally conducted telephonically, but may also occur on site.

Unless defined in the L.A. Care/PPGs delegation agreement, PPGs are not delegated to perform concurrent review.

Concurrent review includes, but is not limited to:

- Verifying medical necessity
- Determining approximate length of stay
- Determining appropriate level or intensity of service and setting of care
- Ensuring access to ancillary care
- Determining and/or changing the level of case management, when appropriate
- Initiating timely discharge planning activities

Hospital inpatient care may be pre-planned/ pre-authorized (elective), urgent or emergency admissions. The PCP is responsible for obtaining required pre-authorizations for elective inpatient care from the PPG. The PCP must notify the PPG of an emergency admission. **Unless delegated for admissions and concurrent review, the PPG must notify L.A. Care of all inpatient admissions.**

While a member is hospitalized, the PCP must:

- Coordinate, with the assistance of UM staff, care for members admitted to out of network facilities for emergency care, or other reasons. After determination of the appropriateness of an emergency admission and a transfer assessment is made, the member will either be transferred to a network facility or care will be continuously monitored at the initial facility

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

Inpatient Concurrent Review
Inpatient concurrent review is usually a coordinated effort between L.A. Care and the PPG. Once notified, L.A. Care's UM staff or its delegate's will perform telephone reviews with the hospital staff.

- Inpatient concurrent review will begin within one (1) day of notification of the admission and include an assessment of the appropriateness of the level of acute care by using accepted criteria.
- Concurrent review will be conducted periodically on or before the dates assigned at the end of the initial review and each subsequent review. For the applicable timeframes, see the most recent version of the UM Timeliness Matrix.
- Concurrent review includes an evaluation of the following:
  - Appropriateness of acute admission
  - Plan of treatment
  - Level of care
  - Intensity of services/treatment
  - Severity of illness
  - Quality of care
  - Discharge planning

- These reviews will be conducted utilizing accepted guidelines for acute levels of care, such as intensity of service and severity of illness criteria, MCG®, Interqual® or other guidelines and criteria developed and/or approved by L.A. Care.
- PPGs may perform the management of hospital admissions by way of a hospitalist program, or retain the services of a hospitalist. At all times, the hospitalist will facilitate care with L.A. Care UM staff or its delegate.
- Concurrent quality issues (Provider Preventable Conditions or Serious Reportable Adverse Events) noted during utilization review will be documented and reported to the PPG, L.A. Care's UM Medical Director and Quality Improvement department. When appropriate, quality issues will be discussed with the attending physician by the UM medical staff for appropriate intervention. Depending on the urgency or gravity of the situation, discussion of the issues may also be necessary with L.A. Care's Senior Executive Administration.
- Utilization review concurrent focus will be proactive, and UM/Case Management levels of focus will be employed as appropriate.
- L.A. Care will coordinate continued monitoring and management of concurrent reviews. Whenever possible, L.A. Care will transfer members admitted to non-contracted hospitals or hospitals where the PPG does not have hospital services, to an in-network hospital.
- Admissions to non-contracted hospitals **(HK only) –** hospitals are reimbursed based on the most recent contracting methodology and require a one-time agreement. PPG must notify LA Care's UM Department immediately to initiate the MOU process.
- Admissions to non-contracted hospitals **(MCLA only) –** hospitals are reimbursed based on the most recent DHCS contract methodology. At this time, L.A. Care utilizes the APR-DRG Methodology to reimburse non-participating hospitals with Medi-Cal contracts, which requires determination of member stability from transition to an in-network hospital.

Admissions to non-contracted hospitals (MCLA only)

- Members admitted to non-contracted will be managed under the APR DRG effective 7/1/2013.
- Admissions to non-contracted hospital will be assessed for the continued length of stay and the ability to provide the most appropriate care for the member.
    - If services can be provided in the facility and continued services can been maintained with a discharge within a total of 5 days from the admission, the member should be maintained in the same facility
    - If the facility is requesting transfer and the member will not be discharged within 5 days from the admission or services needed to care for the member cannot be met in the current facility, L.A. Care and it's delegates will transfer to an in-network provider or the most appropriate facility to manage care

CCS

- Members under the age of 21 years and who have conditions eligible for services through CCS, L.A. Care will ensure timely referrals are made to and for CCS specialists, hospitals and specialty centers.
    - Providers must follow the most recent CCS Numbered Letter instructions on referral to CCS paneled hospitals using CCS paneled physicians. Providers are referred to the DHCS website for full instructions: http://www.dhcs.ca.gov/Services/CCS/Pages/default.aspx
- For members admitted to non-CCS paneled facility, L.A. Care and its delegates will ensure timely referrals are made to CCS and CCS staff informed of the member's stability for transfer as needed. Once stable, L.A. Care or its delegates will obtain approval to transfer to an appropriate CCS-paneled center.
- L.A. Care and its delegates will ensure, the cases where CCS is pending a determination, L.A Care will approve medically necessary services as needed. Authorization documentation will evidence appropriate decision-making pending the final CCS decisions; decisions will not be held pending CCS final decisions. Once the CCS decision is made, the authorization/referral will be updated in the appropriate information system to reflect the decision and the CCS Service Authorization Referral (SAR)

Discharge Planning

- L.A. Care's UM staff will begin discharge planning within 24 hours of notification of admission and will facilitate the involvement of a multidisciplinary team of physicians, nursing, social work, and others, as appropriate.
- Patient and family intervention will occur, as appropriate, throughout the stay to assure discharge plans are in place and appropriate for each member. Discharge plans will consider the disease process, treatment requirements, the family situation, available benefits and community resources.
- Average length-of-stay guidelines will be used for discharge planning purposes. Discharge screens, lower level of care guidelines, or clinical decision made by the physician are to be used for the final discharge date plan.
- Questionable continued stay plans are to be discussed with the attending physician and then reviewed by L.A. Care's physician reviewer for further discussion with the attending physician.
- **For SPD members, PPGs delegated for concurrent review must maintain a provision for discharge planning when a SPD member is admitted to a hospital or institution and continuing into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:**

    - Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment and other services received
    - Documentation of pre-discharge factors, including an understanding of medical condition by

the member or a member representative of the SPD member as applicable, physical and mental function, financial resources, and social supports
- Services needed after discharge, type of placement preferred by the SPD member/representative of the member/representative, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD member/representative and pre-discharge counseling recommended
- Summary of the nature and outcome of the SPD member/representative involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

Transition of Care (SPD ONLY) – PPGs delegated for concurrent review must maintain a discharge planning process or transition to the next level of care that includes a workflow and supportive documentation for **communication to the primary care provider, SNF or specialist**.

- TOC documentation should ensure:
  - Documentation of status of admission, planned or unplanned
  - Date reflecting the notification of the admission
  - Name of staff member assigned to manage the transition
  - Date TOC record (care plan) is shared to next care setting or usual care practitioner
  - Date of notification sent to the PCP or usual practitioner
  - Date Member or Member's family notified of the transition
  - Diagnosis
  - Follow up apt with usual practitioner (should be within 10 days of admission, but no later than 30 day)
  - If member readmitted, date of last admission
  - Length of stay in the most recent hospital (related to the reported admission)
  - Date of notification to L.A. Care of the admission

Emergency Notification of Admission

PPGs that do not have extended delegation must report all elective and emergency inpatient admissions to L.A. Care's UM department within 24 hours of the admission. These notifications may occur by calling in or faxing the patient's admission face sheet to the following:

1-877-452-CARE (1-877-452-2273)
Fax: 213-438-5777

Maternity Length of Stay

L.A. Care and/or PPGs shall have procedures in place that require members who deliver vaginally, or by caesarean section, to be provided appropriate maternity benefits as required by the Newborn and Mother Health Act of 1997. Prior authorization is not required for these benefits as follows:

- Post partum stay of 48 hours following normal vaginal delivery
- Post partum stay of 96 hours following caesarean section delivery

NOTE: For PPGs managing the concurrent review, L.A. Care's Auto Authorization policy allows for up to 48 hours pre-delivery inpatient services while the member is in active labor. If more than 48 hours pre-delivery have occurred, services should be reviewed based on medical necessity.

Decisions to discharge mothers/newborns earlier than 48 or 96 hours post delivery are to be made by the treating physician in consultation with the mother and must included appropriate documentation for follow-

up plans in the member's medical record.

When the mother/newborn are discharged prior to 48 hours for vaginal delivery/96 hours for cesarean section delivery, L.A. Care and/or PPGs shall cover a post discharge follow-up visit, when agreed to by the mother and ordered by the treating physician. A post discharge follow up visit must occur within 48 hours of discharge or 96 hours post cesarean section, when prescribed by the treating physician.

The treating physician, in consultation with the mother, shall determine whether the visit will occur at home by a home health nurse or whether the member shall see the physician in the physician's office.

The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physician assessments.

L.A. Care's PCPs and OB/GYN providers are expected to provide written notification of these maternity benefits to members during prenatal care. L.A. Care shall provide written notification of these maternity benefits to members through the EOC.

Maternity Kick Payment Reporting (MCLA)

PPGs and providers are required to report live births to ensure accuracy of reporting and reconciliation of maternity kick payments.

Post Service

Post Service (Retrospective Review) is the assessment of the appropriateness of medical services after the services have been provided. Post Service Review is conducted when there has been no notification or request for review prior to services being rendered. Decisions are based on medical necessity and appropriateness of care using UM Criteria and the member's benefit structure.

Post Service Review includes, but is not limited to:

- Reviewing for medical necessity and clinical appropriateness of services in those instances where authorization was not obtained. These services are usually related to the urgency of the care provided.
- Reviewing for eligibility and benefit coverage.

Retrospective Claim Review

Retrospective Claim Review is the assessment of the appropriateness of medical services related to a provider/facility claim. Retrospective Review is conducted in collaboration with the Claims Department and subject to the review timelines associated with the Claims Department. Decisions are based on medical necessity and appropriateness of care using UM Criteria and the member's benefit structure.

Retrospective Claim Review includes, but is not limited to:

- Reviewing for medical necessity and clinical appropriateness of services in those instances where authorization was not obtained.
- Reviewing for eligibility and benefit coverage at the time of service.

PPGs with Extended Delegation

- PPG is responsible for submitting electronic data within 5 days of the decision. If a claim is submitted and the PPG referral determination is not in L.A. Care's claims system, L.A. Care staff may contract the PPG for the final determination. PPGs turn-around time will be based on the urgency of the claim determination requirement, L.A. Care will make every effort to provide adequate time to investigate the referral request.

SPECIALIZED DURABLE MEDICAL EQUIPMENT - Wheelchairs

Medi-Cal covers a wheelchair if it is needed to:

- Prevent significant illness or disability
- Ease severe pain
- Maintain bodily functions needed to perform daily activities

Medi-Cal does not cover a wheelchair if a household or furniture item could otherwise serve the member's needs.

Providers are required to obtain prior authorization from L.A. Care for:

- The purchase or a rental of standard and custom wheelchair
- The repair of a standard or custom wheelchair that exceeds $250

To ensure member safety and the appropriate equipment is provided, L.A. Care requires an evaluation by a physiatrist or physical therapist and an in-home assessment be submitted at the time of the referral request. **L.A. Care does not delegate the UM decision making for customized wheelchairs; contact L.A. Care's UM Department for information on the contracted vendor for in-home assessments**.

The following description outlines how providers should request authorization for purchase or rental of a standard or custom wheelchair, as well as for the repair of a wheelchair.

HOW TO REQUEST AUTHORIZATION OF A STANDARD WHEELCHAIR

For Member in need of a standard wheelchair, the member's PCP or specialist should complete an Authorization Request Form. In completing the form, please be sure to supply the following information:

- Member's name, date of birth, phone number, address and Medi-Cal identification number
- Full name, address, telephone number and signature of the prescribing provider
- Date of request
- Diagnosis codes
- Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes
- Identify rental (short term usage – less than 8 months) versus purchase (long term usage – more than 8 months)
- Copy of physiatrist or physical therapist evaluation

PPGs with standard delegation:

PPG should submit the Authorization Request Form to the L.A. Care's UM Department. L.A. Care will approve, modify or deny the request for a standard wheelchair in accordance with L.A. Care Policies UM 101 Referral Management and UM 104 Pre-Service Authorizations

PPGs with extended delegation:

PPG process the request using a L.A. Care contracted ancillary provider in accordance with L.A. Care Policies UM 101 Referral Management and UM 104 Pre-Service Authorizations.

HOW TO REQUEST AUTHORIZATION OF A CUSTOM WHEELCHAIR

L.A. Care does not delegate the UM decision making for customized wheelchairs; contact L.A. Care's UM Department for information on the contracted vendor for in-home assessments

PPGs should complete an Authorization Referral form, Customized Wheelchair Evaluation Request (CWER) form and Wheelchair Clinical Questionnaire. Contact L.A Care UM Department to obtain copies of these forms: Custom Wheelchair Evaluation Request (CWER) and Wheelchair Clinical Questionnaire.

In completing the form, please be sure to supply the following information:

- Member's name, date of birth, phone number, address and Medi-Cal identification number
- Full name, address, telephone number and signature of the prescribing provider
- Date of request
- Diagnosis codes
- Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes
- Copy of physiatrist or physical therapist evaluation
- Member's medical condition or diagnosis necessitating the custom wheelchair, including functional limitations and a description of how the custom wheelchair would improve the member's medical status or functional ability

PPG should fax the CWER and Clinical Questionnaire to L.A. Care's UM Department at (213) 438-5777
L.A. Care will approve, modify or deny the request for a standard wheelchair in accordance with L.A. Care Policies UM 101 Referral Management and UM 104 Pre-Service Authorizations. For referral request submitted without adequate information, L.A. Care UM Department staff will notify the member and provider of the need to defer the decision allowing time for an in-home assessment; the referral will be completed within the 14 days of the submitted request.

Request for a customized wheelchair evaluation, will be accompanied by an evaluation by a contracted Evaluation Service Provider to arrange for an assessment of the member. The Evaluation Service Provider will assess the member and the medical necessity of a customized wheelchair based upon criteria, based upon the member's medical needs and living environment. The Evaluation Service Provider will submit a letter of recommendation based upon its initial assessment of the member to L.A. Care UM Staff. If the Evaluation Service Provider's letter of recommendation varies from the provider's original request, it will be reviewed by L.A. Care's Medical Director for the final determination. If L.A. Care approves a customized wheelchair, L.A. Care will make arrangements with a selected wheelchair provider. The wheelchair provider will arrange for a fitting appointment with the member. For more information, please see Custom Wheelchair Request and Approval Process - Provider Fact Sheet. To obtain a copy of this attachment, Custom Wheelchair Request and Approval Process - Provider Fact Sheet, contact L.A. Care's UM Department at (877) 431-2273.

HOW TO REQUEST AUTHORIZATION OF A WHEELCHAIR REPAIR

PPGs with extended delegation:
PPG process the request using a L.A. Care contracted ancillary provider.

PPGs with standard delegation:
PPG should submit the Authorization Request Form to the L.A. Care's UM Department. L.A. Care will approve, modify or deny the request for a standard wheelchair in accordance with L.A. Care L.A. Care Policies UM 101 Referral Management and UM 104 Pre-Service Authorizations.

Wheelchair repair requests with a cumulative cost less than $250 that do not utilize miscellaneous or "by report" codes, and that do not exceed frequency limitations, do not require prior authorization.

If a member requires a wheelchair repair costing more than $250 that does not utilize miscellaneous or "by report" codes, PPG should complete an authorization request form. If a wheelchair repair costing more than $250 that does not utilize miscellaneous or "by report" codes, the PPG should complete a Wheelchair Repairs Authorization Request Form. Contact L.A. Care's UM Department to obtain a copy of this form: Wheelchair Repairs Authorization Request.

In completing the form, please be sure to supply the following information:

- Member's name, date of birth, phone number, address and Medi-Cal identification number
- Full name, address, telephone number and signature of the prescribing provider
- Date of request
- Diagnosis codes
- Specific item(s) requested, including Healthcare Common Procedure Coding System (HCPCS) codes
- Description of the repair or maintenance required

PPG should fax the Wheelchair Repairs Authorization Request Form to L.A. Care's UM Department at (213) 438-5777
L.A. Care UM staff review the request for benefit coverage, frequency limits and medical necessity. L.A. Care U.M. Department will approve, modify or deny the request for wheelchair repair in accordance with L.A. Care Policies UM 101 Referral Management and UM 104 Pre-Service Authorizations

SECOND OPINION PROCESS

The second opinion program provides members and providers with the ability to validate the need for specific procedures. The use of screening criteria will be employed in addition to securing a second physician consult, when necessary. Second opinions will be rendered by an appropriately qualified health care professional identified as a primary care physician or a specialist who is acting within his or her scope of practice, and who possesses clinical background, including training and expertise related to the particular illness, disease, condition or conditions associated with the request for a second opinion. Second opinions shall be provided to L.A. Care MCLA and Medi-Cal members at no cost and Healthy Kids (HK) & PASC-SEIU members shall not be responsible for costs beyond their applicable co-pay for second opinions approved by L.A. Care or the delegated PPG.

PPGs shall maintain policies to ensure second opinion request will be processed in accordance with the state regulatory requirements. PPGs requiring assistance in locating a specialist for assistance in processing requests for second opinions may contact the L.A. Care UM Department.

STANDING REFERRAL PROCESS

PPGs must maintain a process for a Member with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling to receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinating the Member's health care.

A standing referral is a referral made by the PCP for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis. A member may request a standing referral to a specialist through his/her PCP or through a participating specialist. The standing referral request will be made in collaboration with the PCP, the treating specialist, and the L.A. Care Medical Director or the delegate. If a treatment plan is necessary in the course of care and is approved by L.A. Care, in consultation with the PCP, specialist and member, a referral shall be made in accordance with the recommended treatment plan. A treatment plan may be deemed unnecessary if L.A. Care approves a current standing referral to a specialist. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member.

Standing referrals do not require L.A. Care, or it's delegates, to refer to a specialist who, or to a specialty care center that, is not employed under contract with L.A. Care or the delegate to provide health care services to members unless there is not a specialist within the network that is appropriate to provide treatment to members as determined by the PCP and in collaboration with the L.A. Care Medical Director, or their designee, as documented in the treatment plan.

L.A. Care Health Plan maintains a referral management process and may delegate the referral management process to delegated entities.

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

Authorization and Referral Processes

Authorization determinations for specialty referral/services shall be processed in accordance with L.A. Care's and/or its delegated entities' policies and procedures for referral management within required time frames for standing referrals, as described in this procedure.

Services shall be authorized as medically necessary for proposed treatment identified as part of the member's care treatment plan utilizing established criteria and consistent with benefit coverage.

Once a determination is made, the referral shall be made to the Specialist within four (4) business days of the date the proposed treatment plan, if any, is submitted to the physician reviewer.

The duration of a standing referral authorization shall not exceed one year at a time, but may be renewed for periods of up to one year, if medically appropriate.

Credentialing Requirements

The specialty provider/special care center shall be credentialed by, and contracted with, L.A. Care or its delegated entities' network to provide the needed services.

If standing referrals are made to providers who are not contracted with L.A. Care or its delegated entities' network, L.A. Care and/or its delegated entities shall make arrangements with that provider for credentialing prior to services rendered, appropriate care coordination, and timely and appropriate reimbursement.

In approving a standing referral, in-network or out-of-network, L.A. Care and PPGs delegated for UM will take

into account the ability of the member to travel to the provider. PPGs can request assistance from L.A. Care for locating a specialist (See Specialty Care Liaison Program Procedure).

HIV/AIDS Referrals
When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, PPGs shall refer the member to an HIV/AIDS specialist.

When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the member's health care, who is infected with HIV/AIDS, PPGs shall refer the member to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician if:

- the nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
- the nurse practitioner or physician meets the qualifications specified in the state regulations; and
- the nurse practitioner or physician assistant and the provider's supervising HIV/AIDS specialist have the capacity to see an additional patient

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

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

TUBERCULOSIS TREATMENT SERVICES PROVIDED BY PRIMARY CARE PROVIDER
PPGs shall have established programs for ensuring that basic care for tuberculosis is provided to members at the primary care provider level through basic case management services.

PPGs shall ensure that primary care providers provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention to include, but not limited to:

- TB screening
- TB diagnosis
- TB treatment
- TB follow-up

PPGS shall ensure that primary care providers coordinate with Local Health Departments in the referral of members requiring Tuberculosis Direct Observed Therapy, a linked and carved out service available through the Local Health Departments (See L.A. Care Health Plan UM Procedure 17046 Tuberculosis, Directly Observed Therapy (DOT).

CERVICAL CANCER SCREENING
PPGs shall have procedures to provide for Cervical Cancer Screening, a covered preventive health benefit for L.A. Care Health Plan members.

The coverage for an annual Cervical Cancer Screening test shall include the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration, upon the

referral of the member's health care provider (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee).

PPGs shall ensure that routine referral processes are followed when the member requests a human papillomavirus (HPV) screening test, in addition to the conventional Pap test, that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

HEALTH RISK ASSESSMENT (HRA)

The Health Risk Assessment (HRA) is a standardized screening tool to collect L.A. Care members' self-reported information about their health and well-being. The HRA information is used as an initial determination of a care management risk level and as a starting point to guide further assessment questions which lead to the formation of an Individualized Care Plan. The HRA is generally conducted telephonically with the assistance non-clinical support staff or by mail. However, there are times where a HRA may be conducted in a face to face interview. L.A. Care's contracted HRA vendor is responsible for arranging face-to-face interviews.

A Health Risk Assessment is conducted for the identified lines of business:

- Seniors and Persons with Disabilities (SPD) members within the first 45 days (high risk) or 105 days (low risk) of enrollment and reassessments at least annually (within 365 days of last HRA).
- Health Risk Assessments for L.A. Care Covered members are completed within 120 days of enrollment.

HRAs are faxed to PCPs (through 9/1/2014) or posted on-line and accessible through the L.A. Care Portal (effective 9/1/2014). Responses to the HRAs result in generic care plan. The generic care plan is also assigned a risk stratification to assist with additional care planning. Staff responsible for the care management will utilize the generic care plan, additional care management assessments and member responses to develop the formal individualized care plan.

CASE MANAGEMENT

Case Management relates to the coordination of care and services provided to members to facilitate appropriate delivery of care and services (NCQA).

Care Management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members' health care across the care continuum. It includes empowering members to exercise their options and access the services appropriate to meet their individual health needs, using communication, education and available resources to promote quality outcomes and optimize health care benefits.
L.A. Care's Care Management Program includes four levels:

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

Basic Care Management

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

The PCP conducts the initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and carved out services, as needed, based on the member's individual treatment plan. The PPG supports the member and PCP through the referral management process. Members whose care management needs do not exceed basic case management are considered low risk and care management activities such as follow up on Health Risk Assessment results (as applicable). PPGs are responsible for developing, updating the Individualized Care Plan (ICP) and organizing an Interdisciplinary Care Team (ICT) and as applicable to the LOB.

Care Coordination

L.A. Care's Care Management Program is a member advocacy program designed and administered to assure that the member's healthcare services are coordinated with a focus on continuity, quality and efficiency in order to produce optimal outcomes. Members who are Low and Moderate Risk level primarily receive care coordination and care management services through the PPG CM staff. These activities include review of the HRA results, completing and updating the ICP as well as organizing the ICT as warranted and as applicable to the LOB.

Care coordination by Care Managers or designated staff is provided for members needing assistance in coordinating their health care services. This service includes members who may have opted out of complex care management but have continuing coordination of health care needs. These include, but are not limited to, members assigned to or receiving:

- Out of Area/Network services
- Hospital discharge follow up calls

Developing the ICP

The HRA is the basis for the Care Plan, supplemented with Member information provided during care management planning to identify any necessary assistance and accommodations, including:

- Educational material on conditions and care options
- Information on how family members and social supports can be involved in care planning, as member chooses
- Self-directed care options and assistance available
- Information on accessing available LTSS, including PASC-SEIU services if applicable
- Available treatment options, supports, and/or alternative courses of care
- Ability to opt out of the Care Planning process

Members and their Caregivers must be engaged to actively design their care plans initially and at re-assessments by:

- Empowering members to identify successes or change self-directed goals based on their condition
- Applying health coaching techniques

If telephonic outreach is unsuccessful in monitoring/ re-assessing the CP, Care Managers may present options to ICT, such as continued telephonic outreach or schedule face-to face assessments

The member has the ability to opt out or decline involvement in the ICP process:

- Explain the care planning process to the member, emphasizing the importance of member participation
- The member will be asked at the beginning of each encounter if he/she chooses to participate, which will be **documented** in the care plan record
- Agreement with the ICP is **documented** in the member record
- Include member appointed ICT members in care planning process (e.g. Caregiver

Developing Care Plan Goals

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

Care Plans must document the identification and management of barriers to member goals:

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

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

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

ICT DOCUMENTATION EXAMPLE:

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

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

PPG CM_____-Lead/attended
L.A. Care CM_____-attended
Mr. Smith-declined invite to PCP_____-attended
L.A. Care LTSS staff _____-attended
Plan: L.A. Care LTSS staff will assist member with PASC-SEIU process and food resources. PPG CM will assist with referral to available disease management programs and provide medication reconciliation. PPG CM will call member to update on ICT plan, update care plan with follow up schedule and offer care plan to be mailed.

The ICP is updated as often as necessary, reflecting if goals are met or not met.

Timing of the ICP

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

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

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

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

Individualized Care Team

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

ICT activities/outcome should be shared documentation (dissemination of ICT reports to all stakeholders).

At a minimum the ICT meeting minutes require:

- the date of meeting
- names and roles of attendees
- fact that Member or representative was invited
- topics discussed

- any revision to the care plan

- The documentation of care plan revision may be at a high level (e.g., "revised priority of goals", or "added goal for weight management"). The actual changes will be documented in the Care Plan.

How an ICT is assembled

ICT documentation can occur in several ways:

- **Informal:** Involving the Care Manager, member and single discipline (ex. PCP, Registered Dietician, Social Worker)

- **Formal:** Structured large meeting format with multiple disciplines prepared to contribute

Whether it is informal or formal, it is essential to document "ICT Convened". This documentation is based on the documented need for ICT (e.g. Review HRA results, multiple issues need coordination)

The Lead ICT member identifies members who need to participate (e.g. PCP, PPG CM) and is responsible for setting up meeting date, time, mode (ex. conference call) as well as sending invitations to all including member

Complex Care Management

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

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

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

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

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

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

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

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

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

Referrals to Complex Case Management
Members may be referred for complex case management by:

- Disease Management (DM) program referrals
  Referrals are received from the DM program upon identification of complex needs according to specified CCM program criteria.
- Discharge planner referrals
  Referrals to the CCM program may be made during the discharge planning process when real or potential complex needs are identified. These referrals may be made by hospital discharge planners or Social Workers involved in the discharge planning process.
- L.A. Care UM (UM Staff) referrals
  Referrals to CCM are made by UM staff when complex needs are identified. This may occur during multidisciplinary conferences or during the concurrent review process.
- Member or caregiver referral
  Members or caregivers are provided with materials containing instructions on how to self-refer and/or access Complex Care Management
- Practitioner referrals
  Contracted Practitioners are provided information on how to refer for Complex Care Management. Referrals for case management or care coordination may be faxed to (213) 438-5034. A copy of the referral form can be found in Attachment C.
- Other referrals including, but not limited to:

    - L.A. Care Health Plan Medical Director Referrals

- PPG Medical Director(s) referrals
- External Service Partners referrals

Identifying Members for Care Management:

Multiple sources are used to identify members who may be a higher risk for adverse outcomes or transitions from their usual environment to needing a higher level of care. L.A. Care uses multiple data sources to identify members that are eligible for the program but no yet referred.

These data sources include, but are not limited to:

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

Complex Case Management services and how to refer patients
For more information about complex case management, or to make a referral, call the L.A. Care UM Department at 1-877-431-2273 and ask to speak with a Case Manager or complete a ***CM REFERRAL FORM*** AND SUBMIT VIA FAX # **(213) 438-5077**.

Targeted Care Management
Targeted Care Management (TCM) assists Members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, Targeted Care Management is available as a carve-out Medi-Cal benefit through the State of California, Los Angeles County Public Health Department and their contractors as specified in Title 22, Section 51351. The Care Managers are responsible for identifying members that may be eligible for TCM services and must refer members, as appropriate, for the provision of TCM services. TCM services are integrated into the overall care plan, as a barometer for measuring

disease progression and cost of care. State and county TCM services may include, but is not limited to, Pediatric and adult partial hospitalization programs (i.e. adult day health care centers, pediatric day care centers, MSSP, AIDS Wavier Programs, community based in-home operation services)

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

Targeted Case Management services and how to refer patients
For more information about targeted case management, or to make a referral, call the L.A. Care UM Department at 1-877-431-2273 and ask to speak with a Case Manager or complete a ***CM REFERRAL FORM*** AND SUBMIT VIA FAX # **(213) 438-5077**

MAJOR ORGAN TRANSPLANTS

Medi-Cal - Major Organ Transplants are Carved out—(See Medi-Cal Linked and Carved out Services Section)

HK, & PASC-SEIU Workers – Major Organ Transplants are not carved out

Major organ transplants are covered benefits as outlined in the member's EOC, including those medically necessary organ transplants and bone marrow transplants, which are not experimental or investigative in nature. Major organ transplant referrals are subject to L.A. Care's prior authorization process and the physician reviewer determination is based on the physician's review of medical necessity.

HOSPICE CARE SERVICES

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

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

Outpatient Hospice Services *(Medi-Cal only)*
MediCal members are eligible for hospice services without prior authorization.

L.A. Care may not require prior authorization for routine home care, continuous home care and respite care or hospice physician services. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day. A MCP may require documentation following the provision of general inpatient and continuous care for reasons of justification. If the documentation does not support these levels of care, or if the documentation included is inadequate, reimbursement may be reduced to the rate for routine home care.

Inpatient Hospice Services *(Medi-Cal only)*

Medi-Cal members may be eligible for additional inpatient hospices services (acute) as described in MMCD All Plan Letter 05003 Hospice Service and Medi-Cal Managed Care.

Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:

1) Certification of physician orders for general inpatient care.
2) Justification for this level of care.

For assistance in accessing this inpatient hospice benefit, PPGs may contact the L.A. Care UM Department.

Hospice in a SNF setting *(MediCal only)*

Medi-Cal members are eligible for additional hospice services in a sub-acute setting. Hospice services are covered cervices and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility. Hospice and Room and board services provided in a sub-acute setting are paid by the hospice provider; L.A. Care will reimburse the hospice provider as defined in MMCD All Plan Letter 05003 Hospice Service and Medi-Cal Managed Care.

L.A. Care maintains a network of hospice providers. Members are not required to utilize a contracted hospice. In situations where a member or member's family elects to utilize a non-contracted hospice provider or is on services with a non-contracted provider at the time of enrollment, PPG should contact L.A. Care's UM Department for contracting assistance.

L.A. CARE APPEALS PROCESS

L.A. Care does not delegate the appeal process to PPGs. The PPG must ensure that a timely appeal process is operational and ensure the submission of appeals to L.A. Care. Requests for appeals received by the PPG must be routed to the LA Care Member Services Grievance and Appeals Unit within 24 hours of receipt at:

L.A. Care Health Plan
Attn: Appeals and Grievance Unit
P.O. Box 811610
Los Angeles, CA 90081
1-888-839-9909
FAX 1-213-438-5748

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

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

Site, and policies and procedures.

- Appeal Procedures provide for:

    - Allowance of least 180 days for Healthy Kids members and at least 90 days for Medi-Cal members after notification of the denial for the member to file an appeal.
    - Acknowledgement of the receipt of the appeal within five (5) calendar days (Acknowledgement upon receipt by phone, if expedited).
    - Documentation of the substance of the appeal and any actions taken.
    - Full investigation of the substance of the appeal, including any aspects of clinical care involved.
    - The opportunity for the member to submit written comments, documents or other information relating to the appeal.
    - An authorized representative to act on behalf of the member.
    - The appointment of a new person to review the appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
    - The appointment of at least one person to review the appeal, who is a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment.
    - Notification of the decision of the appeal to the member within 30 calendar days of receipt of the request, or 72 hours if expedited.
    - Providing to the member upon request, access to and copies of all documents relevant to the member's appeal.
    - Notification to the member about further appeal rights.
    - Members who have disagreement with the appeal decision, and wish to appeal further, have the right to contact and file a grievance with the Department of Managed Health Care (DMHC), or to request an Independent Medical Review (IMR).

Standard Review

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

    - Final determination
    - A statement setting forth the specific medical and scientific reasons for the determination, and a description of alternative treatments, supplies, and/or services as appropriate
    - Reasons other than medical necessity (e.g., non-covered benefits, etc.) will include the statement of benefit structure

- Instructions for appealing further to the Department of Managed Health Care (DMHC) will include DMHC's address and toll-free telephone number, as applicable
- The phone number and extension of L.A. Care's physician reviewer

Expedited Review

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

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

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

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

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

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

INDEPENDENT MEDICAL REVIEW (IMR)

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

- The medical necessity of a proposed treatment.
- Experimental or investigational therapies for a life-threatening or seriously debilitating disease or condition.

- Claims for out-of-plan emergency or urgent medical services.

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

INITIAL and PERIODIC HEALTH ASSESSMENTS

ADULTS

PPGs are responsible for maintaining and disseminating to its Provider Network, protocols and High Risk Categories by adult age groupings based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) for use in determining the provision of clinical preventive services to asymptomatic, health adult Members (age 21 and older).

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

L.A. Care Health Plan shall provide lists of new member enrollees to the PPGs on a monthly basis.

PPGs shall have processes in place to ensure the provision of an IHA (complete history and physical examination) to each new adult member (over age 21) within 120 calendar days that:

- Includes a health education behavioral assessment using an age appropriate DHS approved assessment tool.
- Makes arrangements for any needed follow-up services that reflect the findings or risk factors discovered during the IHA and health education behavioral assessment.

- Documents the member's completed IHA and health education behavioral assessment tool in the members' medical record and makes available during subsequent preventive health visits.

- PPGs shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented.

    - Documented attempts that demonstrate unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.

    - For follow-up on missed and broken appointment documentation requirements see Section: Coordination of Medically Necessary Services.

When New Member's Health does not indicate any Urgency for an IHA (based on previous medical records if available):

- If the PCP has access to a new L.A. Care member's medical records from a previous Plan or other PCP, and those records indicate that the member has had an IHA within the previous 12 months, and the examination provides evidence that there is no urgency for an IHA, then the visit can be waived until the next periodic visit is due.

- For members whose health status does not indicate urgency, and if conducting the assessment as part of the first visit is not feasible, the PCP must contact the member within 90 days after the member's first medical visit to schedule a initial health assessment appointment.

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

- Blood pressure.
- Height and weight.
- Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over.
- Clinical breast examination for women over 40.
- Mammogram for women age 50 and over.
- Pap smear (or arrangements made for performance) on all women determined to be sexually active.
- 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,
- Screening for TB risk factors, including a Mantoux skin test on all persons determined to be at high risk.
- Health education behavioral risk assessment.

Adult Preventive Services
PPGs shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members.

PPGs 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 and older).

As a result of the IHA or other examinations, discovery 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 adult IHA described above shall be provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

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

Immunizations for Adults
PPGs are responsible for ensuring all adults are fully immunized and shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations and L.A. Care Preventive Health Guidelines (see L.A. Care Website/Provider Resources/Clinical Practice Guidelines).

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

Children
L.A. Care Health Plan shall provide lists of new member enrollees to the PPGs on a monthly basis.
PPGs shall have processes in place to ensure the provision of an IHA (complete history and physical examination and an individualized behavioral health assessment) to each new member under age 21 in required timeframes as follows:

For members under the age of 18 months, PPGs are responsible to cover and ensure the provision of an IHA within 120 days following the date of enrollment.

- For members 18 months of age and older upon enrollment, PPGs are responsible to ensure an IHA is performed with 120 days of enrollment.

- PPGs shall cover and ensure the provision of an IHA (complete history and physical examination and an individualized behavioral health assessment) to each new member under age 21 as follows:
  - Performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each child at the time of enrollment is accomplished at the IHA.

  - The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age.

  - Includes a health education behavioral assessment using an age appropriate DHS approved assessment tool.

  - Arrangements are made for any needed follow-up services that reflect the findings or risk factors discovered during the IHA and health education behavioral assessment.

  - Document the members' completed IHA and health education behavioral assessment tool in the members' medical record and to be made available during subsequent preventive health visits.

  - PPGs shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented.

  - Documented attempts that demonstrate PPGs unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.

Children's Preventive Services
PPGs shall provide preventive health visits for all members less than twenty-one (21) years of age at times specified by the most recent AAP periodicity schedule.

This schedule requires more frequent visits than does the periodicity schedule of the CHDP program.

PPGs shall provide, as part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age specific health education behavioral assessment, as necessary.

Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, PPGs shall ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.

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 CHDP program, an appointment shall be made for the member to be examined within two weeks of the request.

At each non-emergency Primary Care encounter with members under the age of twenty-one (21) years, the member (if an emancipated minor) or the parent(s) or guardian of the member shall be advised of the children's preventive services due and available from PPGs, if the member has not received children's

preventive services in accordance with CHDP preventive standards for children of the member's age. Documentation shall be entered in the member's medical record which shall indicate the receipt of children's preventive services in accordance with the CHDP standards, or proof of voluntary refusal of these services in the form of a signed statement by the member (if an emancipated minor) or the parent(s) or guardian of the member. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

The Confidential Screening/Billing Report form, PM 160-PHP, shall be used to report all children's preventive services encounters to DHS and the local children's preventive services program within thirty (30) calendar days of the end of each month for all encounters during that month.

- Original – Goes to L.A. Care Health Plan
- Yellow- Copy to the Local CHDP office
- White- Goes in the Medical Chart
- Pink- Goes to the parents

Immunizations
PPGs shall ensure that all children receive necessary immunizations at the time of any health care visit.

PPGs shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP)

Documented attempts that demonstrate L.A. Care's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement.

If immunizations cannot be given at the time of the visit, the member must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made.

Appropriate documentation shall be entered in the member's medical record that indicates all attempts to provide immunizations.

A receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statement by the member (if an emancipated minor) or the parent(s), or guardian of the member, shall be entered in the member's medical record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

Upon federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, PPGs shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within 60 calendar days of the vaccine's approval date.

> **Medi-Cal only** - PPGs shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program.

Policies and procedures must be in accordance with any Medi-Cal Fee-For-Service guidelines issued prior to the final ACIP recommendations.

PPGs shall provide information to all network providers regarding the VFC Program.

Blood Lead Screens
PPGs shall cover and ensure the provision of a blood lead screening test to members at ages one (1) and two (2) in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000.

PPGs shall document and appropriately follow up on blood lead screening test results.

PPGs shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide test.

If the blood lead screen test is refused by the member, proof of voluntary refusal of the test in the form of a signed statement by the member (if an emancipated minor), or the parent(s) or guardian of the member, shall be documented in the member's medical record.

If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

Documented attempts that demonstrate a PPG's unsuccessful efforts to provide the blood lead screen test shall be considered sufficient in meeting this requirement.

Screening for Chlamydia
PPGs shall screen all females less than 21 years of age, who have been determined to be sexually active, for Chlamydia.

Follow up of positive results must be documented in the member's medical record.

PPGs shall make reasonable attempts to contact appropriately identified members and provide screening for Chlamydia.

All attempts shall be documented.

Documented attempts that demonstrate PPGs unsuccessful efforts to contact a member and screen for Chlamydia shall be considered sufficient in meeting this requirement.

If the member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the member (if an emancipated minor) or parent(s), or guardian of the member ,shall be documented in the member's medical record.

If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

Human Papillomavirus (HPV) vaccinations are covered benefits and should be provided based on the recommended USPSTF guidelines. Please see the most recent versions at L.A. Care's website for Clinical Guidelines at: http://www.lacare.org/clinical-practice-guidelines

MISSED OR BROKEN APPOINTMENTS

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

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

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

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

Missed and Broken Procedure or Laboratory Test

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

Unusual Specialty Services

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

Services Received in an Alternative Care Setting

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

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

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

PPGs must maintain a program for Children with Special Health Care Needs, which includes, but is not limited to, the following:

- L.A. Care performs a New Member Outreach call to all newly enrolled members that includes a health risk assessment to identify Children with Special Health Care Needs within 60 days of enrollment.

- The outcomes of the health risk assessment are routed to the assigned PCP and delegated PPG to coordinate medically necessary care.

- Members identified as CSHCN are referred to the Care Management Program for assistance in care coordination

- The PPGs/PCPs are responsible for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as PCP, standing referrals, or other methods as defined by regulatory and L.A. Care policy requirements.

- L.A. Care's PPGs/PCPs are responsible for ensuring that each Child with Special Health Care Needs, receives a comprehensive assessment of health and related needs and that all medically necessary follow-up services are documented in the medical record, including needed referrals. The comprehensive assessment should be completed at the time of the Initial Health Assessment and periodically thereafter.

- L.A. Care has an established case management/ care coordination Care Management Program for Children with Special Health Care Needs that includes the coordination with other agencies, which provide services for children with special health care need (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency)

- L.A. Care monitors and identifies opportunities for improving the quality and appropriateness of care for children with special health care needs through established quality processes:

    - HEDIS results
    - Utilization Reports (e.g. IHA, Hospitalizations, ER, Ambulatory Care)
    - Potential Quality of Care Issues (PQIs)
    - Grievance and Appeals
    - Member and Provider Satisfaction Surveys

DISEASE MANAGEMENT

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

The Centers for Medicare and Medicaid Services defines disease management as a "system of coordinated health care interventions and communication for populations with conditions in which patient self-care is substantial". Disease Management supports the provider-patient relationship and treatment plan while emphasizing prevention and self-management.

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

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

Providers or members may contact L.A. Care Member Services to inquire about the available programs.

Behavioral Health Services, Dental Services, and Vision Care Services (also described on the Grid Attached on page 119)

BEHAVIORAL HEALTH SERVICES
(Described in further detail in Attachment B)

Behavioral Health Services

L.A. Care Health Plan is responsible for behavioral health services for L.A. Care Covered™. The behavioral health aspects of the UM program are described in a separate UM program description and in polices/procedures developed by L.A. Care's contracted behavioral health vendor, and approved by L.A. Care.

The plan has contracted with Beacon Health Strategies, LLC and College Health IPA to administer the delivery of behavioral health and substance use services for LA Care members. While Beacon is the contracted administrative service provider with the Health Plan, College Health IPA will render all utilization management determinations.

For certain diagnoses, as defined in the L.A. Care Covered™ benefit structure, the Los Angeles County Department of Mental Health may assume responsibility. In these instances, the Behavioral Health vendor, Beacon Health Strategies, coordinates and ensures continuity of care.

All behavioral health referrals are to be reviewed through Beacon Health Strategies in coordination with College Health IPA:

- Beacon Health Strategies performs medical review on all referrals for behavioral health services, including but not limited to, outpatient, inpatient, day residential care, and will coordinate the requested services as necessary.
- Beacon Health Strategies, following medical review, provides and/or coordinates care to facilitate authorization of medically necessary mental health services and/or substance abuse services, including pharmacy, laboratory, and ancillary services provided to a member who has experienced family dysfunction and/or trauma, to the extent that such services are required as a course of treatment for the health and recovery of the child and the family members.

Behavioral Health Services include chemical dependency and mental health services. L.A. Care Health Plan provides these services through Beacon Health Strategies.

- For referring your patients to receive any Behavioral Health Services you may directly call **(877)-344-2858, Option 6, then Option 3** to speak with a Beacon representative, 24/7.
- For Crisis Intervention, please call **(877)-344-2858, Option 6, then Option 3** to speak with a Beacon representative, 24/7.

Members may directly access behavioral health services by calling the numbers above.

Chemical Dependency Services

Inpatient Detoxification

L.A. Care Health Plan covers hospitalization in a participating hospital only for medical management of withdrawal symptoms, including room and board, participating physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient Chemical Dependency Care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

Additional covered services include:

- Individual chemical dependency evaluation and treatment
- Group chemical dependency

L.A. Care Health Plan covers methadone maintenance treatment for all Enrollees when medically necessary at a licensed treatment center approved by the Medical Group.

Transitional Residential Recovery Services

L.A. Care Health Plan cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. These settings provide counseling and support services in a structured environment.

Chemical Dependency Services Exclusion

Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical Dependency Services" section

Mental Health Care

L.A. Care Health Plan covers Services specified in this "Mental Health Care" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder." For example, the DSM identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.
"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa

- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the DSM, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

    - as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without

treatment

- the child displays psychotic features, or risk of suicide or violence due to a mental disorder

- the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Inpatient Mental Health Services

L.A. Care Health Plan covers inpatient psychiatric hospitalization in a participating hospital. Coverage includes room and board, drugs, and Services of participating physicians and other providers who are licensed health care professionals acting within the scope of their license.

Outpatient Mental Health Services

We cover the following Services when provided by participating physicians or other participating providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Additional covered services include:

- Individual mental health evaluation and treatment
- Group mental health treatment

Behavioral Health Treatment for Autism and Pervasive Developmental Disorders

Behavioral Health Treatment for members with Autism or Pervasive Developmental Disorders is covered when prescribed by a Physician or licensed psychologist who is a Plan Provider and the treatment is provided under a treatment plan prescribed by a Participating Provider. Behavioral Health Treatment must be prior authorized and obtained from Participating Providers.

Behavioral Health Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered**.**

"Behavioral Health Treatment" is defined as follows: Professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Exclusions and Limitations

- Alternative Therapies, unless the treatment is prescribed by a licensed physician and surgeon or by a licensed psychologist as Behavioral Health Treatment for pervasive developmental disorder or autism, and such treatment is provided pursuant to a treatment plan administered by qualified autism providers.
- Biofeedback, unless the treatment is prescribed by a licensed physician and surgeon or by a licensed psychologist as Behavioral Health Treatment for pervasive developmental disorder or autism, and such treatment is provided pursuant to a treatment plan administered by qualified autism providers.
- Non-skilled care that can be performed safely and effectively by family members (whether or not such family members are available to provide such services) or persons without licensure

certification or the presence of a supervising licensed nurse, except for authorized homemaker services for hospice care, and except for Behavioral Health Treatment that is provided by a Qualified Autism Service Professional or Qualified Autism Service Paraprofessional for the treatment of pervasive developmental disorders or autism.

Intensive Psychiatric Treatment Programs

We cover **at no charge** the following intensive psychiatric treatment programs at a participating facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Healthy Kids:
L.A. Care is responsible for behavioral health services for Healthy Kids. The behavioral health aspects of the UM program are described on a separate UM program description and in polices/procedures developed by the Behavioral Health vendor and approved by L.A. Care

Healthy Kids, & PASC-SEIU Workers:
L.A. Care Health Plan does not delegate the provision of behavioral health services for Healthy Kids, or PASC-SEIU Workers members to the PPGs.

Members can self-refer or be referred by their Primary Care Physician to the Behavioral Health Services provided by the vendor

L.A. Care has contracted with a Behavioral Health Vendor and all behavioral health referrals are to be reviewed through the Behavioral Health vendor:

The Behavioral Health vendor performs medical review on all referrals for behavioral health services, including but not limited to, outpatient, inpatient, day residential care, and will coordinate the requested services as necessary with the Department of Mental Health for members for Serious Emotional Disorders (SED) and Serious Mental Illness (SMI) services.

The behavioral health vendor, following medical review, provides and/or coordinates care to facilitate authorization of medically necessary mental health services and/or substance abuse services, including pharmacy, laboratory, and ancillary services provided to a member who has experienced family dysfunction and/or trauma, to the extent that such services are required as a course of treatment for the health and recovery of the child and the family members.

VISION SERVICES

Healthy Kids Vision Services
L.A. Care Healthy Kids vision benefits are covered and are the responsibility of and provided by LA Care.

LA Care has contracted with the Vision Vendor- VSP - to coordinate L.A. Care's Healthy Kids members' vision benefits.

To find a Healthy Kids eye doctor for a Healthy kids member, L.A. Care Healthy Kids members should call VSP at the toll free number 1-800-877-7195.

PASC-SEIU Workers Vision Services

Vision benefits are not covered under L.A. Care.

Medi-Cal (MCLA) Vision Services

L.A. Care has arranged with a vendor to coordinate MCLA vision services for L.A. Care and its PPGs as follows:

MCLA members should be advised to contact L.A. Care's contracted Vision Vendor for covered vision services. The vendor will coordinate services and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members according to the member's current Medi-Cal benefits for eye examinations and lenses. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions.

Medi-Cal members are eligible for eye examination with refractive services, but the dispensing of prescription lenses at least every two years is dependent on whether the member has the benefit as described below:

L.A. Care MCLA Adults (age 21 and over):
On July 15, 2010, the State of California reinstated adult Optometry services retrospective to July 1, 2009 (See MMCD All Plan Policy Letter#10-010 "Reinstatement of Optometry Services"). To date, this reinstatement does not include lenses for adults (services provided by fabricating optical laboratories).

For MCLA Members – Children up to Age 21:

MCLA Eye exams are covered by L.A. Care and children are limited to one pair of eyeglasses every two years unless:

- Prescription has changed at a minimum of .50 diopters
- Replacement lenses are needed because the member's previous lenses have been lost, stolen, broken, or marred and damaged beyond the member's control to a degree significantly interfering with vision or eye safety (a certificate or statement is required)
- Frame needs replacement because a different size or shape is necessary.
- This includes lenses and covered frames for eyeglasses when authorized.

For eyeglasses for eligible members, L.A. Care's contracted vision vendor will coordinate services with the PIA and the Department of Health Care Services (DHCS) is responsible for reimbursing the PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA.

CCS Referrals for Certain Eye Conditions
Eye conditions leading to a loss of vision, strabismus requiring surgery, infections such as keratitis, choroiditis; and chronic diseases such as glaucoma, cataract, retinal detachment, ptosis, optic atrophy or retrolental fibroplasis may be covered by CCS. Contact the L.A. Care UM Department or CCS for assistance. Ordinary refractive errors, chronic chalazion, anisometropia, amblyopia, strabismus when periodic refraction, glasses or when patching is needed are not covered by CCS.

Dental Services

Dental Services for Medi-Cal Are Carved Out To Denti-Cal (See Medi-Cal Carved Out Section)

Dental Services for Healthy Kids, and PASC-SEIU Workers

Healthy Kids (HK): Dental Services for Healthy Kids members are provided as a covered benefit under L.A. Care as designated in the member's EOC.

- **L.A. Care has contracted with the dental Vendor- Liberty Dental - to coordinate L.A. Care's HK members' dental benefits.**
- **To find a dentist, HK members should call Liberty Dental at toll free number 1-800-766-7775.**
- **For questions about dental benefits:** HK members can also call L.A. Care's Member Services Department at1-888-839-9909.

PASC-SEIU Workers Dental Services

Dental benefits are only covered under L.A. Care if medically necessary; no coverage for routine dental services (e.g., cleaning, cosmetic).

MATRIX FOR LINKED AND CARVE OUT SERVICES by PRODUCT LINE

LINKED AND CARVE OUT PROGRAM	MEDI-CAL	HEALTHY KIDS
CALIFORNIA CHILDREN SERVICES (CCS)	**X**	**X**
SCHOOL LINKED CHDP SERVICES	**X**	
TB/DOT	**X**	
WIC	**X**	
DEVELOPMENTAL DISABILITIES SERVICES (DDS)	**X**	
EARLY INTERVENTION/EARLY START	**X**	
SPECIALTY MENTAL HEALTH	**X**	**ROUTINE & SPECIALTY MENTAL HEALTH SERVICES ARE NOT CARVED OUT AND ARE COORDINATED**

		THROUGH L. A. CARE'S CURRENT BEHAVIORAL HEALTH VENDOR
ALCOHOL AND DRUG TREATMENT	**X**	**ALCOHOL & DRUG TREATMENT SERVICES ARE NOT CARVED OUT AND ARE COORDINATED THROUGH L.A. CARE'S CURRENT BEHAVIORAL HEALTH VENDOR**
LOCAL EDUCATION AGENCY	**X**	
HIV/ AIDS HOME AND COMMUNITY BASED WAIVER PROGRAMS	**X**	
DENTAL SERVICES	**X**	**X**
VISION	**X**	**X**
TARGETED CASE MANAGEMENT	**X**	
EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT	**X**	
EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SRVCS	**X**	

5.0 UTILIZATION MANAGEMENT (This Section applies to Medi-Cal Only)

CARE COORDINATION WITH LINKED AND CARVED OUT SERVICES

Coordination of Care for Linked and Carved out Services
Care Managers are available to assist members, who may need or who are receiving services from out of plan providers and/or programs, in order to ensure coordinated service delivery and efficient and effective joint case management. However, the coordination of care and services remains the responsibility of each member's PCP.

PPG's and the member's PCP will monitor the following:

- Member referral to and/or utilization of special programs and services
- Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- Routine medical care, including providing the necessary preventive medical care and services
- Provision of Initial Health Assessments and completion of the age-specific Individual Health Education and Behavioral Assessment (IHEBA)

PPGs and PCPs are encouraged to make referrals to local health departments, mental health programs and regional centers.

Out-of-Plan Case Management and Coordination of Care for Linked and Carved out Services L.A. Care shall implement procedures to identify individuals, who may need or who are receiving services from out of plan providers and/or programs, in order to ensure coordinated service delivery and efficient and effective joint case management.

CARE COORDINATION WITH MEDI-CAL LINKED AND CARVED-OUT SERVICES

Linked and Carved Out Services

L.A. Care maintains Memorandum of Understanding (MOU) agreements defined by the DHCS contract to promote continuity and coordination of care for Medi-Cal members between the health plan and local public health programs (Linked and Carved-Out Programs). The agencies meet regularly with L.A. Care staff to monitor the effectiveness of the MOU.

Memorandum of Understanding (MOU) means a document defining services to be provided, when reimbursement is not made by L.A. Care, but the L.A. Care and/or its PPGs is responsible for coordinating the services. Also see subcontract definition below.

The Managed Medi-Cal Program requires L.A. Care to establish and maintain MOUs for the following carved-out services:

- California Children Services (CCS)
- Maternal and Child Health (MCH)
- Child Health and Disability Prevention (CHDP) Program
- Tuberculosis Direct Observed Therapy (DOT)
- Women, Infants, and Children (WIC) Supplemental Nutrition Program
- Regional Centers for Services for Persons with Developmental Disabilities
- Specialty Mental Health Services
- Public Health Department

Subcontract means a written agreement entered into by L.A. Care with a provider of health care services who agrees to furnish Covered Services to members or with any other organization or person(s) who agree(s) to

perform any administrative function or service for L.A. Care specifically related to fulfilling L.A. Care's obligation to DHS under the terms of the DHS Contract. Subcontracts must specify scope and responsibilities of both parties in the provision of services to members as follows:

- Billing and reimbursements
- Reporting responsibilities
- How services are to be coordinated between the agency and L.A. Care and/or its PPGs, including exchange of medical information as necessary

Subcontracts include, but are not limited to, the following linked services:

- Family Planning Services
- Sexually Transmitted Disease (STD) Services
- HIV Testing and Counseling Services
- Immunizations
- School Based Child Health and Disability Prevention (CHDP) Services (with Covina Valley USD, Long Beach USD, and Los Angeles USD)

Linked agencies have defined roles and responsibilities to ensure coordination of care for members. In most instances, the agency, not L.A. Care, is financially responsible for the linked services

DESCRIPTION AND RESPONSIBILITIES FOR THE LINKED AND CARVED OUT PROGRAMS

CALIFORNIA CHILDREN SERVICES (CCS) – MEDI-CAL

CCS services are carved out of and excluded from L.A. Care Health Plan's responsibilities under the Medi-Cal contract with DHS, and will be provided by the L.A. County CCS in accordance with the current Memorandum of Understanding (MOU) between L.A. Care Health Plan and CCS.

NOTE: L.A. Care maintains a MOU between LA Care and CCS to provide services to Healthy Kids members presenting a qualifying medical condition AND when the families provide documentation of financial eligibility. CCS will provide member assistance with completion of the required financial documentation necessary.

Services provided by the CCS program are not covered under the DHS State contract.

Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, L.A. Care and/or its PPGs shall refer the member to the local CCS office for determination of eligibility.

L.A. Care and/or its PPGs shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:

- Ensure that L.A. Care and/or its PPGs' providers perform appropriate baseline health assessments and diagnostic evaluations which provide the sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition;
- Assure that contracting providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within L.A. Care and/or its PPGs' network; and only from the date of referral;
- Enable initial referrals of members with CCS-eligible conditions 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;

- Ensure that L.A. Care and/or its PPGs continue to provide all Medically Necessary Covered Services to the member until CCS eligibility is confirmed;
- Ensure that, once eligibility for the CCS program is established for a member, L.A. Care and/or its PPGs shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS, and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

If the local CCS program does not approve eligibility, L.A. Care and/or its PPGs remain responsible for the provision of all Medically Necessary Covered Services to the member. If the local CCS program denies authorization for any service, L.A. Care and/or its PPGs remain responsible for obtaining the service, if it is medically necessary and paying for the service if it has been provided.

Identification
Identify and track current and new enrollees with potential and/or eligible CCS conditions.

Eligibility
L.A. Care Health Plan shall be responsible for generating and distributing, to its PPGs and the member's PCP, lists received from CCS of L.A. Care members identified as being eligible or authorized to receive CCS services.

L.A. Care will send these lists to its PPGs and to the member's PCP on a monthly basis.

L.A. Care and/or its PPGs will notify the member's PCP, and will work with the local CCS office to ensure the member is receiving appropriate medical care and that coordination of care is documented in the member's medical records.

L.A. Care and/or its PPGs will undertake regular activities, such as review of encounter data necessary to identify members with potential CCS conditions and assure appropriate referrals to CCS.

Referral
Members (parent/guardian) may self-refer to CCS.

L.A. Care will make available to its PPGs, a list of CCS paneled providers and facilities as received from the local and/or State CCS program office.

PCP or specialist may refer to CCS paneled provider or CCS local program using the L.A. Care, and/or its delegated provider's, referral process or refer the member directly to CCS.

L.A. Care and/or its PPGs are required to provide to PCPs, information on CCS paneled providers and facilities including mechanism for accessing specific provider facility contact information for referral.

The CCS program authorizes Medi-Cal payments to L.A. Care and/or its delegated provider's network physicians who currently are members of the CCS panel, and to other 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 in accordance with subparagraph D below. L.A. Care and/or its PPGs shall inform providers, except as noted above, that CCS reimburses only CCS paneled providers.

L.A. Care and/or its PPGs 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 L.A. Care and/or its PPGs, or a L.A. Care and/or its delegated provider's network physician, via telephone, FAX, or mail. In an emergency admission, L.A. Care and/or its PPGs, or L.A. Care and/or its PPGs' network physician shall be allowed until the next business 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.

L.A. Care will ensure that the member and provider manuals document the CCS referral options and processes.

Coordination of Care:
L.A. Care and/or its PPGs shall:

- Designate a CCS coordinator (liaison) to interface with a designated L.A. Care CCS Coordinator, the CCS office, CCS panel provider, the member's family or guardian.
- Implement procedures to ensure confidential transfer of medical documentation between the PCP and CCS paneled providers in compliance with all federal and state regulations.
- Ensure that the PCP provides basic case management for the member and assures appropriate referrals for members with potential and/or eligible CCS conditions.
- Make available CCS Program referral forms to all member families/guardians and PCP offices.
- Continue to provide case management of all services (primary and specialty care) until eligibility has been established with the CCS program.
- CCS program case management is responsible for the CCS eligible condition and authorizes medically necessary care.
- L.A. Care and/or its PPGs must continue to provide primary care case management, coordination of services, and health care service other than those required for the CCS condition and keep active CCS case logs.
- For inpatient admissions CCS referrals, authorization for inpatient hospital stays is limited to the time of eligibility for the CCS program. It is recommended that the L.A. Care and/or its PPGs or designated CCS coordinator continue to track the hospitalization in collaboration with the CCS Case Manager.
- L.A. Care's PPGs are capitated to provide services not unrelated to the treatment of the CCS eligible condition.

Referral/Care Coordination of Members to the Genetically Handicapped Persons Program (GHPP)
L.A. Care and/or its PPGs shall have mechanisms in place to refer members who may be eligible for services provided by the Genetically Handicapped Persons to assure appropriate care coordination of members who will no longer be eligible for CCS at age of 21, but will still need services.

Dispute Resolution
L.A. Care and/or its PPGs need to have a mechanism in place to resolve disputes between the PCP or Specialist and the CCS program office.

In the absence of a resolution, L.A. Care and/or its PPGs Liaison will notify L.A. Care UM of all unresolved disputes regarding CCS services.

All dispute resolutions must be resolved within 30 calendar days.

L.A. Care and/or its PPGs are required to provide any medically necessary special services during the time of dispute resolution.

L.A. Care will facilitate any unresolved disputes.

Disagreements with regards to CCS program eligibility, payments for the treatment of services of the CCS eligible condition and associated or complicated conditions must be resolved cooperatively between L.A. Care and the county CCS program.

If the dispute is not resolved at the local level, L.A. Care must notify the Medi-Cal Managed Care contract manager, and the county CCS program must notify the State CCS Regional Office. The State Children's Medical Services (CMS) program and the Medical Managed Care Division will ultimately render a joint decision if the problem is not resolved at the lower level.

Training and Education
L.A. Care and/or its PPGs will coordinate with the local CCS, to develop and implement training programs for L.A. Care and/or its PPGs, PCPs, and L.A. Care Staff.

L.A. Care will ensure that provider manuals and the member enrollment materials outline information describing CCS benefits and eligibility.

MATERNAL AND CHILD HEALTH – COMPREHEHSIVE PRENATAL SERVICES PROGRAM (CPSP) – MEDI-CAL

L.A. Care and it's PPGs must complete a comprehensive risk assessment tool for all pregnant female Members that is comparable to the American College of Obstetrics and Gynecology standard and Comprehensive Perinatal Services Program (CPSP) standards.

The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.

The risk assessment tools shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

Standard Obstetrical Record Elements
Standard Obstetrical record elements shall be included in the obstetric, nutritional, psychosocial and educational examination of pregnant members in compliance with DHS and the most current guidelines of the American College of Obstetrics and Gynecology (ACOG), CPSP, and Title 22. Obstetrical records include the **CPSP Patient Records -**Comprehensive Perinatal Services Program Documentation Forms and/or any obstetric record that applies with the CPSP standards for documentation.

Referral to Specialists
L.A. Care and its PPGs are responsible for ensuring that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

Pregnant women that are at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals.

Specialists may include, but are not limited to:

- Cardiologists
- Psychiatrists
- Internists
- Infectious Disease
- Geneticists

- Specialty High-Risk Obstetricians
- Oncologists
- Endocrinologists

Examples of these referral types and protocols may include, but are not limited to:

- Diabetes
- Hypertension
- Hepatitis
- HIV+
- Genetic Problems
- Epilepsy or Neurological Disorder
- Renal Disease
- Alcohol or Drug Abuse
- Maternal Cardiac Disorders
- Thyroid or Other Endocrine Disorders
- Epilepsy or Neurological Disorder

Common Pregnancy Conditions/Issues Requiring Multidisciplinary Management

Pregnant members exhibiting any of the following representative conditions/ issues will have interventions and referrals developed utilizing the Nutrition (N), Psychosocial (PS), or Health Education (HE) protocols:

- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Fear of physicians, hospitals, and medical personnel (HE)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- Housing and transportation problems (PS)
- Domestic violence (PS)
- No previous contact with health care systems (HE)
- Multiple gestation (HE), (PS), (N)
- Need for bed rest during pregnancy (PS), (HE)
- Previous receipt of unfriendly health care services (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)

Common Postpartum Conditions/Issues Requiring Multidisciplinary Management:

- Postpartum blues, postpartum depression (PS)
- Housing, food, transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Breastfeeding difficulties (HE)
- Sexual pain/difficulties (HE)
- Severe anemia (N)

Comprehensive Perinatal Services Personnel

The primary component of quality multidisciplinary management of comprehensive perinatal care is personnel. Participating obstetrical providers must ensure that health education, nutrition, psychosocial assessment, re-assessment and intervention are administered by qualified personnel. Training of Comprehensive Perinatal Services personnel will be provided by L.A. Care with technical assistance from the County of Los Angeles Comprehensive Perinatal Service Program.

Comprehensive Perinatal practitioners may include any of the following:

- General Practice physician
- Family Practice physician
- Pediatrician
- Obstetrician-Gynecologist
- Certified Nurse Mid-Wife
- Registered Nurse
- Nurse Practitioner
- Physician's Assistant
- Social Worker
- Health Educator
- Childbirth Educator
- Registered Dietitian
- Comprehensive Perinatal Health Worker

Ancillary Services/staff who may provide services within specific components of Comprehensive Perinatal services or services available within Linked/Carved out Services include, but are not limited to:

- Geneticists
- Other medical specialists
- Public Health Services
- Family Planning Services
- Substance Abuse Prevention Service
- Community-Based Organizations
- Community Outreach Services
- Agencies providing transportation
- Domestic Violence Units
- Child Protective Services
- Local Diabetes and Pregnancy Programs
- Dental Services
- Specialty Mental Health Services
- Translation Services
- Women's Center
- Respite Care Services

Other Referrals include, but are not limited to:

- WIC Supplemental Nutritional Program

L.A. Care and its PPGs shall ensure that all pregnant, breastfeeding and postpartum women, and infants and children who are eligible for WIC supplemental food services will be assessed, and if appropriate, referred to the Los Angeles County Public Health Services WIC Program.

Family planning referral protocols may include assistance with birth control issues, STD information or control, procedure or counseling.

A referral may be done, but is not required for this service, as members can self-refer to Family Planning Services. For instance,

Social Work referrals due to:

- Family Abuse/Domestic Violence
- Financial Problems
- Other identified social needs

SCHOOL LINKED CHILD HEALTH AND DISABILITIES PREVENTION PROGRAM (CHDP) – MEDI-CAL

L.A. Care has a mutually agreed upon arrangement with the local School Districts that provide EPSDT/CHDP services. That arrangement describes:

> Eligibility requirements, scope of services, client services , outreach, tracking follow-up, health education, data collection, quality assurance mechanisms, dispute resolution and billing/ reimbursement mechanisms governing the relationship between and among L.A.Care and the participating school districts.

L.A. Care will directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information.

L.A. Care will provide guidelines specifying coordination of services reporting requirements, quality standards, processes to ensure services are not duplicated and process for notification to member/student/parent on where to receive initial and follow-up services.

PPGs are required to maintain a "medical home" and ensure the overall coordination of care and case management of members who obtain CHDP services through the local school districts or school sites.

PCP will provide basic case management for the member and coordinate the provision of any referrals or additional services necessary to diagnose and/or treat conditions identified during the school EPSDT/CHDP assessment.

PCP will also provide ongoing preventive and primary services, as required.

EPSDT/CHDP services are provided to members for school entry only while maintaining the "medical home" with the PCP for ongoing health care management.

The PCP, as the medical home, is responsible for ongoing comprehensive health care delivery.

Reimbursement to Schools for the Provision of School Based EPSDT/CHDP Services

L.A. Care Health Plan shall be responsible to pay school district claims directly for EPSDT/CHDP services provided in accordance with the agreement as determined by the total amount of claims

L.A. Care will generate a PPG Claims Paid reconciliation report to identify claims paid on behalf of the PPG by L.A. Care for that capitation period.

Provider Training

L.A. Care will collaborate with the PPGs and the Los Angeles area CHDP programs to ensure provider training regarding school linked EPSDT/CHDP services.

TUBERCULOSIS/DIRECT OBSERVATION THERAPY (MEDI-CAL)

L.A. Care and its PPGs must provide screening for all members at risk for TB to determine risk factors for and diagnosis of Tuberculosis. Mantoux skin tests will be performed on all persons at increased risk of developing TB. Children will be screened for TB risk factors and will follow recommended guidelines for the

provision of Mantoux skin testing.

In collaboration with the Local Health Departments TB Control, L.A. Care will provide education and access to training upon request.

L.A. Care and its PPGs must have systems in place to:

- Coordinate services provided to members diagnosed with active TB through the Local Health Department TB Control Department and DOT.
- Each confirmed TB case or suspected case must be reported within one business day to the local Health Department.
- Maintain evidence that members with a suspected or confirmed TB diagnosis are reported to the Local Health Department within one business day.
- All individuals at increased risk for TB will be offered TB testing and managed, according to CDC guidelines for the management of individuals identified at high risk for TB, unless they have documentation of prior positive test results, TB disease and/or treatment.

The Primary Care Physicians (PCP), as required by the current California TB guidelines, understand that a tuberculin reaction of 5mm of induration or greater is classified as positive in the following groups:

- Persons known to have or at risk for HIV infection
- Close recent contact with a person who has infectious TB
- Persons who have a chest x-ray consistent with tuberculosis
- Persons who are immunosuppressed
- Other groups as identified in the current California TB Guidelines.

A tuberculin reaction of 10mm of induration or greater is classified as positive in all other persons. The PCP will evaluate all members with a positive skin test, even if asymptomatic.

To report positive results, the PCP's must document the appropriate action as follows:

- Positive tests in children under the age of three (3) are reported to the Local Health Department and L.A. Care Management Program.
- All members with a new positive skin test must be evaluated for active TB which may include a chest x-ray.
- When active TB is suspected, an appropriate culture must be obtained from sputum or other body fluid/tissue, as appropriate.

When TB is suspected, treatment will be initiated prior to bacteriological confirmation. The PCP must refer appropriate members to the Local Health Department TB Control

Program to provide members with active TB, the services of Directly Observed Therapy (DOT). All active cases determined to be at risk for non-compliance will be referred to the TB Control Program for evaluation of DOT services.

Directly Observed Therapy (DOT) for TB is offered by local health departments (LHDs) and is a linked and carved out service.

L.A. Care and/or its PPGs shall assess the risk of non-compliance with drug therapy for each member who requires placement on anti-tuberculosis drug therapy.

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

- Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);
- Members whose treatment has failed or who have relapsed after completing a prior regimen;
- Children, adolescents and individuals who have demonstrated noncompliance (those who failed to keep office appointments).

L.A. Care and/or its PPGs shall refer members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

L.A. Care and/or its PPGs shall assess the following groups of members for potential noncompliance and for consideration for DOT:

- Substance abusers
- Persons with mental illness
- The elderly
- Persons with unmet housing needs
- Persons with language and/or cultural barriers

If, in the opinion of L.A. Care and/or its delegated entities' providers, a member with one or more of these risk factors is at risk for noncompliance, the member shall be referred to the LHD for DOT.

L.A. Care and/or its delegated entities 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.

L.A. Care Health Plan, in conjunction with its delegated entities, will work in close collaboration with the Public Health Departments of the County of Los Angeles and the cities of Pasadena and Long Beach to ensure compliance with guidelines for TB treatment and control.

WOMEN, INFANTS AND CHILDREN (WIC) NUTRITIONAL SUPPLEMENT PROGRAM – MEDI-CAL

WIC services are defined as a carve out service and are provided as a benefit to eligible Women, Infants, and Children through referral to the Carved Out Service, the WIC Supplemental Nutrition Program.
L.A. Care and its PPGs must have systems to identify and refer eligible members needing WIC services are referred to appropriate WIC sites/services.

IDENTIFICATION

Eligibility Verification
Eligibility for WIC services is determined by the WIC centers based on residency and other factors.

PCP and other Physicians or Primary Care Providers WIC Referrals
PCPs, Other Physicians or other Primary Care Providers WIC referral process as part of its Initial Health Assessment 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 to the WIC program as mandated by Title 42, CFR 431.635 (c).
As part of the referral process, PCPs, Other Physicians or other Primary Care Providers referring to the WIC program must include:

- A current hemoglobin or hematocrit laboratory value
- Present height and weight

- Confirmation of the pregnancy date
- Birth weight and length for infants
- For small or pre-term infants, documentation of the gestational age

PCPs, Other Physicians or other Primary Care Providers must document these laboratory values and the referral in the member's medical record.

Members Self-Referral to WIC
Members may self-refer to WIC.

Basic Case Management
The PCP maintains the role of the overall case manager for the member, which includes assuring appropriate referrals for members needing WIC services and providing routine preventive and other necessary care.

Transfer of Information between Providers and WIC
L.A. Care and its PPGs/PCPs must implement HIPAA compliant procedures to ensure confidential transfer of medical documentation including CPSP assessment, and WIC program dietary assessment forms, to and from the PCP to WIC Centers in compliance with all federal and state regulations.

DEVELOPMENTAL DISABILITIES SERVICES (DDS) – MEDI-CAL

L.A. Care and its PPGs must maintain policies, procedure, and processes in place to address the following: identification, diagnosis, referral, and tracking of members with potential and eligible DDS conditions for the provision of all screening, preventive, medically necessary, and therapeutic services.

L.A. Care and its PPGs will utilize network providers for diagnosis and treatment of members with developmental disabilities.

Members may access the Regional Centers if services are needed and not available within the L.A. Care network.

L.A. Care and its PPGs will refer members with developmental disabilities to the Regional Centers for those non-medical services such as respite, out-of home placement, supportive living, etc.

Identification

L.A. Care will:
For existing Medi-Cal members, L.A. Care obtains a list of eligible members currently enrolled in a Regional Center. This list is distributed to the assigned PCPs and PPGs to ensure care coordination.

On a monthly basis, L.A. Care provides PPGs and PCPs with a list of members receiving services through the community Regional Centers. This information serves as notification to providers and allows them to coordinate any services requested by L.A. Care or the Regional Center. For a listing of current approved ICD-9 codes of potential eligible DDS conditions, you may contact the UM Department or visit www.dds.cahwnet.gov for additional information about DDS.

PPGs will:
Maintain mechanisms to support the identification of members with eligible and potential DDS conditions and use the list of members with potential and eligible DDS conditions generated by L.A. Care Health Plan and any additional information generated by the L.A. Care to facilitate the provision of basic case management and coordination of care by the PCP.

Be responsible to track the identified potential and eligible DDS members and the services provided to them to

assure coordination and continuity of care.

Notify PCPs of potential and eligible DDS members and work with the PCPs and the local Regional Centers to ensure these members continue to receive preventive and medically necessary care and that coordination of care is documented in member medical records.

PCPs will:
Be responsible for basic case management and coordination of care for members with potential and eligible DDS conditions.

Eligibility
L.A. Care will verify member eligibility and send the list of members to the PPGs by facsimile, encrypted email or via a secure PPG FTP sites.

Referral
Members (parent/guardian) may self refer to the Regional Centers for confirmation of Regional Center eligibility criteria. A current listing of the local Regional Centers is available at www.lacare.org or www.dds.cahwnet.gov .

Members must submit a signed consent form for "Release of Medical Information" to facilitate data exchange.

The PCP or specialist should refer potential and eligible members directly to the Regional Center and are encouraged to include the specific member information in the referral matching Regional Center eligibility criteria.

PPGs must:
Implement procedures to ensure confidential transfer of medical documentation to and from the PCP to Regional Centers in compliance with all federal and state regulations.

Establish procedures to support the identification and management of problems with the PCP, Regional Centers, and L.A. Care.

Ensure that the PCP maintains the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

PCPs must:
Maintain the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

HOME AND COMMUNITY BASED WAIVER PROGRAMS

L.A. Care maintains processes and mechanisms for the identification of candidates for the Medi-Cal Home and Community-Based Waiver Programs. Through its care management programs, L.A. Care identifies members who may need services or placement in a Medi-Cal HCBS Waiver Program and works with the PCP in order to ensure coordinated service delivery and efficient and effective case management for services needed by the Member.

When L.A. Cares identifies Members who may benefit from the Home and Community-Based Services (HCBS) Waiver programs, L.A. Care refers them to the specific Agency – needed for assessment:

- In-Home Medical Care Waiver,
- Nursing Facility Subacute Waiver,

- Nursing Facility A/B Waiver, and.
- Home and Community-Based Services (HCBS) Waiver Programs for Persons with Developmental Disabilities

If the agency administering the waiver program concurs with L.A. Care's assessment of the Member and there is available placement in the waiver program, L.A. Care is responsible for continuing to cover and ensure that all medically necessary care unrelated to the Home and Community Based Services Waiver Program is provided when a member has been referred to and been accepted or has directly accessed the Home and Community Based Services Waiver Program.

Members Meeting Criteria for a HCBS Waiver Program
Although Services provided under the Home and Community-Based Services (HCBS) Waiver Programs are a Linked/Carved-Out Service and not covered under L.A. Care , members meeting criteria for placement and when placement is available, these members are **not** disenrolled from L.A. Care and receive the carved out waiver services while remaining enrolled in L.A. Care.

- L.A. Care maintains systems to identify members with conditions that may meet the requirements for participation in this waiver and refers these members to the appropriate HCBS Waiver program

- If the agency concurs with the L.A. Care's assessment of the member and there is available placement in the waiver program, the member will receive waiver services and L.A. Care shall continue to provide all other medically necessary covered services to members while in the HCBS Waiver Program.

Members Not Meeting Criteria for a Waiver Program or Placement Not Available for Members Who Do Meet Criteria for a Waiver Program

- If the HCBS Agency determines that the member does not meet the criteria for a waiver program or if placement is not available, L.A. Care continues to be responsible for the member's care.

- If the member is denied placement because of the limited number available for the waiver program, L.A. Care UM shall:
    - Maintain contact with the appropriate agency to assure the member is reconsidered when space is available
    - Continue comprehensive case management and shall continue to cover all Medically Necessary Covered Services to the Member.

HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS) SERVICES

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home And Community Based Services Waiver Program – Medi-Cal

L.A. Care members, who are subsequently diagnosed with HIV/AIDS as defined by the most recently published Mortality and Morbidity Report from the Centers of Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from L.A. Care. Services provided under the HIV/AIDS Home and Community Based Services Waiver are provided through a carved out program. Members must meet the eligibility requirements of the program and enrollment is dependent on available space.

L.A. Care and its PPGs/PCPs should refer any member that may meet the qualifications of the waiver program to the L.A. Care Management Program.

EARLY INTERVENTION/EARLY START – MEDI-CAL

L.A. Care and its PPGs are responsible for assuring identified eligible members under the age of three 3 years with or at risk for developmental disabilities are referred to Early Start/Early Intervention Services (including CHDP). The Early Start Program is administered through the Department of Developmental Services (DDS). DDS is responsible for coordinating a wide array of services for:

- California residents with developmental disabilities
- Infants at high risk for developmental disabilities
- Individuals at high risk for parenting a child with a disability
- Conducting oversight activities to monitor the need for EPSDT Early Start/Early Intervention Services
- Services are evaluated during the IHA within the required timeframes as described below of Plan membership and during preventive health visits thereafter:
- When medically indicated, the provision of medically necessary Early Start/Early Intervention Services within Plan and
- When medically indicated, the provision and/or coordination of Early Start/Early Intervention Services if these services are delivered out-of-Plan.
- Coordinating with the Plan Partners and local programs to develop and implement programs for PCPs.

PPGs must:

Have systems in place to address the identification, diagnosing, referral, case management, tracking, and reporting of members who are eligible for Early Start/Early Intervention Services.

Have systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those:

- With a condition *known* to lead to developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing.

- In whom a significant developmental delay is suspected.

- Whose early health history places them at risk for delay.

Collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program.

Provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment service identified in the individual family service plan developed by the Early Star/Early Intervention Program, with Primary Care Provider participation.

Identification

L.A. Care and its PPGs must:

- Identify current and new enrollees needing Early Start/Early Intervention services.
- Track the identified persons and the services provided to them to assure coordination and continuity of care.
- Ensure members receive an Initial Health Assessment (IHA), through the member's PCP.

For members under the age of 18 months, PPGs/PCPs are responsible to cover and ensure the provision of an

IHA within 60 days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less

For members 18 months of age and older upon enrollment, PPGs/PCPs are responsible to ensure an IHA is performed with 120 days of enrollment and that the IHA will be consistent with the American Academy of Pediatrics and EPSDT Periodicity Schedule of assessment requirements.

Eligibility
L.A. Care and its PPGs are:

Required to review encounter data to determine members' eligible for Early Start/Early Intervention Services. The following conditions are among those which potentially place infants and children at risk of developmental disabilities:

- HIV/AIDS
- Cancer
- Blindness, hearing impaired
- Retardation
- Heart conditions
- Epilepsy
- Juvenile diabetes
- Cleft palate
- Lung disorders, asthma, cystic fibrosis
- Downs syndrome
- Physically handicapped due to extensive orthopedic problems
- Neurologically impaired, spinal cord injuries
- Sickle cell anemia.

Referral
L.A. Care works with the local Regional Centers for assistance in locating programs which are available for infants and children who are eligible for early intervention services through local education agencies and family resource centers.

L.A. Care Health Plan works closely with the local Early Start Programs and Regional Centers to ensure that medical and health assessment information is provided/processed in a timely manner as follows:

- Children must be referred to an Early Start Program within two (2) working days of identifying that child as potentially requiring developmental interventions services.
- Federal Regulation requires that the Early Start programs and Regional Centers complete the individual family service plan, eligibility assessments and eligibility determination within forty five (45) days from the receipt of the referral.
- Parents or guardians may refer children directly to Early Start/Early Intervention Services.

PCPs or specialists may refer to Early Start/Early Intervention programs for children who meet the eligibility criteria using the L.A. Care and/or its delegated entities' referral process, or refer the member directly to Early Start/Early Intervention programs.

Once it is determined that a referral is needed, L.A. Care and/or its delegated entities' liaison/coordinator will contact PCP to make referrals to an Early Start Program.

L.A. Care and/or its delegated entities will notify PCPs and can work with the local regional centers for assistance in locating programs which are available for infants and children who are eligible for early intervention services through local education agencies and family resource centers.

Coordination of Care

PPGs shall:

- Designate a Case Manager to interface with a designated L.A. Care Liaison, Early Start/Early Intervention programs, Regional Centers, L.A. City Special Education Programs (SELPA), PCP, and the member's family or guardian as necessary.
- Implement procedures to ensure confidential transfer of medical documentation to and from the PCP to Early Start/Early Intervention programs in compliance with all Federal and State regulations.
- Establish procedures for identification and management of problems with the PCP, Early Start/Early Intervention programs, SELPAS' Regional Centers, and L.A. Care.
- Ensure that the PCP maintains the role of the overall case manager for the member and assure appropriate referrals for members assessed as needing Early Start/Early Intervention programs.
- Provide comprehensive case management as necessary
- Maintain logs of active EI/ES cases.
- Ensure that members continue to receive medically necessary care and that coordination of care is documented in members' medical records.
- Continue to provide medically necessary covered services while the member receives waiver services as long as the member is enrolled in L.A. Care.

PCP Responsibilities

When eligible members for early intervention services are referred to an Early Start Program, the PCP shall assure:

- Participation/cooperation in the development of the member's Regional Center individual service plan
- Provision of available medical reports, as requested, to the early intervention team, keeping in mind the 45-day time lines required by state and federal statute for the completion of the initial Individual Family Service Plan (IFSP)
- Follow up and coordination of treatment plans between the PCP, specialists and Early Start Programs. Consultations and ongoing responsibilities for preventive care and all medically necessary services are specified by the specialty care, diagnostic and treatment services, therapies and durable medical equipment.

Problem Resolutions

L.A. Care is available to review and attempt to resolve any disagreements over diagnosis and/or treatment authorizations with providers, local Regional Centers and the Local Education Agencies. Any unresolved issues should be forwarded to the L.A. Care UM Liaison for assistant.

SPECIALTY MENTAL HEALTH – MEDI-CAL

All inpatient mental health and outpatient specialty mental health services are carved out of and excluded from L.A. Care Health Plan's responsibilities under the Medi-Cal contract with DHS, and will be provided by the L.A. County Department of Mental Health (LAC/DMH) in accordance with the current Memorandum of Understanding (MOU) between L.A. Care Health Plan and LAC/DMH.

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

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

The resolution of disputes is a shared responsibility between L.A. Care and LAC/DMH and will be processed as defined in the fully executed Memorandum of Understanding, L.A. Care policies and the established state laws and regulations.

ALCOHOL & DRUG TREATMENT PROGRAMS – MEDI-CAL

Inpatient Detoxification

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

- Life threatening withdrawal from sedatives, barbiturates, hypnotics or medically complicated alcohol and other drug withdrawal.
- Inpatient detoxification is covered in the rare cases where it is medically necessary to monitor the member for life threatening complications; two or more of the following must be present, tachycardia, hypertension, diaphoresis, significant increase or decrease in psychomotor activity, tremor, significant disturbed sleep pattern, nausea, vomiting and threatened delirium tremens.
- When the member is medically stabilized, the PCP/L.A. Care shall provide a referral and follow-up to a Substance Abuse Treatment Program.

Outpatient

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

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

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

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

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

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

Pregnant Members

All pregnant members identified as substance abusers will be recommended for a toxicology screen. If the member refuses this test, the PCP will explain the potential negative health outcomes of drugs and alcohol on

the mother and unborn fetus. Treatment will be recommend and a list of treatment programs and the toll free number to access a treatment program will be given to the member. L.A. Care Health Plan will assist with care coordination for members, as requested.

The member will be asked to sign a release of information and confidentiality statement, allowing the treatment program and the PCP or appropriate medical provider, to coordinate and communicate about the member's treatment progress.

It is the responsibility of the PCP, or appropriate medical provider, to notify the inpatient facility where the pregnant woman is likely to deliver , of the existence of a positive toxicology screen or that substance abuse or use is suspected.

It is the responsibility of the hospital after the birth, to determine if the fetus has been drug or alcohol exposed. The hospital will perform the necessary diagnostic tests and inform Department of Children and Family Services if drug and alcohol exposure is suspected.

LOCAL EDUCATION AGENCY (LEA) – MEDI-CAL

L.A. Care and its PPGs will maintain systems to refer members to the carve out program and services through the Local Education Agency Services (LEA).

L.A. Care and its PPGs are responsible for:

- Providing all of the medically necessary covered services and
- Ensuring the member's PCP cooperates and collaborates in the development of the Individual Education Plan (IEP), Individualized Health and Support Plan (IHSP) or the Individual Family Service Plan (IFSP).

L.A. Care is responsible for:

- Providing a Primary Care Physician and all medically necessary covered services for the members, and shall ensure that the member's Primary Care physician cooperates and collaborates in the development of the Individual Education Plan (IEP) or the Individual Family Service Plan.
- Providing basic or complex/comprehensive case management and care coordination to the member as necessary to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the Local Education Agency with Primary Care Provider participation.

PPGs/PCPs are responsible for:

- Providing all medically necessary covered diagnostic, preventive and treatment services identified in the IEP development.
- Referring the members to the L.A. Care Utilization Management Care Management Program.

DENTAL SERVICES for MEDI-CAL MEMBERS

Dental Care Treatment Services are a carved out benefit to Medi-Cal members through the Medi-Cal Denti-Cal Program. Dental Services for adults ages 21 and over will no longer be payable under the Dentil-Cal program with a few exceptions. Exemptions to the eliminated adult dental services include:

- Medical and surgical services provided by a doctor of dental medicine or dental surgery would be considered physician services and which service may be provided by the either a California licensed physician or a dentist
- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy and 60 days post-partum
- Members under the Early and Periodic Screening, Diagnosis and Treatment program

- Members who are under 21 years of age and whose course of treatment is scheduled to ,continue after he/she turns 21 years of ages (continuing services for EPSDT member)

L.A. Care and its PPGs are responsible for Dental Screening and Referral of Members to the Carved out Medi-Cal Denti-Cal Program for Dental Treatment when treatment needs are identified and continuing benefit coverage exists.

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

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

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

- For members under twenty-one (21) years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) years or earlier if conditions warrant.
- For members under 6 years of age, fluoride varnish shall be provided up to 3 times in a 12 month period as indicated in MMCK APL Letter 07-008. Furthermore PPG agrees to train providers on fluoride varnish including:
  a) How to obtain fluoride varnish supplies
  b) Providing fluoride varnish applications, periodic dental assessments and parental anticipatory guidance on scheduling visits.
  c) Referring children to a dentist for dental examinations and care at 1 year of age per Child Health and Disability Prevention (CHDP) guidelines.
  d) Coordinating member care with dental professionals and
  e) Documenting dental assessments and documenting fluoride varnish (using HCPCS Code D1203) in the member medical record and on encounter date provided to the PPG.

Covered Medical Services not provided by Dentist or Dental Anesthetists:

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

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

Financial Responsibility for General Anesthesia including Conscious Sedation for Dental Services and Associated Facility Office Charges
L.A. Care and its PPGs are responsible for covering general anesthesia and associated facility/office charges for dental procedures rendered in a hospital, surgery center, or office setting when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital, surgery center, or office setting (*as defined by the Division of Financial Responsibility - DOFR).* A prior authorization of general anesthesia and associated charges required for dental care procedures is

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

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

- Members who are under seven (7) years of age.
- Members who are developmentally disabled, regardless of age.
- Members whose health is compromised and for whom general anesthesia Is medically necessary, regardless of age.

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

Referral to Medi-Cal Dental Providers through Carved Out Medi-Cal Dental Program
L.A. Care and its PPGs must refer members to the appropriate Medi-Cal dental providers for treatment of dental care needs.

Updated lists of Medi-Cal dental providers are made available to network providers.

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

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

Routine dental care and orthodontics are not covered by CCS.

TARGETED CASE MANAGEMENT SERVICES

Members Eligible For and/or Who are Receiving Targeted Case Management Services (Carved Out Services) – MEDI-CAL
Identification and Referral: L.A. Care and/or its PPGs are responsible for determining whether a member requires Targeted Case Management services, and must refer members who are eligible for Targeted Case Management services to a Regional Center or local governmental health program as appropriate for the provision of Targeted Case Management services.

Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups:

- Persons who have language or other comprehension barriers.
- Are unable to access or appropriately utilize services themselves.
- Have demonstrated noncompliance with their medical regimen.
- Are unable to understand medical directions because of language or other comprehension barriers.
- Have no community support system to assist in follow-up care at home.
- Persons who are 18 years of age and older and who Are on probation and have a medical and/or mental condition.
- Have exhibited an inability to handle personal, medical, or other affairs; or are under public conservatorship of person and/or estate; or have a representative payee.
- Are in frail health and in need of assistance to access services in order to prevent institutionalization.

"High-risk persons" means those persons who have failed to take advantage of necessary health care services, or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect, or violence, including, but not limited to, the following individuals:

- Women, infants, children and young adults to age 21 Pregnant women.
- Persons with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome.
- Persons with reportable communicable disease.
- Persons who are technology dependent. Solely for the purposes of the Targeted Case Management Services program, "technology dependent persons" means those persons who use a medical technology, embodied in a medical device, that compensates for the loss of normal use of a vital body function and require skilled nursing care to avert death or further disability.
- Persons with multiple diagnoses who require services from multiple health/social service providers.
- Persons who are medically fragile. Solely for the purposes of the Targeted Case Management Services program, "medically fragile persons" means those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.

Member Receiving Targeted Case Management Services
For Members who are receiving Targeted Case Management services specified in Title 22, CCR, Section 51351, L.A. Care and/or its PPGs shall be responsible for coordinating the member's health care with the Targeted Case Management provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the Targeted Case Management provider that are Medi-Cal Covered Services.

Targeted Case Management Services means carved-out Medi-Cal services as specified in Title 22, CCR, Section 51351 as follows:

Targeted case management services shall include at least one of the following service components:

- A documented assessment identifying the beneficiary's needs. The assessment shall support the selection of services and assistance necessary to meet the assessed needs and shall include the following, as relevant to each beneficiary:
    - Medical/mental condition
    - Physical needs, such as food and clothing
    - Social/emotional status
    - Housing/physical environment
    - Familial/social support system
    - Training needs for community living
    - Educational/vocational needs
- Development of a comprehensive, written, individual service plan, based upon the assessment specified in subsection (a)(1) above. The plan shall be developed in consultation with the beneficiary and/or developed in consultation with the beneficiary's family or other social support system. The plan shall be in writing and, as relevant to each beneficiary, document the following:
    - The nature, frequency, and duration of the services and assistance required to meet identified needs.
    - The programs, persons and/or agencies to which the beneficiary will be referred
    - Specific strategies to achieve specific beneficiary outcomes.
    - Case manager's supervisor's signature.

Implementation of the service plan includes linkage and consultation with and referral to providers of service. The case manager shall follow-up with the beneficiary and/or provider of service to determine whether services were received and whether the services met the needs of the beneficiary. The follow-up shall occur as quickly as

indicated by the assessed need, but shall not exceed thirty days(30)from the scheduled service.

Assistance with accessing the services identified in the service plan includes the following:

- Arranging appointments and/or transportation to medical, social, educational and other services.
- Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or providers of service.
- Crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary.

For the target populations defined above at the beginning of Section

- 5.37 Targeted Case Management -"Members Eligible For and/or Who are Receiving Targeted Case Management Services (Carved Out Services)," crisis assistance planning shall be restricted to non-medical situations.
- Periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued. The review or reinvestigation shall be:
- Completed at least every six months,
- Conducted by the case manager in consultation with the beneficiary and/or in consultation with the beneficiary's family or social support system, and approved by the case manager's supervisor.
- Any modifications to the plan of service shall be made in writing and become an addendum to the plan of service.

When Members Under the of Age 21 Are Not Accepted For Targeted Case Management Services, Care Coordination/ Case Management Services are required to be provided In-Plan

If members under age twenty-one (21) have been referred by L.A. Care and/or its PPGs to a Regional Center or local governmental health program but who have not been accepted for Targeted Case Management Services, L.A. Care and/or its PPGs shall ensure the members access to services in-Plan that are comparable to EPSDT Targeted Case Management services.

L.A. Care and/or PPG Responsibilities for EPSDT Targeted Case Management Services:

Financial Responsibility: L.A. Care and/or its PPGs are not responsible for payment for services provided under:

- CCS
- Specialty Mental Health
- Targeted Case Management services provided by a State-contracted referral provider such as a Regional Center or other governmental agency

L.A. Care and/or its PPGs do have financial responsibility for and shall provide the following (but not limited to) EPSDT Supplemental Services in-network to members when medically necessary for the purpose of assuring care coordination for:

- Targeted Case Management services provided in-network.
- EPSDT supplemental services include those targeted case management services designed to assist children in gaining access to necessary medical, social, educational and other services.
- Also See L.A. Care UM Procedure 17033 EDSDT Supplemental Services for a full list of EPSDT Supplemental Services.

EPSDT SUPPLEMENTAL SERVICES FOR MEMBERS UNDER THE AGE OF 21 YEARS – MEDI-CAL

For members under the age of twenty-one (21) who are receiving medically necessary ESPDT Supplemental Services and Targeted Case Management Services through the Regional Centers or local governmental health programs as appropriate, L.A. Care and its contracted PPGs are responsible for providing ongoing care coordination/case management services.

L.A. Care and its contracted PPGs are **not** financially responsible for the payment of services provided under:

- CCS
- Specialty Mental Health
- Targeted Case Management Services provided by the Regional Centers or local governmental health programs

For members under the age of twenty-one (21) who are **not** receiving medically necessary EPSDT Supplemental Services and Targeted Case Management Services through the Regional Centers or local governmental health programs as appropriate, L.A. Care and its contracted PPGs are responsible for providing access to in-network services that are comparable to EPSDT Targeted Case Management Services

EPSDT Supplemental Services include those targeted case management services designed to assist children in gaining access to necessary medical, social, educational and other services.

L.A. Care is responsible for:

- Assuring members under the age of 21 years are referred to EPSDT (Screening (including CHDP services provided by the PCP) and Supplemental services.
- Conducting oversight activities to monitor the need for EPSDT Screening and EPSDT supplemental services are evaluated during the IHA within the initial 120 days of Plan enrollment membership and during preventive health visits; when medically indicated.
- The provision of medically necessary EPSDT supplemental services within Plan and the provision and coordination of EPSDT supplemental services if these services are delivered out-of-plan; when medically indicated.
- Coordinating with the local EPSDT programs to develop and implement educational programs for PCPs.

L.A. Care and/or PPG Responsibilities/Financial Responsibility

L.A. Care and/or its PPGs shall provide or arrange and pay for EPSDT supplemental services or members under the age of 21 years, including case management and supplemental nursing services except when EPSDT supplemental services are provided as California Children's Services (CCS) services, or as mental health services

L.A. Care and/or its PPGs are responsible to have implemented Policies and Procedures to ensure the identification, diagnosis, referral, and tracking of eligible members for referral to EPSDT screening services and determining the Medical Necessity of EPSDT supplemental services using criteria established in Title 22, CCR, Section 51240 and 51340.1.

L.A. Care and/or its PPGs shall provide the following (but not limited to) EPSDT supplemental services to members when medically necessary for the purpose of assuring care coordination:

- Targeted Case Management services
- EPSDT supplemental services include those targeted case management services designed to assist children in gaining access to necessary medical, social, educational and other services.
- Cochlear implants

- Supplemental nursing services
- Psychology
- Occupational therapy
- Audiology
- Orthodontics
- DME
- Incontinence medical supplies (including diapers) at home or in board and care facilities

For young children when their developmental deficits are such that bowel and/or bladder control cannot be achieved

Where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence

- Hearing aids
- Dental and Psychotropic drugs
- Medical nutrition services assessment and therapy
- Pharmacy
- Physical therapy evolution and services
- Pulse oximeters
- Speech therapy

Members are identified for EPSDT Supplemental Services in the following ways:
L.A. Care and/or its PPGs, provider network PCPs/specialists identify the need for and make the appropriate referral for EPSDT supplemental services at the time of the Initial Health Assessment or at any subsequent health assessment visit.

The member, the member's parents, legal guardian, and/or other family members may identify the need for EPSDT supplemental services.

The local CHDP program may identify the member's need for EPSDT supplemental services prior to the member's enrollment in Medi-Cal Managed Care.

Any health professional, in or out-of-Plan, or school professional may identify the member's need for EPSDT supplemental services when an encounter results in one or more of the following:

- The determination of the existence of a suspected illness or condition.
- A change or complication(s) in the condition.
- A determination that a pre-existing condition may now be amenable to specific therapeutic intervention.

Prior Authorization
L.A. Care and/or its PPGs may apply their referral authorization processes to EPSDT supplemental services based upon medical necessity criteria using the criteria established in Title 22, CCR, Sections 51340 and 51340.1 subject to the Medi-Cal and other regulatory grievance and appeal procedures. The requirements for documentation of authorizations, denials and appeals shall be in accordance with applicable contractual and regulatory requirements.

Upon identification of the need for EPSDT supplemental services, including EPSDT supplemental services that are not covered services under the terms of their contract (i.e., CCS and MH) L.A. Care and/or its delegated entities must provide the member with a referral to an appropriate provider or organization.

EPSDT Supplemental Services Will Meet the Following Criteria:

- The services requested are to correct, or ameliorate a defect, physical or mental illness, discovered during any health assessment.
- The supplies, items and/or equipment requested are medical in nature.
- The services requested are not solely for the convenience of the member, the family, the physician or any other provider of service.
- The services requested are not primarily cosmetic in nature or designed to primarily improve the member's appearance.
- The services requested are safe and are not experimental and are recognized as an accepted modality of medical practice.
- The services requested are the most cost effective when compared with alternatively acceptable and available modes of treatment.
- The services requested are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the medical condition of the member.
- The service requested improves the overall health outcome as much as, or more than, the established alternatives.
- The predicted beneficial outcome outweighs the potential harmful effects.

Care Coordination and Liaison Process for EPSDT Supplemental Services

L.A. Care and/or its PPGs will:

- Ensure that the PCP provides basic case management for the member and assures appropriate referrals for members with potential and/or eligible EPSDT supplemental services needs.
- Implement procedures to ensure confidential transfer of medical documentation between the PCP and EPSDT supplemental services providers in compliance with all federal and state regulations.
- Provide liaison/case management staff to coordinate EPSDT supplemental services including but not limited to:
    - Developing and implementing written plans for communicating issues of EPSDT supplemental services eligibility, available services, arranging consultation with regional supple-mental service providers, and providing coordination of care of services with network providers.
    - Facilitating bi-directional communication between regional EPSDT supplemental service providers and the member's PCP, whether or not the referral is for a covered service.
    - Coordinating and providing the member with appropriate out-of-Plan referrals when necessary for EPSDT supplemental services not covered by the Plan.
    - Maintaining an ESPDT supplemental services referral log(s) which includes the services provided and the treatment outcomes.

EPSDT supplemental services – In Home Shift Nursing/Private Duty Nursing (PDN)

EPSDT services are provided to full-scope Medi-Cal beneficiaries who are under the age of 21. Services may be authorized once medical necessity criteria have been met.

L.A. Care is responsible for providing PDN services; L.A Care does not delegate this responsibility to PPGs. PPGs must submit prior authorization requests to LA. Care UM Department.

Authorized services must meet either the regular Medi-Cal definition of medical necessity or the Institutional Level of Care definition for medical necessity services, which is outlined in CCR, Title 22, Division 3, Section 51124.6, 51335, 51343.1 and 51343.2

Authorized services must be cost-effective to the Medi-Cal program. This means that the individual cost of providing EPSDT private duty nursing services in home settings must be less than the total cost incurred by the Medi-Cal program for providing the care in a licensed health care facility.

When necessary, a home health assessment will be arranged to validate the necessity of the requested services and to ensure that the home is an appropriate environment for the provision of the requested services.

EPSDT services are subject to prior authorization. When medical necessity criteria have been met, such requests will be approved. Cases in which medical necessity criteria have not been met will be denied or modified as appropriate to meet the needs of the member.

How To Refer a Member for EPSDT PDN

If a provider has a member who requires EPSDT PDN services, the provider should complete an Authorization Request Form and submit it to L.A. Care's UM Department.

Authorization requests must be accompanied by medical documentation sufficient to support the medical necessity of the services. Required documentation includes the following:

- Completed prior authorization request form (clearly mark requested service as –"**FOR EPSDT SUPPLMENTAL SERVICES – PRIVATE DUTY NURSE"**)
- Plan of Treatment (POT) signed by a physician (within 30 days);
- Nursing Assessment, signed by a physician (within 30 days);
- Medical information supporting the nursing services requested, i.e. medication record, discharge summary notes, and treatment notes.

PDN will be assessed utilizing the information provided by the requesting physician and criteria defined in Title 22 Title 22, Division 3, Section 51124.6 (Pediatric Sub-Acute Care):

- Tracheostomy with dependence on mechanical ventilation for a minimum of 6 hours per day.

- Dependence on tracheostomy care requiring suctioning at least every 6 hours, and room air mist or oxygen as needed, and dependence on one of the six treatment procedures listed below :
    1) intermittent suctioning at least every 8 hours and room air mist and oxygen as needed
    2) continuous IV therapy, including administration of a therapeutic agent necessary for hydration or of IV pharmaceuticals, or IV pharmaceutical administration of more than one agent, via peripheral or central line, without continuous infusion
    3) peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours
    4) tube feeding by means of a nasogastric or gastrostomy tube
    5) other medical technologies required continuously, which require the services of a professional nurse
    6) biphasic positive airway pressure at least 6 hours a day, including assessment or intervention every 3 hours and lacking either cognitive or physical ability to protect his or her airway

- Dependence on total parenteral nutrition or other IV nutritional support, and dependence on one of the treatment procedures specified above.

- Dependence on skilled nursing care in the administration of any 3 of the 6 treatment procedures listed above

- Dependence on biphasic positive airway pressure or continuous positive airway pressure at least 6 hours a day, including assessment or intervention every 3 hours and lacking either cognitive or physical ability to protect his or her airway and dependence on one of the 5 treatment procedures specified in procedures 1-5 listed above.

PDN hours will be approved based on the services to be provided and the willingness of family participation in care. Authorizations will be given for up to 90 calendar days at a time, pending continued eligibility. All services will be coordinated by L.A. Care staff.

EPSDT PDN and CCS

The California Children's Services (CCS) program may authorize EPSDT supplemental service requests for skilled nursing services, Private Duty Nursing (PDN), also known as shift nursing, from a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN) and/or Pediatric Day Health Care (PDHC) services under the EPSDT benefit. Under Medi-Cal, the day program is less than 24 hours, individualized, and family-centered, with developmentally appropriate activities of play, learning, and social integration designed to optimize the individual's medical status and developmental functioning, so that he or she can remain with the family. These services do not include respite care (See *California Code of Regulations* [CCR], Title 22, Section 51184[k] [1] [B].) L.A. Care will coordinate services with local CCS agency.

EXCLUDED SERVICES REQUIRING MEMBER DISENROLLMENT – MEDI-CAL
MAJOR ORGAN TRANSPLANTS

Except for kidney transplants, major organ transplant procedures that are covered by Medi-Cal Fee-for-Service are not covered by L.A. Care. When a member is identified as a potential major organ transplant candidate, L.A. Care must refer the member to a Medi-Cal approved transplant center. If the transplant center Physician considers the member to be a suitable candidate, L.A. Care will submit a Treatment Authorization Request (TAR) to either the San Francisco Medi-Cal Field Office (for adults) or the California Children's Services Program (for children) for approval. L.A. Care Health Plan's Care Manager will notify the Member Services Department to initiate disenrollment of the member when all of the following has occurred:

- Referral of the member to the organ transplant facility.
- Facility's evaluation has concurred that the member is a candidate for major organ transplant
- Major organ transplant is authorized by either DHS Medi-Cal Field Office or the CCS Program

L.A. Care and its PPGs are responsible for providing all medically necessary covered services until the member has been disenrolled from L.A. Care.

Upon disenrollment, L.A. Care will ensure continuity of care by transferring all for the member's medical documentation to the transplant physician. The effective dates may be retroactive to the beginning of the month in which the member was approved so Care Managers will follow all services provided through the completion of the disenrollment.

LONG TERM CARE *(IMPORTANT CHANGES BEGINNING APRIL 1, 2014)*

Long term care (LTC) is defined as care in a facility for longer than the month of admission plus one month. Effective April 1, 2014 California's Coordinated Care Initiative (CCI) began transitioning LTC services to managed care for a sub-set of beneficiaries. As the CCI benefit transition is tied to dual eligibility or beneficiaries' month of birth, PPGs are encouraged to contact L.A. Care for assistance in understanding member's eligibility for LTC services.

UTILIZATION MANAGEMENT Linked and Carved out Services (This Section applies to Healthy Kids Only)

Linked Services are specific supplemental or wrap-around services to L. A. Care Health Plan Members provided by State/Federally funded agencies. While not as defined for the Healthy Kids members, linked agencies may include, but may not be limited to:

- Early Intervention/Early Start and Developmental Disability Services (DDS) through the Regional Centers.
- Women Infant and Children (WIC) Nutritional Program Services.

Healthy Kids Linked agencies have defined roles and responsibilities to ensure coordination of care for members. In most instances, the agency, not L.A. Care Health Plan, is financially responsible for the linked services.

CALIFORNIA CHILDREN SERVICES (CCS)

LA Care maintains an MOU between L.A. Care and CCS to provide services to Healthy Kids members presenting with a qualifying medical condition AND when the families provide documentation of financial eligibility. CCS will provide member assistance with the completion of the required financial documentation.

Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, L.A. Care and/or its PPGs shall refer the member to the local CCS office for determination of eligibility.

L.A. Care and/or its PPGs shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:

- Ensure that L.A. Care and/or its PPGs' providers perform appropriate baseline health assessments and diagnostic evaluations which provide the sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition.
- Assure that Contracting Providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within L.A. Care and/or its PPGs' network; and only from the date of referral.
- Enable initial referrals of member's with CCS-eligible conditions 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.
- Ensure that L.A. Care and/or its PPGs continue to provide all Medically Necessary Covered Services to the member until CCS eligibility is confirmed.

- Ensure that, once eligibility for the CCS program is established for a member, L.A. Care and/or its PPGs shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

  If the local CCS program does not approve eligibility, L.A. Care and/or its PPGs remain responsible for the provision of all Medically Necessary Covered Services to the member. If the local CCS program denies authorization for any service, L.A. Care and/or its PPGs remain responsible for obtaining the service, if it is medically necessary and paying for the service if it has been provided.

Identification

Identify and track current and new enrollees with potential and/or eligible CCS conditions.

Eligibility
L.A. Care Health Plan shall be responsible for generating and distributing, to its PPGs and the member's PCP, lists received from CCS of L.A. Care members identified as being eligible or authorized to receive CCS services.

L.A. Care will send these lists to its PPGs and to the member's PCP on a monthly basis.

L.A. Care and/or its PPGs will notify the member's PCP and work with the local CCS office to ensure member is receiving appropriate medical care and that coordination of care is documented in the member's medical records.

L.A. Care and/or its PPGs will undertake regular activities, such as review of encounter data necessary to identify members with potential CCS conditions and assure appropriate referrals to CCS.

Referral
Members (parent/guardian) may self refer to CCS.

L.A. Care will make available to its PPGs a list of CCS paneled providers and facilities as received from the local and or state CCS program office.

PCP or specialist may refer to CCS paneled provider or CCS local program using the L.A. Care and/or its delegated provider's referral process, or refer the member directly to CCS.

L.A. Care and/or its PPGs are required to provide PCPs information on CCS paneled providers and facilities including mechanism for accessing specific provider facility contact information for referral.

The CCS program authorizes Medi-Cal payments to L.A. Care and/or its delegated provider's network physicians who currently are members of the CCS panel and to other 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 in accordance with subparagraph D. below. L.A. Care and/or its PPGs shall inform providers, except as noted above, that CCS reimburses only CCS paneled providers. L.A. Care and/or its PPGs 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 L.A. Care and/or its PPGs or L.A. Care and/or its delegated provider's network physician, via telephone, FAX, or mail. In an emergency admission, L.A. Care and/or its PPGs or L.A. Care and/or its PPGs' network physician shall be allowed until the next business 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.

L.A. Care will ensure that the member and provider manuals document the CCS referral options and processes.

Coordination of Care

L.A. Care and/or its PPGs shall:

- Designate a CCS coordinator (liaison) to interface with a designated L.A. Care CCS Coordinator, the CCS office, CCS panel provider, the member's family or guardian.
- Implement procedures to ensure confidential transfer of medical documentation between the PCP and CCS paneled providers in compliance with all federal and state regulations.
- Ensure that the PCP provides basic case management for the member and assures appropriate referrals for members with potential and/or eligible CCS conditions.
- Make available CCS Program referral forms to all member families/guardians and PCP offices.
- Continue to provide case management of all services (primary and specialty care) until eligibility has been established with the CCS program.
- CCS program case management is responsible for the CCS eligible condition and authorizes medically necessary care.
- L.A. Care and/or its PPGs must continue to provide primary care case management, coordination of services, and health care service other than those required for the CCS condition and keep active CCS case logs.
- For inpatient admissions CCS referrals, authorization for inpatient hospital stays is limited to the time of eligibility for the CCS program. It is recommended that the L.A. Care and/or its PPGs or designated CCS coordinator continue to track the hospitalization in collaboration with the CCS Case Manager.
- L.A. Care's PPGs are capitated to provide those services that not related to the treatment of the CCS eligible condition.

Referral/Care Coordination of Members to the Genetically Handicapped Persons Program (GHPP)

L.A. Care and/or its PPGs shall have mechanisms in place to refer members who may be eligible for services provided by the Genetically Handicapped Persons to assure appropriate care coordination of members who will no longer be eligible for CCS at age 21, but will still need services.

Dispute Resolution

L.A. Care and/or its PPGs need to have a mechanism in place to resolve disputes between the PCP or Specialist and the CCS program office. In the absence of a resolution, L.A. Care and/or its PPGs Liaison will notify L.A. Care UM of all unresolved disputes about CCS services. All dispute resolutions must be resolved within 30 calendar days.

L.A. Care and/or its PPGs are required to provide any medically necessary special services during the time of dispute resolution. L.A. Care will facilitate any unresolved disputes.

Disagreements with regards to CCS program eligibility, payments for the treatment of services of the CCS eligible condition and associated or complicated conditions must be resolved cooperatively between L.A. Care and the county CCS program.

If the dispute is not resolved at the local level, L.A. Care must notify the Medi-Cal Managed Care contract manager, and the county CCS program must notify the state CCS Regional Office. The state Children's Medical Services (CMS) program and the Medical Managed Care Division will ultimately render a joint decision if the problem is not resolved at the lower level.

Training and Education:

- L.A. Care and/or its PPGs will coordinate with the local CCS program and L.A. Care, to develop and implement training programs for L.A. Care and/or its PPGs, PCPs, and L.A. Care Staff.

- L.A. Care will ensure that provider manuals, and member enrollment materials outline information describing CCS benefits and eligibility.

MATERNAL AND CHILD HEALTH – (HEALTHY KIDS)

L.A. Care and its PPGs must complete a comprehensive risk assessment tool for all pregnant female members that is comparable to the American College of Obstetrics and Gynecology standard. The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.

The risk assessment tools shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

Standard Obstetrical Record Elements

Standard Obstetrical record elements shall be included in the obstetric, nutritional, psychosocial and educational examination of pregnant members in compliance with DHS and the most current guidelines of the American College of Obstetrics and Gynecology (ACOG), CPSP, and Title 22.

Referral to Specialists

L.A. Care and its PPGs are responsible for ensuring that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

Pregnant women that are at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals.

Specialists may include, but are not limited to:

- Cardiologists
- Psychiatrists
- Internists
- Infectious Disease
- Geneticists
- Specialty High-Risk Obstetricians
- Oncologists
- Endocrinologists

Examples of these referral types and protocols may include, but are not limited to:

- Diabetes
- Hypertension
- Hepatitis
- HIV+
- Genetic Problems
- Epilepsy or Neurological Disorder
- Renal Disease
- Alcohol or Drug Abuse
- Maternal Cardiac Disorders

- Thyroid or Other Endocrine Disorders
- Epilepsy or Neurological Disorder

Common Pregnancy Conditions/Issues Requiring Multidisciplinary Management
Pregnant members exhibiting any of the following representative conditions/ issues will have interventions and referrals developed utilizing the Nutrition (N), Psychosocial (PS), or Health Education (HE) protocols:

- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Fear of physicians, hospitals, and medical personnel (HE)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- Housing and transportation problems (PS)
- Domestic violence (PS)
- No previous contact with health care systems (HE)
- Multiple gestation (HE), (PS), (N)
- Need for bed rest during pregnancy (PS), (HE)
- Previous receipt of unfriendly health care services (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)

Common Postpartum Conditions/Issues Requiring Multidisciplinary Management:

- Postpartum blues, postpartum depression (PS)
- Housing, food, transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Breastfeeding difficulties (HE)
- Sexual pain/difficulties (HE)
- Severe anemia (N)

Other Referrals include, but are not limited to:

- WIC Supplemental Nutritional Program

L.A. Care and its PPGs shall ensure that all pregnant, breastfeeding and postpartum women, and infants and children who are eligible for WIC supplemental food services will be assessed, and if appropriate, referred to the Los Angeles County Public Health Services WIC Program.

Family planning referral protocols may include assistance with birth control issues, STD information or control, procedure or counseling.

A referral may be done, but is not required for this service, as members can self refer to Family Planning Services

Social Work- Social Work referrals due to:

- Family Abuse/Domestic Violence
- Financial Problems
- Other identified social needs

CHILD HEALTH AND DISABILITIES PREVENTION PROGRAM (CHDP)

L.A. Care has a mutually agreed upon arrangement with the local School Districts that provide EPSDT/CHDP services. That arrangement describes:

- Eligibility requirements, scope of services, client services and outreach, tracking and follow-up, health education, data collection, quality assurance mechanisms, dispute resolution and billing/ reimbursement mechanisms governing the relationship between and among L.A. Care and the participating school districts.
- How L.A. Care will directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information.
- Guidelines specifying coordination of services reporting requirements, quality standards, processes to ensure services are not duplicated, and process for notification to member/student/parent on where to receive initial and follow-up services.
- PPGs are required to maintain a "medical home" and ensure the overall coordination of care and case management of members who obtain CHDP services through the local school districts or school sites.
- PCP will provide basic case management for the member and coordinate the provision of any referrals or additional services necessary to diagnose and/or treat conditions identified during the school EPSDT/CHDP assessment.
- PCP will also provide ongoing preventive and primary services, as required.
- EPSDT/CHDP services are provided to members for school entry only while maintaining the "medical home" with the PCP for ongoing health care management.
- The PCP, as the medical home, is responsible for ongoing comprehensive health care delivery.

Reimbursement to Schools for the Provision of School Based EPSDT/CHDP Services

L.A. Care Health Plan shall be responsible for paying school district claims directly for EPSDT/CHDP services provided in accordance with the agreement as determined by the total amount of claims.

L.A. Care will generate a PPG Claims Paid reconciliation report to identify claims paid on behalf of the PPG by L.A. Care for that capitation period.

L.A. Care Claims Department is responsible for routing the PM160 forms to the appropriate PCP for identified care coordination within 30 days of claims payment.

Provider Training

L.A. Care will collaborate with the PPGs and the Los Angeles area CHDP programs to ensure provider training regarding school linked EPSDT/CHDP services.

TUBERCULOSIS/DIRECT OBSERVATION THERAPY (HEALTHY KIDS)

L.A. Care and its PPGs must provide screening for all members at risk for TB to determine risk factors for and diagnosis of Tuberculosis. Mantoux skin tests will be performed on all persons at increased risk of developing TB. Children will be screened for TB risk factors and follow recommended guidelines for the provision of Mantoux skin testing.

In collaboration with the local Health Departments TB Control, L.A. Care will provide education and access to training upon request.

L.A. Care and its PPGs must have systems in place to:

- Coordinate services provided to members diagnosed with active TB through the Local Health Department TB Control Department and DOT.
    - Each confirmed TB case or suspected case must be reported within one business day to the local Health Department.
- Maintain evidence that members with a suspected or confirmed TB diagnosis are reported to the local Health Department within one business day.

All individuals at increased risk for TB will be offered TB testing and managed, according to CDC guidelines for the management of individuals identified as high risk for TB, unless they have documentation of prior positive test results, TB disease and/or treatment.

The Primary Care Physicians (PCP), as required by the current California TB Guidelines, that a tuberculin reaction of 5mm of induration or greater is classified as positive in the following groups:

- Persons known to have or at risk for HIV infection
- Close recent contact with a person who has infectious TB
- Persons who have a chest x-ray consistent with tuberculosis
- Persons who are immunosuppressed
- Other groups as identified in the current California TB Guidelines.

A tuberculin reaction of 10mm of induration or greater is classified as positive in all other persons. The PCP will evaluate all members with a positive skin test, even if asymptomatic.

To report positive results, the PCP's must document the appropriate action as follows:

- Positive tests in children under three (3) are reported to the Local Health Department and L.A. Care Management Program
- All members with a new positive skin test must be evaluated for active TB which may include a chest x-ray.
- When active TB is suspected, an appropriate culture must be obtained from sputum or other body fluid/tissue, as appropriate
- When TB is suspected, treatment will be initiated prior to bacteriological confirmation. The PCP must refer appropriate members to the local Health Department TB Control Program to provide the services of Directly Observed Therapy (DOT) to members with active TB.. **All active cases determined to be at risk for non-compliance will be referred to the TB Control Program for evaluation of DOT services.**

Directly Observed Therapy (DOT) for TB is offered by Local Health Departments (LHDs) and is a linked and carved out service.

L.A. Care and/or its PPGs shall assess the risk of noncompliance with drug therapy for each member who requires placement on anti-tuberculosis drug therapy.

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

- Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);
- Members whose treatment has failed or who have relapsed after completing a prior regimen;
- Children, adolescents and individuals who have demonstrated noncompliance (those who failed to keep office appointments).

L.A. Care and/or its PPGs shall refer members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

L.A. Care and/or its PPGs shall assess the following groups of members for potential noncompliance and for consideration for DOT:

- Substance abusers.
- Persons with mental illness.
- The elderly.
- Persons with unmet housing needs.
- Persons with language and/or cultural barriers.

If, in the opinion of L.A. Care and/or its delegated entities' providers, a member with one or more of these risk factors is at risk for noncompliance, the member shall be referred to the LHD for DOT.

L.A. Care and/or its delegated entities 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.

L.A. Care Health Plan, in conjunction with its delegated entities, will work in close collaboration with the Public Health Departments of the County of Los Angeles and the cities of Pasadena and Long Beach to ensure compliance with guidelines for TB treatment and control.

WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM NUTRITIONAL SUPPLEMENT PROGRAM (HEALTHY KIDS)

WIC services are defined as a carve out service and are provided as a benefit to eligible Women, Infants, and Children through referral to the Carved Out Service, the WIC Supplemental Nutrition Program.

L.A. Care and its PPGs must have systems to identify and refer eligible members needing WIC services to appropriate WIC sites/services.

IDENTIFICATION

Eligibility Verification

Eligibility for WIC services is determined by the WIC centers based on residency and other factors.

PCP and other Physicians or Primary Care Providers WIC Referrals

PCPs, other Physicians or other Primary Care Providers WIC referral process as part of its Initial Health Assessment 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 to the WIC program as mandated by Title 42, CFR 431.635 (c).

As part of the referral process, PCPs, Other Physicians or other Primary Care Providers referring to the WIC program must include:

- a current hemoglobin or hematocrit laboratory value
- present height and weight
- confirmation of the pregnancy date
- birth weight and length for infants
- for small or pre-term infants, document the gestational age.

- PCPs, Other Physicians or other Primary Care Providers must document these laboratory values and the referral in the member's medical record

Members Self-Referral to WIC

Members may self-refer to WIC.

Basic Case Management

The PCP maintains the role of the overall case manager for the member which includes assuring appropriate referrals for members needing WIC services and providing routine preventive and other necessary care.

Transfer of Information between Providers and WIC

L.A. Care and its PPGs/PCPs must implement HIPAA compliant procedures to ensure confidential transfer of medical documentation including CPSP assessment, WIC program dietary assessment forms, to and from the PCP to WIC Centers in compliance with all federal and state regulations.

DEVELOPMENTAL DISABILITIES SERVICES (DDS) –HEALTHY KIDS

L.A. Care and its PPGs must maintain policies, procedures, and processes in place to address the following: identification, diagnosis, referral, and tracking of members with potential and eligible DDS conditions for the provision of all screening, preventive, medically necessary, and therapeutic services.

L.A. Care and its PPGs will utilize network providers for diagnosis and treatment of members with developmental disabilities.

Members may access the Regional Centers if services are needed and not available within the L.A. Care network.

L.A. Care and its PPGs will refer members with developmental disabilities to the Regional Centers for those non-medical services such as respite, out-of home placement, supportive living, etc. for members with substantial disabilities if such services are needed.

Identification

L.A. Care will:

For existing MediCal members, L.A. Care obtains a list of eligible members currently enrolled in a Regional Center. This list is distributed to the assigned PCPs and PPGs to ensure care coordination.

On a monthly basis, L.A. Care provides PPGs and PCPs with a list of members receiving services through one of the community Regional Centers. This information serves to notify providers and allow them to notify providers and allow them to coordinate any services requested by L.A. Care or the Regional Center. For a listing of current approved ICD-9 codes of potential eligible DDS conditions, you may contact the UM Department or visit www.dds.cahwnet.gov. for additional information about DDS.

PPGs will:

Maintain mechanisms to support the identification of members with eligible and potential DDS conditions and use the list of members with potential and eligible DDS conditions generated by L.A. Care Health Plan and any additional information generated by L.A. Care to facilitate the provision of basic case management and coordination of care by the PCP.

Be responsible for tracking the identified potential and eligible DDS members and the services provided to them to assure coordination and continuity of care.

Notify PCPs of potential and eligible DDS members and work with the PCPs and the local Regional Centers

to ensure these members continue to receive preventive and medically necessary care and that coordination of care is documented in member medical records.

PCPs will:
Be responsible for basic case management and coordination of care for members with potential and eligible DDS conditions.

Eligibility
L.A. Care will verify member eligibility and send the list of members with potential and eligible DDS conditions to the PPGs via secure PPG FTP sites.

Referral
Members (parent/guardian) may self-refer to the Regional Centers for confirmation of Regional Center eligibility criteria. A current listing of the local Regional Centers is available at www.lacare.org or www.dds.cahwnet.gov

Submit a signed consent form for "release of Medical Information" to facilitate data exchange.

The PCP or specialist should refer potential and eligible members directly to the Regional Center and are encouraged to include the specific member information in the referral matching Regional Center eligibility criteria.

PPGs must:
Implement procedures to ensure confidential transfer of medical documentation to and from the PCP to Regional Centers in compliance with all federal and state regulations.

Establish procedures to support the identification and management of problems with the PCP, Regional Centers, and L.A. Care.

Ensure that the PCP maintains the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

PCPs must:
Maintain the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

EARLY INTERVENTION/EARLY START (HEALTHY KIDS)

L.A. Care and its PPGs are responsible for assuring identified eligible members under the age of 3 years with or at risk for developmental disabilities are referred to Early Start/Early Intervention Services (including CHDP). The Early Start Program is administered through the Department of Developmental Services (DDS). DDS is responsible for coordinating a wide array of services for:

- California residents with developmental disabilities
- Infants at high risk for developmental disabilities
- Individuals at high risk for parenting a child with a disability
- Conducting oversight activities to monitor the need for EPSDT Early Start/Early Intervention Services;

Services are evaluated during the IHA within the required timeframes as described below of Plan membership and during preventive health visits thereafter:

- When medically indicated, the provision of medically necessary Early Start/Early Intervention

Services within Plan.
- When medically indicated, the provision and/or coordination of Early Start/Early Intervention Services if these services are delivered out-of-Plan.

Coordinating with the Plan Partners and local programs to develop and implement programs for PCPs.

PPGs must:
Have systems in place to address the identification, diagnosing, referral, case management, tracking, and reporting of members who are eligible for Early Start/Early Intervention Services.

Have systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those:
- With a condition known to lead to developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing.
- In whom a developmental delay is suspected.
- Whose early health history places them at risk for delay.

Collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program

Provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment service identified in the individual family service plan developed by the Early Star/Early Intervention Program, with Primary Care Provider participation.

Identification
L.A. Care and its PPGs must:

Identify current and new enrollees needing Early Start/Early Intervention services.

Track the identified persons and the services provided to them to assure coordination and continuity of care.

Ensure members receive an Initial Health Assessment (IHA), through the member's PCP.

For members under the age of 18 months, PPGs/PCPs are responsible for covering and ensuring the provision of an IHA within 60 days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger whichever is less

For members 18 months of age and older upon enrollment, PPGs/PCPs are responsible to ensure an IHA is performed with 120 days of enrollment and that the IHA will be consistent with the American Academy of Pediatrics and EPSDT Periodicity Schedule of assessment requirements.

Eligibility
L.A. Care and its PPGs are:

Required to review encounter data to determine members' eligible for Early Start/Early Intervention Services. The following conditions are among those which potentially place infants and children at risk of developmental disabilities:

- HIV/AIDS
- Cancer
- Blindness, hearing impaired
- Retardation
- Heart conditions
- Epilepsy
- Juvenile diabetes
- Cleft palate
- Lung disorders, asthma, cystic fibrosis
- Downs syndrome
- Physically handicapped due to extensive orthopedic problems
- Neurologically impaired, spinal cord injuries
- Sickle cell anemia

Referral
L.A. Care works with the local Regional Centers for assistance in locating programs which are available for infants and children who are eligible for early intervention services through local education agencies and family resource centers.

L.A. Care Health Plan works closely with the local Early Start Programs and Regional Centers to ensure that medical and health assessment information is provided/processed in a timely manner as follows:

Children must be referred to an Early Start Program within two (2) working days of identifying that child as potentially requiring developmental interventions services.

Federal Regulation requires that the Early Start programs and Regional Centers complete the individual family service plan, eligibility assessments and eligibility determination within forty-five (45) days from the receipt of the referral.

Parents or guardians may refer children directly to Early Start/Early Intervention Services.

PCPs or specialists may refer to Early Start/Early Intervention programs for children who meet the eligibility criteria using the L.A. Care and/or its delegated entities' referral process, or refer the member directly to Early Start/Early Intervention programs.

Once it is determined that a referral is needed, L.A. Care and/or its delegated entities' liaison/coordinator will contact the PCP to make referrals to an Early Start Program.

L.A. Care and/or its delegated entities will notify PCPs and can work with the local regional centers for assistance in locating programs which are available for infants and children who are eligible for early intervention services through local education agencies and family resource centers.

Coordination of Care
PPGs shall:

- Designate a Case Manager to interface with a designated L.A. Care Liaison, Early Start/Early Intervention programs, Regional Centers, SELPAS, PCP, and the member's family or guardian as necessary.
- Implement procedures to ensure confidential transfer of medical documentation to and from the PCP to Early Start/Early Intervention programs in compliance with all federal and state regulations.
- Establish procedures for identification and management of problems with the PCP, Early Start/Early Intervention programs, SELPAS' Regional Centers, and L.A. Care.
- Ensure that the PCP maintains the role of the overall case manager for the member and assure appropriate referrals for members assessed as needing Early Start/Early Intervention programs.
- Provide comprehensive case management as necessary.
- Maintain logs of active EI/ES cases.
- Ensure that members continue to receive medically necessary care and that coordination of care is documented in members' medical records.
- Continue to provide medically necessary covered services while the member receives waiver services as long as the member is enrolled in L.A. Care.

PCP Responsibilities:
When eligible members for early intervention services are referred to an Early Start Program, the PCP shall assure:

- Participation/cooperation in the development of the member's Regional Center individual service plan.
- Provision of available medical reports, as requested, to the early intervention team, keeping in mind the 45-day time lines required by state and federal statute for the completion of the initial IFSP.
- Follow up and coordination of treatment plans between the PCP, specialists and Early Start Programs. Consultations and ongoing responsibilities for preventive care and all medically necessary services are specified by the specialty care, diagnostic and treatment services, therapies and durable medical equipment.

Problem Resolutions
L.A. Care is available to review and attempt to resolve any disagreements over diagnosis and/or treatment authorizations with providers, local Regional Centers and the Local Education Agencies. Any unresolved issues should be forwarded to the L.A. Care UM Liaison for assistance.

Attachment A
L.A. Care UM Timeliness Standards

		Notification Timeframe	
Type of Request	Decision	Initial Notification	Written Notification
EMERGENCY CARE	No prior authorization required; follow the reasonable lay person standard to determine that the presenting complaint might be an emergency.	N/A	N/A
POST-STABILIZATION FOLLOWING MEDICAL SCREENING IN THE EMERGENCY ROOM	**Decision Timeframe:** Within 30 minutes of request or the requested service is deemed approved	**Practitioner:** **For approvals**: within 30 minutes of request, (if after hours, a tracking number is provided authorizing the requested service and follow-up the next business day with an authorization number.) **For denials/modifications:** verbal notification within 30 minutes of requests and fax (with confirmation) or electronic notification to the requesting practitioner the same day of the denial decision	**Practitioner: Written Notification: For approvals:** If no response within the required 30 minutes, the requested service is deemed approved. (If after hours, a tracking number is provided authorizing the requested service and follow-up the next business day with an authorization number.) **Practitioner and Member - For denials/ modifications:** written notification to requesting practitioner and member deposited with the United States Postal Service in time for pick-up within 3 calendar days from the receipt of the original request.
Type of Request	Decision	Initial Notification	Written Notification

DELAY OF PRE-SERVICE URGENT **Delay of Expedited Request**	**D E C I S I O N T I M E F R A M E** The time limit for a decision of an expedited request may be extended past the original 72 hours by an additional 48 hours up to 5 calendar days if the member requests an extension. If more information is needed, notify the requesting practitioner or member by phone within 24 hours of receipt of the initial request. Allow at least 48 hours for the practitioner or member to provide the additional information. Make the decision within 48 hours of a) receiving a response from the member or practitioner or b) the expiration of the 48 hours allowed for the additional information to be supplied, whichever is sooner.	**Practitioner** Verbal notification to requesting practitioner and member as soon as the decision is made not to exceed 5 calendar days if the member requests an extension, or within 48 hours of receiving additional requested information or expiration of the extension without receipt of additional requested information.	**Practitioner and Member:** **For denials/modifications,** written notification to requesting practitioner and member deposited with the United States Postal Service in time for pick-up by 5 calendar days or within 48 hours of receiving additional requested information or expiration of the extension without receipt of additional requested information not to exceed 5 calendar days. **NOA TEMPLATE: Delay**
PRE-SERVICE ROUTINE **Non-urgent Request**	**Decision Timeframe** Within 5 working days of receipt of request	**Practitioner:** **Initial Notification:** **All decisions:** Within 24 hours of the decision with confirmation **(Notification May Be Oral and/or Electronic)** **Member:** **Approvals:**	**Practitioner and Member:** Within 2 working days of denial/modification decision **NOA TEMPLATE: Denial or Modify**

		Notification Timeframe	
Type of Request	Decision	Initial Notification	Written Notification
DELAY OF PRE-SERVICE ROUTINE **Non-urgent Request - Extension Needed**	**Decision Timeframe** **Medi-Cal-**Within 5 working days of receipt of information not to exceed 14 calendar days from date of receipt of request **HK**- Within 5 working days of receipt of information not to exceed 30 calendar days from receipt of request	**Practitioner:** **All decisions:** Within 24 hours of the decision with confirmation **(Notification May Be Oral and/or Electronic)**	**NOA TEMPLATE: Delay** **Medi-Cal HR/HK:** **Practitioner and Member:** Within 2 working days of decision to delay; however: HK: 30 days allowed for delay And Medi-Cal: 14 days allowed for delay; Member can request an additional 14 days to total 28 days; (And the additional 14 days is granted only if the member or provider makes the request or the Plan/PPG can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. **This means the decision making & notification processing, must not exceed the last day of the delay time limit (for Medi-Cal - 14 or 28 days, and HK -30 days) and also when requested information has not been received, not**

			before the last day of the delay time limit (for Medi-Cal 14 or 28 days, and for HK-30 days). **Important NCQA Note:** Since the State allows only 14 days for making the decision for Medi-Cal & 30 days for HK, NCQA would expect the member is given the full 14 days-Medi-Cal or 30 days for HK to respond. Although we realize this provides very little time for your organization to make a decision, NCQA believes it is more important to provide the member with as much time as possible within the state's mandated requirement, to provide the information. Please also understand that delaying to ask for additional information is not a requirement: The organization may make a decision within the routine 5 business day timeframe on the information received initially with the request without requesting any additional information.
		Notification Timeframe	

Type of Request	Decision	Initial Notification	Written Notification
MEDI-CAL ONLY- **REQUESTS TO CONTINUE ROUTINE CURRENT SERVICE/TREATMENT (such as PT, Long Term Care, etc.)** **Exceptions from the advance notice required in this section:** The notice may be mailed not later than the date of action if: (a) There is factual information confirming the death of a member; (b) There is receipt of a clear written statement signed by a member that-- (1) Member no longer wishes services; or (2) Information is given that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information; (c) The member has been admitted to an institution where the member is ineligible under the plan for further services; (d) The member's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (e) The fact is established that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; (f) There is a change in	**Decision Timeframe** within 5 working days of receipt of request	**Practitioner:** **All decisions:** Within 24 hours of the decision with confirmation **(Notification May Be Oral and/or Electronic)** **Member:** **Approvals:** Within 24 hours (Written Notification)	**Practitioner and Member:** **Written Notification: For denials/modifications:** the notice must be mailed at least 10 days before the date of action, except as permitted by the exceptions described in column "Type of Request" **NOA Template**: Terminate

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

facility, and the member's practitioner requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request. If L.A Care receives a request for coverage of an acute inpatient stay after the member's discharge, L.A. Care handles the request as a postservice issue.	LA Care UM immediately requests necessary information. For operational purposes 24 hours is considered equivalent to 1 calendar day. **Hospital Inpatient Stay Requests** Hospital Inpatient Stay Requests are considered Concurrent Urgent and the Urgent Concurrent decision timeframe applies unless: Necessary information is not received within 24 hours of receipt of the request for authorization and at least one call has been made to conduct the review or request the necessary information. The timeframe for decision making changes from Concurrent Urgent to Pre-Service Urgent (see Pre-Service Urgent above). When the hospital inpatient care has already been received, LA Care can decide to review the request for the already-rendered care as part of the Urgent Concurrent request, or change the timeframe to Post-Service request (see		

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

	handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., Pre-Service or Post-Service).		oral notification. **NOA Template:** Terminate
POST-SERVICE / RETROSPECTIVE REVIEW	**Decision timeframe:** within 30 calendar days from receipt or request	**Practitioner and Member:** None specified	**Practitioner and Member:** Within 30 calendar days of receipt of the request. **NOA Template**: Denial or Modify
HOSPICE - INPATIENT CARE	**Decision Timeframe:** Within 24 hours of receipt of request	**Practitioner: Initial Notification:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner and Member: Written Notification** Within 2 working days of making the decision **NOA Template:** Terminate

ATTACHMENT B

L.A. CARE HEALTH PLAN
VISION, DENTAL, AND BEHAVIORAL HEALTH BENEFIT GRID BY PRODUCT LINE

	L.A. Care Direct Line Medi-Cal (MCLA)	L.A. Care Healthy Kids (HK)
Vision Benefits	MCLA Vision care services are covered and are the responsibility of and provided by L.A. Care. • LA Care has contracted with Vision Vendor- VSP - to coordinate L.A. Care's MCLA members' vision care and lenses services. • All referrals for Vision care services should be referred to VSP. • To access MCLA vision care and lenses benefits, MCLA members should be directed to call VSP at the toll free number 1-800-877-7195. • To find out more about MCLA eye exams or vision care coverage, MCLA members can also call L.A. Care Member Services at the toll free number 1-888-839-9909 **For MCLA Members up to Age 21, and certain adults as defined by DHCS,** MCLA Eye exams are covered by L.A. Care and e carved out to the Prison Industry Labs. Lenses are limited to one pair of eyeglasses every two years unless: • Prescription has changed at a minimum o f .50 diopters • replacement lenses are needed because the member's previous lenses have been lost, stolen, broken, or marred and damaged beyond the member's control to a degree significantly interfering with vision or eye safety (a certificate or statement is required) • Frame needs replacement because a different size or shape is necessary. • This includes lenses and covered frames for eyeglasses when authorized. **L.A. Care MCLA Adults (age 21 and over):** According to MMCD All Plan Policy Letter #10-010 "Reinstatement of Optometry Services", on July 15, 2010 the State of California reinstated Optometry services for MCLA Adults	L.A. Care HK vision and lenses benefits are covered and are the responsibility of and provided by LA Care. • L.A. Care has contracted with Vision Vendor- VSP - to coordinate L.A. Care's HK members' vision care and lenses services. • All referrals for Vision care services should be referred to VSP. • To access HK vision care and lenses benefits or to find a HK eye doctor, HK members should be directed to call VSP at the toll free number 1-800-877-7195. • To find out more about HK eye exams or vision care coverage, HK members can also call L.A. Care Member Services at the toll free number1-888-839-9909

	L.A. Care Direct Line Medi-Cal (MCLA)	L.A. Care Healthy Kids (HK)
	retrospective to July 1, 2009 To date, reinstatement of Optometry Services for MCLA Adults does not include lenses for adults.	
Dental Benefits	MCLA dental benefits are **not** covered under L.A. Care, but are carved out to the Medi-Cal Denti-Cal Program. Effective July 1, 2009 the State of California excluded Adult dental services from the Medi-Cal Denti-Cal Program L.A. Care is responsible for ensuring that MCLA members up to age 21 are referred to appropriate Medi-Cal dental providers through the Medi-Cal Denti-Cal Program. To find a Denti-Cal dentist, MCLA members up through age 21 should call Denti-Cal at the toll free number 1 (800) 322-6384. Denti-Cal can also be contacted on the internet at http://www.denti-cal.ca.gov/	HK dental benefits are covered under L.A. Care and are the responsibility of and provided by L.A. Care. LA Care has contracted with the dental Vendor- SafeGuard Dental - to coordinate L.A. Care's HK members' dental benefits. To find a dentist, HK members should call SafeGuard Dental at toll free number 1-800-766-7775. For questions about dental benefits, HK members can also call L.A. Care's Member Services Department at the toll free number 1 -888-839-9909.
Behavioral Health Benefits	L.A. Care covers MCLA Mental Health Services that can be provided on an outpatient basis by the Member's doctor (such as treatment for anxiety, depression, or behavioral health problems) L.A. Care covers Inpatient Detoxification Alcohol/Drug Treatment: L.A. Care is responsible for and covers appropriate medical inpatient detoxification provided under the following circumstances: Life threatening withdrawal from sedatives, barbiturate, hypnotics or medically complicated alcohol and other drug withdrawal. This Inpatient detoxification is covered in the rare cases where it is medically necessary to monitor the member for life threatening complications; two or more of the following must be present, tachycardia, hypertension, diaphoresis, significant increase or decrease in psychomotor activity, tremor, significant disturbed sleep pattern, nausea and vomiting, threatened delirium tremens. When the member is medically stabilized, the PCP/L.A. Care shall provide a referral and follow-up to a	HK Behavioral health services are covered by L.A. Care Health Plan. L.A. Care is responsible for all HK behavioral health benefits--Inpatient and outpatient. This includes mental health services and alcohol/drug treatment services. HK behavioral health benefits are coordinated by L.A. Care's behavioral health vendor. HK members may receive behavioral health services with or without a referral from their doctor. HK members can access behavioral health services through any of the following ways: • Call L.A. Care behavioral health vendors toll-free number at the toll free number **1-877-344-2858.** • Self-refer directly to a mental health provider listed in our provider directory.

	L.A. Care Direct Line Medi-Cal (MCLA)	L.A. Care Healthy Kids (HK)
	Substance Abuse Treatment Program. MCLA Specialized Behavioral Health Services are carved out from L.A. Care: MCLA members may receive specialized mental health services (treatment for serious mental illness and serious emotional disturbance) from the Los Angeles County Department of Mental Health (LACDMH) with or without a referral from their PCP. LACDMH may be reached toll free at 1-800- 854-7771 MCLA Alcohol/Drug Treatment Carved Out Services: MCLA members may receive specialized health services from the Los Angeles County Alcohol & Drug Treatment Program with or without a referral from their PCP. The following services are the responsibility of and provided by the Alcohol and Drug Programs of L.A. County: • Outpatient Methadone Maintenance • Outpatient Drug Free Treatment Services • Perinatal Residential Services • Day Care Habilitative Services • Naltrexone Treatment Services (Opiate Addiction) • Outpatient Heroin Detoxification Services The Los Angeles County Alcohol & Drug Treatment Services Program can be reached toll free at the Community Assessment Services Center toll free number 1-800-564-6600.	• Call L.A. Care Member Services at the toll free number 1-888-839-9909 (TTY 1-866-522-2731) • Ask their doctor to recommend a mental health provider listed in our provider directory. • See the Plan Benefits section of their Healthy Kids Member Handbook to learn more about Behavioral Health Services.

Attachment C

CASE MANAGEMENT REFERRAL

FAX TO: L.A. CARE (213) 438-5034

Referral Source:

☐ Member Self Referral ☐ Provider Referral ☐ Hospital Discharge Planner

☐ IPA/Medical Group Referral IPA/PPG Name:_____

Other Referral _____

Product Line/ Type of Referral: ☐ Healthy Kids (HK) ☐ SPD

☐ MEDI-CAL (MCLA) ☐ CBAS ☐ MEDICARE ☐ Health Integrated

☐ URGENT ☐ ROUTINE

Date Referred	☐ Care Coordination ☐ High Risk/Complex ☐ Teen Pregnancy (<19 yrs)	
Referred by	Referral Contact Phone #	
Member Name	Health Plan	
CIN#	PCP	
DOB	PCP Phone #	
Phone	Dx 1.	ICD9
Address	2.	
Language	3.	

1. What issue has occurred to prompt this referral to CM?

2. What services have already been provided for this member?
3. Recent ER or hospital visits? Recent discharge from a skilled nursing facility?
For LA Care CM/Coordinator to complete:
Recommended action:
Member contacted?
PCP contacted?
IPA or MG CM contacted?

Care Management Referral Criteria

SPD and SNP Referrals

☐ **SNP members receive an initial and annual HRA through the CM program. Members may already be enrolled in or receiving care management. Please contact LA Care Care Management Department to see is there is an assigned CM Team.**

☐ **SPD member are initially stratified and assessed for potential CM interventions. Members may already be enrolled in or receiving care management through L.A. Care or a L.A. Care contracted vendor. Please contact LA Care Care Management Department to see is there is an assigned CM Team.**

High Risk Profiles

The presence of three or more of the following criteria in the same member qualifies the member for program enrollment: (select all that apply)

☐ **Four or more ACTIVE chronic diagnoses**

☐ **Four or more medications prescribed on a chronic basis**

☐ **Medication profiles with greater than nine (9) medications**

☐ **Two or more hospitalizations in the past twelve months**

☐ **Age of 75 or older**

☐ **Significant impairment or one or more major activities of daily living, such as bathing, toileting, dressing, ambulating, feeding**

☐ **Evidence of malnutrition or failure to thrive**

☐ **Hospice**

Complex Needs

The presence of one complex need qualifies the patient for case management.

☐ **Spinal Injuries – Describe:**

☐ **Transplants – Describe:**

☐ **Cancer– Describe:**

☐ **Serious Trauma– Describe:**

☐ **HIV/AIDS**

☐ **Other– Describe:**

Pharmacy Review

Patients who meet any of the pharmacy criteria qualify for case management.

- ☐ **Medication profiles with greater than nine (9) medications**
- ☐ **Member on a biological drug (Embrel, ProCrit)**

High Risk Pregnancy

Patient who is considered high risk whether pre-conceptual assessment, a current risk pregnancy factor, or at risk for premature delivery

- ☐ **Mothers over age 35**
- ☐ **Pre-term labor**
- ☐ **Pre-eclampsia or eclampsia**
- ☐ **Pre-existing medical conditions – Kidney/heart/blood conditions/autoimmune conditions/STD, HIV/AIDS**

Care Coordination

Members that need short term, focused interventions to manage their healthcare needs and do not meet criteria for complex case management

- ☐ **Member needs short-term, focused interventions to manage their health care needs and do not meet criteria for complex case management**

Administrative Referral

Referral by discretion of Care Management team

- ☐ **Includes any single or combination of social issues, traumatic injury, and multiple disease types as determined by the C.M. assessment**

Limited data on the use of IGRAs for:

- » Children younger than 5 years of age;
- » Persons recently exposed to *M. tuberculosis*;
- » Immunocompromised persons; and
- » Serial testing.

- Tests may be expensive.

What are the steps in administering an IGRA test?

Confirm arrangements for testing in a qualified laboratory, and arrange for delivery of the blood sample to the laboratory in the time the laboratory specifies to ensure testing of samples with viable blood cells.

- Draw a blood sample from the patient according to the test manufacturer's instructions.
- Schedule a follow-up appointment for the patient to receive test results.
- Based on test results, provide follow-up evaluation and treatment as needed.

How do you interpret IGRA test results?

IGRA interpretations are based on the amount of IFN-g that is released or on the number of cells that release IFN-g. Both the standard qualitative test interpretation (positive, negative, or indeterminate) and the quantitative assay measurements (Nil, TB, and Mitogen concentrations or spot counts) should be reported.

As with the tuberculin skin tests (TSTs), IGRAs should be used as an aid in diagnosing infection with *M. tuberculosis*. A positive test result suggests that *M. tuberculosis* infection is likely; a negative result suggests that infection is unlikely. An indeterminate result indicates an uncertain likelihood of *M. tuberculosis* infection. A borderline test result (T-Spot only) also indicates an uncertain likelihood of *M. tuberculosis* infection.

A diagnosis of LTBI requires that TB disease be excluded by medical evaluation. This should include checking for signs and symptoms suggestive of TB disease, a chest radiograph, and, when indicated, examination of sputum or other clinical samples for the presence of *M. tuberculosis*. Decisions about a diagnosis of *M. tuberculosis* infection should also include epidemiological and historical information.

Recommendations on when to use IGRA tests

- IGRAs can be used in place of (but not in addition to) TST in all situations in which CDC recommends TST as an aid in diagnosing *M. tuberculosis* infection, with preferences and special considerations noted below. This includes contact investigations, testing during pregnancy, and screening of health care workers and others undergoing serial evaluation for *M. tuberculosis* infection. Despite the indication of a preference, use of the alternative test (FDA-approved IGRA or TST) is acceptable medical and public health practice. Caution in interpretation should be used when testing certain populations because of limited data on the use of IGRAs (see Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection, United States).
- Populations in which IGRAs are preferred for testing:
  - » Persons who have received BCG (either as a vaccine or for cancer therapy); and
  - » Persons from groups that historically have poor rates of return for TST reading.
- TST is preferred over IGRAs for testing children less than 5 years of age.
- As with TST, IGRAs generally should not be used for testing persons who have a low risk of infection and a low risk of disease due to *M. tuberculosis*.
- Each institution and TB control program should evaluate the availability and benefits of IGRAs in prioritizing their use.

- Routine testing with both TST and IGRA is not recommended. However, results from both tests might be useful in the following situations:
  - » When the initial test is **negative** and:
    - – The risk for infection, the risk for progression to disease, and the risk for a poor outcome are high (e.g., HIV infected persons or children under 5 years of age who are exposed to a person with infectious TB).
    - – There is clinical suspicion for TB disease (e.g., signs, symptoms, and/or radiographic evidence suggestive of TB disease) and confirmation of *M. tuberculosis* infection is desired.
    - – Taking a positive result from a second test as evidence of infection increases detection sensitivity.
  - » When the initial test is **positive** and:
    - – Additional evidence of infection is required to encourage acceptance and adherence (e.g., foreign-born healthcare workers who believe their positive TST is due to BCG). A positive IGRA might prompt greater acceptance of treatment for LTBI as compared with a positive TST alone.
    - – The person has a low risk of both infection and progression from infection to TB disease. Requiring a positive result from the second test as evidence of infection increases the likelihood that the test reflects infection. An alternative is to assume, without additional testing, that the initial result is a false positive or that the risk for disease does not warrant additional evaluation or treatment, regardless of test results.
  - » In addition, repeating an IGRA or performing a TST might be useful when the initial IGRA result is indeterminate, borderline, or invalid and a reason for testing persists.

Multiple negative results from any combination of these tests cannot exclude *M. tuberculosis* infection. Steps should be taken to minimize unnecessary and misleading testing of persons at low risk.

Selection of the most suitable test or combination of tests for detection of *M. tuberculosis* infection should be based on the reasons and the context for testing, test availability, and overall cost of testing.

Can IGRAs Be Given To Persons Receiving Vaccinations?

As with TST, live virus vaccines might affect IGRA test results. However, the effect of live virus vaccination on IGRAs has not been studied. Until additional information is available, IGRA testing in the context of live virus vaccine administration should be done as follows:

- Either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine
- At least one month after smallpox vaccination

Additional Information

Centers for Disease Control and Prevention. Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection, United States. (PDF) *MMWR* 2010; 59 (No.RR-5). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e

http://www.cdc.gov/tb

Attachment E

California Tuberculosis Screening Guidelines for Child Care Centers and Schools

Who Needs TB Screening Exam?	Facility Licensing Authority	Statute, Regulation and/or Policy Directives	Initial Exam	Repeat Examination	Exam to Consist Of
Children in Child Care Centers Excludes services without a contract or agreement between the parent and center for regular care of child.	Health & Safety Code (HSC) Section 1596.60. authorizes the California Department of Social Services, Community Care Licensing Division (DSS/CCL) to regulate public & private child care settings	California Code of Regulations (CCR), Title 22; Division 12 – CHILD CARE FACILITY LICENSING REGULATIONS; Chapter 1; Article 6, Section 101220 DSS/CCL Policy Letter sent to Child Care District Office Regional Managers in August 1997 DSS/CCL Evaluators Manual Procedures in Section 101220(b)(2)	All children must be evaluated for risk factors for tuberculosis (TB) as part of the medical assessment required for admission. (Form 701). A Mantoux TB skin test is only required when the physician determines the child has risk factors for TB. Prior to, within 30 calendar days following child's enrollment. Medical assessment should not be more than one year old when obtained.	May be necessary if subsequent enrollment in a different facility and the medical assessment is more than one year old. Whenever the child's physician determines TB testing should be performed due to risk factors for TB.	1.TB Risk Assessment 2. A Mantoux TB skin test or test for TB infection recommended by the Centers for Disease Control & Prevention (CDC) and approved by the Food and Drug Administration (FDA) is required only if deemed necessary by the physician performing a TB risk factor assessment.
Staff/Volunteers in Child Care Centers Excludes public school employees	DSS/CCL as above	CCR, Title 22, Article 6, Section 101216 DSS/CCL Evaluators Manual Procedures in Section 101216(g)	TB testing result required as part of facility personnel health screening (Form 503). Not more than 1 year prior or 7 days after employment or licensure.	No stated requirement	Mantoux TB skin test, or test for TB infection recommended by CDC and approved by the FDA
Students in Kindergarten to 12th Grade (K – 12) Public, Charter or Private Schools	Health and Safety Code (HSC) authorizes the Local Health Officer (LHO) to regulate TB examinations of persons applying for first admission to any school or institution in the jurisdiction.	HSC Sections 121475-121520 School districts are required under the law to work with the Local Health Officer on TB examinations and may use the school district funds, property & personnel.	HSC 121490 If so ordered by the LHO, the exam must consist of a Mantoux TB skin test, or test for TB infection recommended by CDC and approved by the FDA. If positive, is followed by an X-ray of the lungs.	No stated requirement	Mantoux TB skin test, or test for TB infection recommended by CDC and approved by the FDA

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Who Needs TB Screening Exam?	Facility Licensing Authority	Statute, Regulation and/or Policy Directives	Initial Exam	Repeat Examination	Exam to Consist Of
K - 12 Teachers, Employees, Volunteers, Transportation Contractors*, **Community College Employees** Employees with frequent or prolonged contact with pupils	Health and Safety Code (HSC) authorizes the Local Health Officer (LHO) to regulate TB examinations of employees of public and private schools. The governing board of schools and districts must cooperate with the LHO. The Education Code (EC) authorizes the Department of Education to direct schools to require TB exams. California Department of Public Health (CDPH) will enforce as necessary.	K-12: EC Section 49406 HSC Sections 121525-121555 Community Colleges: EC Section 87408	TB exam is a condition of initial employment and expense is the responsibility of the applicant. Within 60 days prior to employment. Employees who initially have a positive TB test must have follow up as required by the Local Health Officer including an X-ray of the lungs, medical evaluation and treatment. Employee is required to submit a certificate from the examining physician showing that the employee is free of active TB disease.	Employees who initially test negative for TB infection are required to repeat a TB exam at least once every 4 years. Once the employee has the physician certification that they are free of active TB, there is no further requirement for repeat X-ray of the lungs every 4 years.	Mantoux TB skin test, or test for TB infection recommended by CDC and approved by the FDA. If positive, is followed by an X-ray of the lungs.
Students Attending the California Schools for the Deaf and Blind	Department of Education	EC Section 59150	Students are tested for exposure to TB at least once every 2 years. The results shall be provided to the school director. The parent or guardian of the student is responsible for the cost, if any.		Mantoux TB skin test, or test for TB infection recommended by CDC and approved by the FDA.

* Contract drivers for public schools who transport pupils on an infrequent basis, not to exceed once a month, are be excluded from this requirement

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6.0 QUALITY IMPROVEMENT (QI) DEPARTMENT

L.A. Care Health Plan's mission is to provide access to quality health care for Los Angeles County's vulnerable and low income communities and residents and to support the safety net required to achieve this purpose. L.A. Care annually prepares a comprehensive Quality Improvement Program that clearly defines L.A. Care's QI structures and processes designed to improve the quality and safety of clinical care and services it provides to its members. A complete written copy of L.A. Care Quality Improvement Program is available by request by calling (213) 694-1250, Ext. 4027.

The L.A. Care Quality Improvement Program, consistent with the L.A. Care mission, strives to:

- Define, oversee, continuously evaluate and improve the quality and efficiency of health care delivered through organizational commitment to the goals and principles of our organization.
- Ensure medically necessary covered services are available and accessible to members taking into consideration the member's cultural and linguistic needs.
- Ensure our contracted network of providers cooperate with L.A. Care quality initiatives.
- Ensure that timely, safe, medically necessary, and appropriate care is available.
- Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards.
- Promote health education and disease prevention designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.
- Maintain a well-credentialed network of providers based on recognized and mandated credentialing standards.
- Protect members' Protected Health Information (PHI).

OBJECTIVES

L.A. Care's quality improvement infrastructure is designed to:

- Identify, implement and monitor interventions, as appropriate, to continually achieve improvement in the quality and safety of clinical care and services.
- Educate practitioners regarding L.A. Care's performance expectations and provide feedback about compliance with those expectations.
- Communicate the quality improvement process to practitioners/providers and members through appropriate persons and venues (e.g. meetings, print media, electronic media, and L.A. Care's website).
- Identify, monitor, and address known or suspected quality of care issues and trends that affect the health care and safety of members.
- Document, monitor and strive to improve the performance of L.A. Care's contracted network.
- Monitor compliance with corrective action plans and interventions.
- Coordinate relevant sources of information available to L.A. Care including quality of care performance review (e.g. QI activities matrix reports, membership services, pharmacy and EPSDT data).
- Monitor the performance of network practitioners in providing access to quality care through the use of health-related indicators, member satisfaction surveys, provider satisfaction surveys, focused studies, facility inspections, medical record audits and analysis of administrative data.
- Monitor L.A. Care and network compliance with the contractual and regulatory requirements of appropriate state and federal agencies and other professional by recognized standards such as NCQA and JCAHO.
- Establish priorities for and conduct focused review studies with emphasis on preventive services, high-volume providers of services and high-risk services.
- Establish and maintain policies, procedures, criteria, and standards for the monitoring of credentialing, recredentialing, and reappointment of plan practitioners.

- Assure that members can achieve resolution to problems or perceived problems relating to service, access or other quality issues.
- Annually measure member and provider satisfaction with L.A. Care.
- Establish, maintain, and enforce a conflict of interest policy regarding peer review activities.
- Establish, maintain, and enforce confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
- Ensure that mechanisms are in place to support and facilitate continuity of care within the health care network and to review the effectiveness of such mechanisms.
- Establish standards of medical and behavioral health care (as required by product line) which reflect current medical literature and national benchmarks; design and implement strategies to improve compliance; and develop objective criteria and processes to evaluate and continually monitor performance and adherence to the guidelines.
- Sponsor the delivery of educational information to practitioners to enhance the diagnosis and management of medical/health conditions.
- Promote preventive health measures, health awareness programs, education programs, patient safety, health care disparities and cultural and linguistic programs that complement Quality Improvement interventions.
- Foster a supportive environment to assist practitioners and providers to improve safety within their practices.

ANNUAL QI PROGRAM EVALUATION

L.A. Care Annually reviews data reports and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a review of completed and continuing program activities and audit results; trending of performance data; analysis of the results of QI initiatives including barriers, successes, and challenges; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year.

ANNUAL QI WORK PLAN

The annual QI Work Plan is developed in collaboration with staff and is based, in part upon the results of the prior year's QI Program evaluation. Each of the elements identified on the Work Plan has activities defined, responsibility assigned and the date by which completion is expected. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee and the Compliance and Quality Committee of the Board.

COMMITTEE STRUCTURE

L.A. Care's quality committees oversee various functions of the QI program. The committees serve as the major mechanism for intradepartmental collaboration for the Quality Program. There is physician network participation on many of L.A. Care's QI Committees.

CLINICAL CARE MEASURES - *HEDIS*

L.A. Care measures clinical performance related to Healthcare Effectiveness Data (HEDIS). L.A. Care expects that the network assist the health plan in continuously improving its HEDIS rates. The network is also expected by contract to cooperate with the annual HEDIS data collection efforts and keep encounter data current and accurate. Common HEDIS measures are Well Child Visits, Well Adolescent Visits, Timely Prenatal and Postpartum Care, Diabetes measures, such as Diabetic Retinal Eye exams, LDLs, AIC and Nephropathy, Breast and Cervical Cancer Screenings, and others.

SERVICE MEASURES

L.A. Care monitors services and member satisfaction by collecting, analyzing and acting on numerous sources of data such as Member Satisfaction (CAHPS), Complaints and Appeals, Access to and Availability of Practitioners and Provider Satisfaction.

CONTINUITY AND COORDINATION OF MEDICAL CARE

How well does your office coordinate care? If referring to a specialist, contact the specialist before the patient's appointment. Have staff set up a quick phone appointment and fax over the patient's medical history. Request that the specialist also contact you once the consultation and/or treatment is finished. Keep track of specialty referrals that require prior authorization. Talk to the PPG or IPA about getting timely hospital discharge reports that will help you follow up and coordinate care after a hospitalization.

CONTINUITY and COORDIATION OF MEDICAL and BEHAVORIAL HEALTH CARE

Medi-Cal

Specialized mental health services for services are provided through the Los Angeles County Department of Mental Health (LACDMH). Services from LACDMH can be provided with or without a referral. LACDMH may be reached toll-free at 1-800-854-7771.

L.A. Care will coordinate and cover laboratory, radiological and radioisotope services needed for the diagnosis, treatment and monitoring of a mental health condition. L.A. Care covers mental health drugs listed on the formulary and prescribed by the PCP doctor or by a licensed mental health provider authorized to prescribe drugs. If medically necessary, L.A. Care may cover a mental health drug not on the formulary.

Healthy Kids

L.A. Care contracts with Beacon Health Strategies to provide inpatient and outpatient mental health services for L.A. Care's Healthy Kids populations, including drug and alcohol abuse services. Mental health care is covered when services are ordered and performed by a plan mental health professional. For a directory of Beacon Health Strategies providers, please refer to the electronic provider and hospital directory on L.A. Care's website. A search for a behavioral health provider will link you directly to the Beacon Health Strategies network. L.A. Care also offers a toll-free behavioral health hotline at 1-877-344-2858.

Care for members determined to have a serious emotional disturbance (SED) condition will be provided by the county mental health department. The member will remain enrolled in the plan and will continue to receive medical care from plan providers for services not related to the SED condition.

PREVENTIVE HEALTH CARE GUIDELINES - SEE L.A. CARE WEBSITE FOR CURRENT AND UPDATED GUIDELINES

CLINICAL PRACTICE GUIDELINES for ACUTE and CHRONIC MEDICAL CARE - SEE L.A. CARE WEBSITE FOR CURRENT AND UPDATED GUIDELINES INCLUDING ASTHMA AND DIABETES

CLINICAL PRACTICE GUIDELINES for BEHAVIORAL HEALTH CARE - SEE L.A. CARE WEBSITE FOR CURRENT GUIDELINES INCLUDING DEPRESSION AND ADHD

DISEASE MANAGEMENT PROGRAMS

The objective of each of L.A. Care's Disease Management Programs is to improve the health status of its eligible members with chronic or other conditions. The programs achieve their objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. Disease management programs are developed from evidenced-based clinical practice guidelines and support the

practitioner–patient relationship, plan of care and foster patient empowerment. Disease management programs are selected based on an analysis of internal data relating to disease prevalence in the L.A. Care population and are currently addressing Asthma (**L.A. Cares About Asthma**) and Diabetes (**L.A. Cares About Diabetes**). To enroll a member contact L.A. Care at **1-866-LA-CARE6 (1-866-522-2736)**.

POPULATION OF FOCUS: SERVING SENIORS AND PERSONS WITH DISABILITIES AND HEALTH DISPARITIES

L.A. Care seeks to improve the health and overall well-being of all its members, including seniors and people with disabilities as well as focusing on health disparities. L.A. Care specifically develops programs that target and accommodate members who are at higher risk for health disparities, including those related to race and ethnicity, language, disabilities and chronic conditions.

PATIENT SAFETY

L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety in their practices. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components. When performance is analyzed for these measures, patient safety is considered, opportunities are identified, prioritized and actions are taken to improve safety.

NURSE ADVISE LINE - 1-800-249-3619

L. A. Care provides a 24 hour, 7 days per week nurse advice line for members of MCLA, and Healthy Kids. This service may help members save time and money, avoid long ER lines, learn self-care management of common ailments, and reduce after hour's calls to physicians. Members can also listen to the audio library of more than 1,000 easy to follow health topics.

MEMBER CONFIDENTIALITY

L.A. Care keeps confidential information secure and makes it available only to L.A. Care employees, contractors, and affiliates who have a need to know and who have signed a confidentiality statement.

L.A. Care ensures that all individuals or agencies who participate in the use, creation, maintenance, or disclosure of protected health information limit the use and disclosure only to the amount necessary to complete the task. Without a signed authorization, disclosure of protected health information is limited to the purposes of treatment, payment, or health care options. These purposes include the use of protected health information for quality of care activities, disease management service referrals, statistical evaluation, claims payment processes, medical payment determinations, practitioner credentialing, peer review activities, and the grievance and appeals process. Network practitioners and providers are obligated to maintain the confidentiality of member information and information contained in a member's medical record and may only release such information as permitted by applicable laws and regulation, including HIPAA.

L.A. Care maintains confidentiality in written, verbal, and electronic communications. L.A. Care has specific policies that outline appropriate storage and disposal of electronic and hard copy materials so that confidentiality is maintained within the plan and network.

DISEASE REPORTING STATEMENT

L.A. Care complies with disease reporting standards as cited by the California Code of Regulations, Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission and intervene rapidly when appropriate. Forms to report diseases can be found at www.lapublichealth.org/acd/cdrs.htm and via a link on the L.A. Care website: www.lacare.org.

7.0 CREDENTIALING

OVERVIEW

- L.A. Care's contracted providers/practitioners are required to be credentialed in accordance with L.A. Care's credentialing criteria and the standards of the Department of Health Services (DHCS), National Committee on Quality Assurance (NCQA), and Centers for Medicare & Medicaid Services (CMS) requirements.

- L.A. Care requires that all providers/practitioners who are performing services for L.A. Care members have a current license at all times to provide patient care to members and abide by State and Federal laws and regulations. All providers/practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. Failure to meet Medi-Cal, NCQA and CMS requirements may be cause for removal from L.A. Care's network

Delegation of Credentialing

Delegation is a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although the organization can delegate the authority to perform such a function, it cannot delegate the responsibility for assuring that those functions are performed appropriately.

- L.A. Care is responsible for monitoring all contracted PPGs', credentialing, and re-credentialing activities. A PPG must pass the L.A. Care Credentialing Department's due diligence (pre-delegation) credentialing audit in order to be delegated the credentialing responsibility. Otherwise, L.A. Care's Credentialing Department is responsible for a PPG's credentialing activities. Regardless of a PPG's credentialing delegation status, L.A. Care retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners, based on credentialing issues at all times.

    - The PPG is accountable for credentialing and re-credentialing its practitioners, even if it delegates all or part of these activities. If the PPG delegates any credentialing and re-credentialing activities, there is evidence of oversight of the delegated activity. There must be annual evidence of a mutually agreed upon delegation agreement by both the PPG and the delegate, i.e., NCQA certified CVOs, non-certified CVOs, etc. The delegation agreement must meet all elements of NCQA's standards. As a note, CMS does not recognize NCQA certified CVOs. As such, all files are subject to full file review.

- When delegates have access to the PPG's protected health information (PHI) on members or practitioners, or create such information in the course of their work, the mutually agreed-upon document must ensure that the information will remain protected. This is not applicable if there is no delegation arrangement, or if the delegation arrangement does not involve the use, creation or disclosure of protected health information.

- If the delegation arrangement does not include the use of PHI in any form, an affirmative statement to that fact in the delegation agreement is sufficient, but is not required; the PPG may document the lack of PHI in a delegation arrangement in other manners.

- Prior to delegation, L.A. Care's Credentialing Department audits the PPG (the potential delegated entity) to determine if the PPG meets L.A. Care's criteria for delegation. The Credentialing Department evaluates the potential delegated entity's ability to perform the delegated activities, which will include all activities related to credentialing and re-credentialing in accordance with the standards of L.A. Care, NCQA, DHCS and CMS. Using a modified version of the Standardized Audit Tool in accordance with L.A. Care, NCQA, DHCS and CMS standards, the Credentialing Department will evaluate each delegated entity's performance.

Types of Delegation Status

- After completion of the pre-delegation audit, the audit tool is scored and recommendations regarding delegation are presented to the Credentialing Committee as follows:

    - **Delegation** – PPG group scores between 80% to 100% on the pre-delegation audit. A corrective action plan must be successfully completed if score is below 100%.

    - **Full delegation** – PPG scores 100%. No CAP required.

        - **Full delegation with a CAP** – PPG scores between 80-99%. CAP required. A corrective action must be successfully completed.

    - **Denial of Delegation** – PPG chooses not to pursue delegation of credentialing, or it receives less than a 70% on the pre-delegation credentialing audit. PPG has a Non-Delegated credentialing status for a minimum of one year. The credentialing of PPG's practitioners is performed by L.A. Care's Credentialing department. Denial of delegation letters will be sent to the PPG.

- Following recommendations by the Credentialing Committee, delegation letters will be sent to the PPG's scoring 80% or above, and Delegation Agreements for credentialing will be executed.

- L.A. Care retains the right to determine in its sole discretion whether to delegate credentialing functions regardless of results of an audit.

Levels of Delegation

- Full – All credentialing activities have been delegated to either the PPG or a combination of a hospital and medical group. The Delegation Agreement will identify in detail exactly what functions have been delegated to the PPG.

Delegation Oversight

- The PPG agrees, upon delegation, to make available to L.A. Care the credentialing and re-credentialing status on the PPG's participating practitioners, including credentialing data elements as well as documents and quarterly reports, as appropriate, using the standardized ICE form or another approved L.A. Care format.

    - On an annual basis, L.A. Care will audit the credentialing and recredentialing activities of the PPG. The PPG's credentialing and recredentialing files will be reviewed according to the following file pull methodology: A roster of practitioners which includes Autism providers credentialed and recredentialed within the audit period and a list of the PPG's UM Medical Director(s) will be requested. In addition, a full roster of the delegate's network will also be requested. L.A. Care will also review the delegate's quarterly reports for comparison and file selection. NCQA's 8/30 methodology will be used in evaluating files. The minimum files reviewed will be eight (8) initial files and eight (8) recredential files. If any credentialing elements are deficient during the review of the 8/30 Rule, then the deficient element(s) will be reviewed for the remaining files, up to a maximum of 30 initial credentialing and 30 recredentialing files.

    - L.A. Care's oversight audit will include a review of the PPG's credentialing policies and procedures, Committee meeting minutes, practitioner credentialing and recredentialing files which includes Autism providers, UM Medical Director(s), a list of contracted health delivery organizations (HDOs), ongoing monitoring reports, oversight audits and any sub-delegations agreements, if applicable.

    - Results of L.A. Care's oversight audit will be reported to the PPG, including the corrective action plan if deficiencies are noted. L.A. Care's Credentialing Department works collaboratively with the PPG when deficiencies have been identified through the oversight process. The delegate is given a Corrective Action Plan (CAP) and asked to respond within 30 days. If no response is received within 30 days, or the CAP is not acceptable or complete, the Regulatory Affairs and Compliance (RA&C) Department sends a second letter requesting a response within 14 days and advising that failure to respond may be cause for revocation of the delegation agreement. The PPG will implement such corrective action plan within the time period stated and will permit a re-audit by L.A. Care or its agent, if requested.

    - If a PPG fails to adequately correct the deficiencies within the required time period, L.A. Care retains the right to perform a focused audit as deemed necessary. If reoccurring deficiencies are identified during the third consecutive audit review, the PPG is subject to additional deductions and referred to Regulatory Affairs and Compliance for de-delegation. L.A. Care may de-delegate credentialing and assume responsibility for all or part of credentialing functions.

    - At L.A. Care's discretion, or in the event that L.A. Care determines that significant deficiencies are occurring related to performance by the delegate and are without remedy and the delegate fails to complete the corrective action plan process and has gone through the exigent process which results in de-delegation, the PPG cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous

audits, delegation will be at the sole discretion of the Credentialing Committee, regardless of the score.

- A PPG that receives a rating of "excellent", "commendable", "accredited", or "certified", from NCQA, will be deemed to meet L.A. Care's requirements for credentialing. These PPGs may be exempt from the L.A. Care audit of credentialing in elements for which they are accredited or certified. As a note, CMS does not recognize NCQA certified CVOs. In such cases, all files may be subject to full file review. If a PPG sub-delegates to an NCQA CVO for primary source activities, the PPG must still perform annual oversight of these activities for the Medicare line of business, if applicable.

    - If the PPG is NCQA accredited, and L.A. Care chooses to use the NCQA accreditation in lieu of a pre-delegation or annual audit, the PPG will be required to demonstrate compliance with the credentialing and recredentialing of UM Medical Director(s) annually. This will be accomplished through a signed Attestation submitted by the Medical Director(s) attesting to compliance with this requirement. If the PPG is not compliant with this process, the PPG will be subject to sanctions according to the PPGSA, Sections 1.36 and 1.37.

- L.A. Care retains overall responsibility for ensuring that credentialing requirements are met and will require documentation from PPG to establish proof of NCQA accreditation status. Elements not listed in the NCQA accreditation documentation will require further validation through due diligence or annual audits. L.A. Care retains the right to perform oversight audits as necessary.

    - L.A. Care retains the right to approve new participating practitioners/providers and sites (delegated or sub-delegated), and to terminate, suspend, and/or limit participation of PPG's practitioners who do not meet L.A. Care's credentialing requirements.

PPG Responsibilities

- PPG must have policies and procedures to address credentialing of practitioners, non-practitioner health care professionals, licensed independent practitioners, Autism providers, UM Medical Director(s) and health delivery organizations that fall within in its scope of credentialing. PPG must state in policy that they do not make credentialing and re-credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the practitioner specializes. A statement that the PPG does not discriminate does not meet the intent of the requirement. The policy must explicitly describe how it both monitors and prevents discriminatory practices to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner which may include but are not limited to periodic audits of credentialing files and practitioner complaints, and maintaining a heterogeneous credentialing committee decisions to sign a statement affirming that they do not discriminate.

    - PPG will establish standards, requirements and processes for the health delivery organizations that are performing services for L.A. Care members to ensure that these practitioners and health delivery organizations are qualified to perform the services, and are licensed and/or certified consistent with L.A. Care, NCQA, DHCS, and CMS requirements. These standards, requirements and processes are applicable whether or not credentialing and re-credentialing activities are delegated. For CBAS facilities, L.A. Care annually verifies license and credentialing status.

    - PPG's policies must explicitly define the process used to ensure that the information submitted to L.A. Care is consistent with the information obtained during the

credentialing process which is included in member materials and practitioner directories. Specifically, any practitioner information regarding qualifications given to members should match the information regarding practitioner's education, training, certification and designated specialty gathered during the credentialing process. "Specialty" refers to an area of practice, including primary care disciplines.

- PPG will establish a peer review process by designating a Credentialing Committee that includes representation from a range of participating practitioners. The credentialing process can encompass separate review bodies for each specialty (e.g., practitioner, dentist, and psychologist) or a multidisciplinary committee with representation from various types of practitioners and specialties.

    - PPG must notify the practitioner, in writing, of any adverse actions to the practitioner and notify L.A. Care of PPG's action taken as soon as the PPG has knowledge. The PPG must require the provider/practitioner to notify the PPG of any adverse action taken against them within 14 days of knowledge.

    - PPG must document the review of adverse events, actions taken, the monitoring and follow through of the process including timeframes and closure of each adverse events.

    - PPG must notify L.A. Care in writing, if any contracted practitioner has any adverse action or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network.

    - PPGs that are delegated for credentialing and recredentialing are required to review, investigate and take appropriate action for any adverse events or criminal actions taken against a contracted provider including, but not limited to fair hearing and reporting to appropriate authorities as delegated. L.A. Care retains the right to approve, close panel to new membership and/or terminate contracted practitioners at all times.

- L.A. Care reserves the right, pursuant to the Participating Practitioner Group Services Agreement, to coordinate, consolidate, and participate in any PPG participating practitioner disciplinary hearing, conducted in accordance with L.A. Care Policy and Procedures, and California Business and Professions Code Section 805.

- PPG will advise L.A. Care of any changes to its credentialing and re-credentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the change. If L.A. Care deems the changed items not in compliance with L.A. Care, NCQA, DHCS, and CMS requirements, L.A. Care shall notify PPG immediately. PPG will have 30 days to be in compliance, and, if not in compliance, L.A. Care may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

- PPG will provide quarterly reports to L.A. Care following the end of each report month (May 15th, August 15th, November 15th, February 15th) with accurate and complete PPG practitioner data. PPG must provide Board certification status and Board expiration date, if applicable, when adding a practitioner to L.A. Care's network and any updates.

- Using the standardized ICE format and Excel grid will include the following:
    - Number of adds/deletes of PCPS (i.e. MDs, DOs, etc.)
    - Number of adds/deletes of SCPS (i.e. MDs, and DOs, etc.)
    - Numbers of adds/deletes of independent practitioners (i.e. DCs, DPMs, etc.)
    - Any new or revised policies and procedures, additions of a computer system, CVO
    - Practitioners termed for quality issues

- PPG will submit a profile of the PCP or SCP, Mid-Levels and Autism practitioners credentialing information to L.A. Care. Along with the profile, first and last page of the contract, W-9, all addenda to the California Participating Physician Application (CPPA), and appropriate hospital coverage letter, if applicable, must be attached.

    - PPG profiles must meet L.A. Care's requirements as follows: Practitioners who do not have hospital privileges with a L.A. Care contracted hospital, may use the PPGs admitting panel or have a direct agreement with a practitioner who has admitting privileges within the same specialty at a L.A. Care contracted hospital. This agreement must capture responsibility for the provisions and coordination of care, when patients are discharged from the hospital, referral of patients back to PCP with a hospital discharge summary, and coordinate a seven day week, 24-hour call coverage utilizing the practitioners that are contracted with the PPG.

- PPG will notify L.A. Care within thirty (30) days of any changes in the status of any of the PPG's participating practitioners, including, but not limited to, termination, resignation.

- PPGs will ensure that practitioners and all of their contracted sites are reviewed in accordance with the requirements of L.A. Care, NCQA, DHCS and CMS requirements. All Practitioners must have a current (i.e., within 3 years of the date of initial credentialing/re-credentialing) full scope site review at the time of initial credentialing/re-credentialing. Practitioners who are only contracted for the Medicare program are required to undergo a medical record review.

- PPG's Board of Governors (Board), or the group or committee to whom the Board has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures on an annual basis.

Provisional Credentialing

The PPG may conduct provisional credentialing (in compliance with L.A. Care, NCQA, DHCS, and CMS requirements) of practitioners who completed residency or fellowship requirements for their particular specialty area within the 12 months before the credentialing decision.

Confidentiality and Practitioner Rights

- PPG's credentialing policies and procedures must clearly state the confidential nature of information obtained in the credentialing process. The PPG must also describe the mechanisms in effect to ensure confidentiality of information collected in this process. The PPG must ensure that information obtained in the credentialing process is kept confidential and, ensure that practitioners can access their own credentialing information, as outlined in *Right to review information,* below.

- During the credentialing process, all information that is obtained is considered confidential. All Committee meeting minutes and practitioner files are to be securely stored and can only be seen by an appropriate Medical Director or his/her equally qualified designee, and the Credentialing Committee members. Documents in these files may not be reproduced or distributed, except for

confidential peer review and credentialing purposes consistent with Section 1157 of the State of California Evidence Code and Section 1370 of the Health and Safety Code of the State of California.

- PPG's policies and procedures must state that practitioners are notified of their right to review information obtained by the PPG to evaluate their credentialing application. The evaluation includes information obtained from any outside source (malpractice insurance carriers, state licensing boards, etc.).

- PPG must have written policies and procedures for notifying a practitioner in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. The policies and procedures must clearly identify timeframes, methods, documentation and responsibility for notification.

- PPG is not required to reveal the source of information if the information is not obtained to meet PPG credentialing verification requirements or if disclosure is prohibited by law.

- Policies and procedures must also state the practitioner's right to correct erroneous information submitted by another source. The policy must clearly state:

    - Timeframe for changes
        - Format for submitting corrections
        - The person to whom corrections must be submitted
        - Receipt of documented corrections
        - How practitioners are notified of their right to correct erroneous information as outlined in this manual.

- PPG's credentialing policies and procedures must state that practitioners have a right to be informed of the status of their applications upon request, and must describe the process for responding to such requests, including information that the PPG may share with practitioners. This element does not require the PPG to allow a practitioner to review references, recommendations or other peer-review protected information

Requirements

- All practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. Failure to meet Medi-Cal, CMS requirements may be cause for removal from L.A. Care's network.

- The PPG/Vendor is required to notify the Plan immediately when providers/practitioners are identified on any sanctions or reports for removal from network.

- These requirements include verification of the following circumstances:

    - **Excluded Providers**
        - Confirmation that practitioners or other health care providers/entities are not "excluded providers" on the Office of the Inspector General (OIG) sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. Organizations employing or contracting with health practitioners/ providers have a responsibility to

check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. All contracted PPGs and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

- Lists of the excluded providers are available at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

- **Medi-Cal Suspended and Ineligible Providers**
  - Medi-Cal law (*Welfare and Institutions Code,* Section 14123) mandates that the Department of Health Care Services (DHCS) suspends a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (b) suspended from the federal Medicare program for any reason.

  - Suspension is automatic when either of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the California Administrative Procedures Act.

  - All contracted PPGs and vendors, i.e., carved out contacts, are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

- **Opt-Out Providers**
  - If a practitioner opts out of Medicare, that practitioner/providers may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services. Payment must be made for emergency or urgently needed services furnished by an "opt-out" practitioner to a member, but payment should not otherwise be made to opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. This list must be checked on a regular basis.

  - All contracted Participating Practitioner Groups (PPGs) and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

- **National Provider Identifier (NPI) Number**
  - All practitioners of Covered Services, including physicians and specialists, must have a valid National Provider Identifier (NPI) Number.

  - All contracted PPGs and vendors are required to verify that their contracted practitioners have a valid NPI number.

- **CLIA Certification**
  - The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S through the Clinical Laboratory Improvement Amendments (CLIA). CLIA requires all facilities that perform even one test, including waived tests, on materials derived from human body for the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of health of, human beings to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of the tests performed.

  - All contracted PPGs and vendors shall ensure that all contracted laboratory testing sites have either a current and valid CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. This must be monitored on an ongoing basis. If a vendor is used to perform laboratory testing, the vendor is required to have a CLIA certificate and there must be a contract between both parties.

- **DEA or CDS Certificate, as applicable**
  - The PPG must have a documented process for allowing a practitioner with a valid DEA certificate and participates within L.A. Care's network, to write all prescriptions for a practitioner who has a pending DEA certificate, or require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications. The PPG will maintain a current DEA or CDS certificate on all contracted providers/practitioners.

- **Medicare Number**
  - All PPGs must ensure that their contracted facilities and contracted practitioners that serve Medicare members must have a Medicare number.

Ongoing Monitoring of Sanctions, Complaints, and Quality Issues

- PPG must implement a process for monitoring practitioner sanctions, complaints and the occurrence of adverse events between re-credentialing cycles. The PPG must conduct ongoing monitoring of all practitioners who fall within the scope of credentialing. The PPG must be fully compliant with L.A. Care, NCQA, DHCS, and CMS and use the approved current sources of sanction information.

- PPG develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles, and takes appropriate action against practitioners when it identifies occurrences of poor quality. PPG identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

- PPG must show how they monitor all adverse events and demonstrate this process has been reviewed by the Credentialing Committee at least every six months. The PPG's Credentials committee may vote to flag a practitioner for ongoing monitoring. The PPG must make clear, the types of monitoring they impose, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the PPG's Credentialing Committee.

- PPG must provide proof of any practitioner identified on the OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc. The PPG must demonstrate that they have taken action to terminate the contracted practitioner. If a practitioner has been identified on any of the lists above, they are to be terminated for all lines of business for L.A. Care.

- PPG must notify L.A. Care promptly and no later than fourteen (14) calendar days of any adverse event or criminal action, changes in privileges, accusation, probation, other disciplinary action against a practitioner, or non-compliance with L.A. Care's policies and procedures. Failure to do so may result in the removal of the practitioner from L.A. Care's network.

- L.A. Care retains the right, based on quality, facility site review, adverse events, criminal actions, or changes in privileges, accusations, and/or probation to close practitioners to new member assignment until such time the L.A. Care's Credentialing Committee determines otherwise.

- PPG who fails to comply with the requested information within the specific timeframe is subject to sanctions as described in L.A. Care's policies and procedures and PPGSA, section 1.36 and 1.37. In the event that the PPG fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and will be subject to L.A. Care's policies and procedures and Credentials committee's outcome of the adverse events.

Recredentialing

- Participating practitioners must satisfy re-credentialing standards required for continued participation in the network. Re-credentialing is completed three years from the month of initial credentialing and every three (3) years thereafter.

- A facility site review does not need to be repeated as part of the re-credentialing process if the site has a current passing score (this applies to PCPs). A passing site review survey will be considered "current" if it is dated within the last three (3) years (with use of new tool) of the re-credentialing date, and does not need to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the Plan

- If a practitioner/provider is contracted for the Medi-Cal and Medicare programs, they are subject to both a site review and medical record review. However, if the practitioner/provider is only contracted for the Medicare program, a medical record review is all that is required. However, Facility Site Review or other L. A. Care staff may visit a provider's office at any time without prior notification.

Credentialing Committee

- The Credentialing Committee will consist of not less than three (3) participating practitioners in good standings with state and federal agencies in order to ensure accurate representation of medical specialties.

- Administrative support staff may attend at the request of the Chair but are not entitled to vote.

- A quorum should consist of three (3) practitioner committee members. Any action taken upon the vote of a majority of members present at a duly held meeting at which a quorum is present shall be an act of the committee.

Meetings and Reporting

- The Credentialing Committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required action; and maintain a permanent record of its proceedings and actions. The activities, findings, recommendations, and actions of the committee must be reported to the governing body or designee in writing on a scheduled basis.

- Additional meetings of the Credentialing Committee may be called by the Committee Chairperson on an as-needed basis.

Committee Decisions

- L.A. Care considers the decision made by the Credentialing Committee to be final.

- The PPG's credentialing policies and procedures must include a time frame for notifying applicants of credentialing decisions, not to exceed sixty (60) calendar days from the Committee's decision.

Participation of Medical Director or other Designated Practitioner

- PPG must have a practitioner (medical director or equally qualified designated practitioner) who has overall responsibility for the credentialing process. Credentialing policies and procedures must clearly indicate the Medical Director is directly responsible for the credentialing program and must include a description of his/her participation.

Committee Functions

- Review and evaluate the qualifications of each practitioner applying for initial credentialing, and recredentialing.

- Investigate, review and report on matters referred by the Medical Director or his/her designee or the Board regarding the qualifications, conduct, professional character or competence of any applicant or practitioner, and;

- Review of periodic reports to the appropriate Committee and/or Board on its activities, i.e., ongoing monitoring reports, credentialing activity reports, etc.

- Review annually policies and procedures relevant to the credentialing process, and make revision as necessary to comply with L.A. Care, NCQA, DHCS, and CMS requirements, regulations and practices.

- PPG's Credentialing Committee must review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care. At a minimum, the Credentialing Committee must receive and review the credentials of practitioners who do not meet the PPG's established criteria.

- PPG's Credentialing Committee must clearly document detailed discussion that reflects thoughtful consideration of credentials reviewed during its meeting in the minutes. Discussion that demonstrates approval/denial does not meet the intent of detailed discussion.

- When the credentialing function is not delegated to the PPG, L.A. Care's Credentialing Department will be responsible for credentialing and recredentialing activities in-house.

- L.A. Care's Credentialing Committee may terminate, suspend or modify participation of those practitioners who fail to meet eligibility criteria. The decisions to terminate, suspend, or modify participation of a contracted practitioner as a result of a reportable quality of care issue shall be subject to an appeals process by the practitioner.

Credentials Committee File Review

- PPG's policies and procedures must describe the process used to determine and approve clean files. They must identify the Medical Director as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean and approved. With regard to clean files, the practitioner may not provide care to members until the final decision of the Credentialing Committee or the Medical Director or his or her equally qualified designee.

- PPG's credentialing and re-credentialing policies must explicitly define the process used to reach a credentialing decision.

Appeal and Fair Hearing

- Delegated PPG, or if not delegated, L.A. Care must have a mechanism for the fair hearing and appeal process for addressing adverse decisions that could result in limitation of a practitioner's participation based on issues of quality of care and/or service, in accordance with all applicable statutes. The process should include notification to practitioner within an established time frame and established time frame for practitioner to request a hearing, scheduling of hearing requests, followed by the procedures hearings, the composition of the hearing committee and the agenda for the hearing.

- PPG must have an appeal process for instances in which it chooses to alter the conditions of a practitioner's participation based upon issues of quality of care and/or service. Except as otherwise specified in this manual, any one or more of the following actions or recommended actions taken for a medical disciplinary cause or reason shall be deemed actual or potential adverse action and constitute grounds for a hearing:

- The following actions entitle the practitioner the opportunity to appear before a Peer Review Committee to present rebuttal evidence before a final determination is made. The practitioner shall have the right to be represented by an attorney during this process. The following actions also entitle the practitioner the opportunity for a hearing before a hearing panel in the event that the final determination of a Peer Review Committee is adverse to the practitioner, unless the right to a hearing has been forfeited as described below. The actions to which this section applies are:

    - Denial of initial panel appointment
    - Denial of reappointment to panel
    - Suspension of panel appointment (except as described below)
    - Revocation of panel appointment
    - Other adverse restrictions on panel appointment (except as described below)

- Peer Review Committee has the right to recommend suspension of a practitioner's panel appointment for up to fourteen (14) calendar days while an investigation is being conducted to determine the need for peer review action, without the practitioner having a right to the rebuttal and/or fair hearing process set forth below.

- A Peer Review Committee has the right to recommend immediate suspension or restriction of a practitioner's membership if the committee reasonably believes that the health of any individual would be jeopardized by the continued participation of the practitioner. In the case of such an immediate suspension or limitation on privileges (summary action), the practitioner has the right to receive notice, opportunity to present rebuttal information and fair hearing, in accordance with the procedure described in L.A. Care's Policy LS-005, but those rights apply subsequent to the summary action, rather than prior to it.

Required Reporting

- PPG must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank/Healthcare Integrity Protection Data Bank within thirty (30) calendar days after the effective date of the action, if any of the following events occur:

- The practitioner's application for participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.

- The practitioner's participation status is terminated or revoked for a medical disciplinary cause or reason.

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

- The practitioner resigns or takes a leave of absence from participation status following notice of any impending investigation based on information indicating medical disciplinary cause or reason or for any of the following:

    - Resigns, retires, or takes a leave of absence.
    - Withdraws or abandons the application.
    - Withdraws or abandons his or her request for renewal.

Expired License

- L.A. Care requires that all practitioners who are performing services for L.A. Care members have a current license at all times to provide patient care to members and abide by State and Federal laws and regulations.

- **Failure to Renew**
    - Practitioners contracted with L.A. Care shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. The license to practice medicine in California must be renewed upon expiration (every two (2) years).

    - If any practitioner fails to renew their license by the expiration date, the following steps will be initiated by L.A. Care.

- If the identified practitioner(s) has member enrollment:

  - Close provider's panel to new members upon license expiration.
  - Notify PPG of expiration and possible reassignment of members
  - Remove assigned members from unlicensed practitioner/practitioner 5 business days following license expiration, if not renewed
  - Reassign members to a qualified licensed credentialed practitioner
  - Remove unlicensed practitioner from network

- If the identified practitioner(s) has no member enrollment:

  - Close practitioner's panel to new members
  - If practitioner has not renewed by the 5th business day following the expiration date, the unlicensed practitioner will be removed from L.A. Care's network

8.0 PROVIDER NETWORK OPERATIONS (PNO)

SPECIFIC AREAS

Provider Contracting

The Provider Network Contracting team is responsible for developing and negotiating financially sound contracts with physicians, Participating Physician Groups (PPGs), hospitals, ancillary providers and other health professionals in order to maintain a comprehensive provider network for the provision of health care services to covered members.

- **PPG Responsibilities:** PPG shall at all times comply with Healthplan's Quality Improvement Program, including, but not limited to, allowing the Healthplan to use practitioner performance data

Provider Relations

Provider Relations Director, Managers and Provider Network Representatives are responsible for the following:

- Serving as key contacts for PPGs, hospitals, and other providers to resolve all operational and ongoing service issues.
- Coordinating closely with Provider Contracting, Member Services, Claims, Utilization Management and PPGs when necessary to resolve issues.
- Training PPG personnel to ensure L.A. Care procedures and requirements are understood and followed.
- Conducting Joint Operations Meetings to ensure that administrators and staff are kept informed of policy and procedure changes.
- Provider grievance resolution.

Provider Network Research & Analysis

The Provider Network Research & Analysis (PNRA) has program responsibility over the multifaceted, highly technical functions that combine the services of information technology, provider network information, and statistical studies and reporting.

In this capacity, PNRA has oversight responsibility for the management, accessibility, and usability of provider information. PNRA is also responsible for conducting comprehensive provider related studies as mandated by the state Department of Health Care Services (DHCS), Medical Risk Management Insurance Board (MRMIB), and other governing agencies/bodies. Other key functions of PNRA are the production of L.A. Care's provider directories; the production of the Quarterly Impact Report, and the entry/updating of contractual terms/rates into MHC for our directly contracted PPGs, hospitals, ancillary providers, and individual providers for claim payment purposes.

PROVIDER TRAINING AND EDUCATION

Provider education is implemented by L.A. Care Health Plan and its PPGs to ensure that all providers receive training in order to operate in full compliance with all applicable Federal and State statutes and regulations. Goals, objectives, curricula, and implementation guidelines are established by L.A. Care. The PPGs are responsible for conducting provider training and orientation. L.A. Care provides additional resources and opportunities for provider education, as needed.

L.A. Care provides special training and workshops for traditional and safety net providers. Ultimately, the goal of provider training and education is to improve the delivery of services to members by providing a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to providers in order to become well informed about products and services offered by L.A. Care and its systems and policies and procedures.

A training and education curriculum will be developed and implemented by the PPGs with collaborative

oversight, guidance, and approval of L.A. Care, or it may be provided directly by L.A. Care. L.A. Care's Health Education & Cultural and Linguistics, Medical Management, Behavioral Health and PNO departments share responsibility for L.A. Care's involvement in the provider training process.

TRAINING AND EDUCATION MATERIALS AND METHODS

All provider training and education materials produced and distributed by PPGs must be approved by L.A. Care prior to distribution. The following provider training and education materials must be used by the PPGs.

Provider Manuals

- Each PPG must distribute a provider manual to its contracted network within Los Angeles County that includes information about L.A. Care's contracted programs. This can also be downloaded through L.A. Care's website at: www.lacare.org.

Orientation Sessions and On-site Visits

- Provider orientation sessions and on-site visits for newly contracted providers will be conducted by PPGs to provide training on the subjects outlined above and the contents of L.A. Care's provider manual. within ten (10) business days of their affiliation date. The training must include, but is not limited to:
    - Federal and State statutes and regulations to ensure provider's full compliance
    - Medi-Cal managed care services
    - Applicable policies and procedures
    - Medi-Cal marketing guidelines
    - Member Rights
    - Member services, including the member's right to full disclosure of health care information and to participate actively in health care decisions
    - Understanding the needs of L.A. Care members, including cultural awareness and sensitivity instruction Seniors and People with Disabilities or chronic conditions.
    - Understanding clinical protocols and evidenced-based guidelines in order to improve clinical, patient interaction, and administrative/management skills.

Provider Bulletins and Newsletters

- PPGs should publish and distribute provider newsletters and/or bulletins at least semi-annually.
- The newsletters should provide relevant and timely information concerning applicable standards, services available to members, quality improvement activities, updates, and other pertinent issues related to the delivery of health services to L.A. Care members.
- Semi-annual general meetings that provide updates on health care delivery issues, hosted by PPGs and its providers, will meet the requirement of publishing semi-annual newsletters/bulletins.

Focused Seminars, Workshops and Symposia

- L.A. Care and PPGs will work together to conduct focused seminars, workshops, and symposia on special topics, including State and Federal regulatory requirements for new products.

PROVIDER DATA MAINTANCE PROCEDURE S

Adding a New Provider

- Prior to adding a new provider record or an additional site for an existing provider into MPD, the PNRA staff will verify with the Credentialing department that the provider is eligible for inclusion in L. A. Care's provider network.
- The physician must meet all credentialing requirements and have no sanctions, debarred status, or expired license.
- All primary care physicians must also receive a passing Facility Site Review score; Health Plans are required to use FSR attachment C to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve a high volume of SPD's. The DHCS recognizes that hospitals represent a unique group of Ancillary providers and therefore health plans are required to Collaborate with the hospitals in their network to assess whether they meet all of the elements in Attachment C and make this information available through both their website and their provider directories: Health plans must demonstrate that they have received adequate documentation from the hospital to complete Attachment C and maintain records that support their assessment of each hospital in their network. Facility Site Reviews are not required for specialty care physicians.
- Upon approval, PNRA staff, based on information contained on the provider profile, enters all eligible providers' data into MPD.

Changing Provider Data

- Upon approval of the written request via electronic/U.S. mail or fax from a PPG/Plan Partner to change a provider's capacity, specialty, member age parameter, or other data element of a provider's record, PNRA staff will make the appropriate update in MPD.

Changing a Provider's Address

- PNRA staff will receive written notification, via U.S./electronic mail or fax, from L. A. Care Health Plan's contracted PPGs or Plan Partners advising that a provider's address should be changed.
- Before the address change is made in MPD, the Facility Site Review department must confirm a passing score for any new PCP added to an existing site, a change in location and/or change in physicians would also require a site review.
- No Facility Site Review is required for a change of address for a specialty care provider. If the specialty provider considers themselves a PCP they are subject to a site review.

Closing a Provider's Panel

- PNRA staff will receive written notification, via U.S./electronic mail or fax, from L. A. Care Health Plan's contracted PPGs or Plan Partners advising that a provider's membership panel should be closed to any new member assignments.
- The PNRA analyst will close the provider's panel in MPD within one (1) business day of receipt.

Terminating a Provider

- PNRA staff will receive notification, via U.S./electronic mail or fax, from L. A. Care Health Plan's contracted PPGs and Plan Partners advising that a provider has been terminated from the entity's network.
- Prior to terminating a provider's record in MPD, PNRA staff will notify Member Services, via a "Change Form", that members assigned to the physician must be moved to a new PCP as designated by the PPG or Plan Partner.
- Once the members have received a sixty (60) calendar day prior notification and have been re-assigned to the new PCP, Member Services will notify PNRA of the transfer via the "Change Form".

- The primary care physician's record will then be terminated in MPD. The member transfer process is not applicable for specialty care providers.
- Completion of the provider termination process should occur within a five (5) business day timeframe.

PROVIDER DIRECTORIES

L.A. Care produces a hard-bound provider directory for all product lines on an annual basis. The directory is a listing of all the PPGs, contracted PCPs, community clinics, hospitals, pharmacies, and other primary care providers. Upon request, L.A. Care will send a directory to the requesting party. Provider's contact information is updated on L.A. Care's website in real time for potential members and members to access. Online directories are also available on L.A. Care's website.

MID-LEVEL MEDICAL PRACTITIONERS

The use of non-physician practitioners is designed to increase members' access to appropriate primary care and specialty medical services, maximize the patient's health and well-being, and promote cost-effective care. The delegation of specified medical procedures to non-physician practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the non-physician practitioner.

Physicians may supervise up to four mid-level medical practitioners according to the following ratios (full-time equivalent physician supervisor to mid-level medical practitioners):

- One physician to four nurse practitioners (NPs).
- One physician to three certified nurse midwives.
- One physician to four physician assistants (PAs).
- Four non-physician practitioners in any combination as long as they do not exceed more than three certified nurse midwives or four physician assistants and maintain the full-time equivalence limits.

Midlevel Support and Patient Care

- A single non-physician practitioner can potentially increase the supervising physician's total member capacity by 1,000 members. However, the physician cannot be responsible for more than 5,000 patients in total.
- The non-physician practitioner may only provide those medical services that he/she is competent to perform and that are consistent with the practitioner's education, training and experience, the terms of which must be delineated in writing by the supervising physician.

- The stipulated scope of practice must be in full compliance with standards set forth by the Physician Assistant Examining Committee of the Medical Board of California, California Board of Nursing, the Nursing Practice Act, DOC, the California Code of Regulations, the California Administrative Code, the California Business and Professions Code, and the requirements of any other applicable professional licensing body, law and regulations.
- A scope of practice agreement which is signed by the non-physician practitioner and the supervising physician, as well as standardized procedures, must be filed and maintained at the medical practice site.

The scope of practice agreement must address the following elements:

- Delegated responsibilities
- Disciplinary policies
- Method and frequency of physician supervision
- Monitoring and evaluation of the non-physician practitioner

    - Chart review requirements
    - Term of the agreement/contract
- The supervision or back-up physician must be available in person or through electronic means at all times when the non-physician practitioner is caring for patients.
- The supervising physician must review, on a continual basis, tasks delegated to the non-physician practitioners for competency.
- Medical record documentation by the non-physician practitioner must be reviewed and countersigned by the supervising physician within thirty (30) calendar days of the date care was provided.

The following requirements must be included within the standardized procedures for mid-level medical practitioners, and reflected in written agreements as indicated above:

- Each PPG must set and implement credentialing elements for mid-level medical practitioners and ensure that they are consistent with the criteria and scope of practice requirements set forth in this manual and any other policies, procedures, and directives issued by L.A. Care.
- As part of the credentialing process, the appropriate credentialing committee, prior to the provision of care by mid-level medical practitioners, must verify that a signed scope of practice agreement, a signed set of procedures by the supervising provider, and appropriate license(s) are present. L.A. Care will audit the PPG's credentialing verification process.

L.A. CARE AGREEMENTS WITH OTHER ENTITIES FOR SPECIAL SERVICES AND PROGRAMS

L.A. Care has executed a Memoranda of Understanding (MOU) with the Los Angeles County CCS program to serve CCS-eligible children. PPGs and their providers are to utilize these agreements to provide for the coordination and continuity of care for members receiving care through special services and programs operated by these entities. (See Section 5 – Utilization Management)

ELIGIBILITY LISTS

Monthly Eligibility lists (E-lists) are placed on the Provider Portal for the PPGs to download on the fifth (5th) business day of each month. The E-list contains current information through the last day of the previous month for members assigned to PCPs with each PPG. Daily eligibility can be verified by L.A. Care's IVR system or by using L.A. Care Connect. Please call L.A. Care's Provider Information Line at 1-866-LA-CARE6 or your assigned Provider Network Representative if you have any questions about your eligibility lists.

PROCEDURE FOR HANDLING PROVIDER QUESTIONS & CONCERNS

Communication

- Providers can communicate their questions and concerns to their PPG or to L.A. Care directly. Providers may communicate with L.A. Care by telephone, in person, in writing, or by e-mail.

Resolution

- Provider Network Representatives from the PPG or L.A. Care will be able to answer most provider questions and resolve provider concerns immediately. Any question or concern, which suggests a quality of care issue, will be handled as a clinical grievance.

- The provider network representative will answer the provider's question(s) and inform the provider of his/her right to file an informal complaint or formal grievance if desired.

- If the provider asks a question over the telephone or in person, the answer will be provided orally. If the provider writes a letter, the answer will be provided in writing within seven (7) business days.

PROVIDER GRIEVANCES

Provider clinical grievances will be handled through L.A. Care's Utilization Management process. Provider administrative grievances will be handled as specified below.

Communication of Formal Grievances

- Providers must communicate their formal grievances directly to their PPG. This communication may be over the telephone, in person or in writing.
- If the provider wishes to file a formal grievance, the Provider Network Representative will give the provider detailed instructions for filing a grievance. The Provider Network Representative will assist providers in filing grievances, including assistance with completing a grievance form, if applicable.
- The Provider Network Representative will record the grievance on the provider grievance log. Regardless of the method of filing of the provider's grievance, the Provider Network Representative will send an acknowledgment letter to the provider within five (5) business days.
- If a provider contacts L.A. Care directly with a grievance, the L.A. Care Provider Network Representative will record the information on the provider grievance log, contact the provider's PPG, and send an acknowledgement letter within five (5) business days.
- The PPG will be responsible for resolving the grievance within thirty (30) calendar days and informing L.A. Care of the resolution/disposition. L.A. Care will be responsible for informing the provider of the resolution/disposition in this case.

Resolution

- All grievances will be resolved within thirty (30) calendar days.
- Extensions to grievances will be requested to the Provider Relations Manager. A fifteen (15) or thirty (30) calendar day extension may be granted. If an extension is granted, a letter to the grieving provider will be sent with appropriate reasons for the extension.
- The PPG and/or L.A. Care will provide written notice of grievance resolution/disposition and deliver each letter by way of certified mail.

Dispute Resolution

- A provider has the right to file an appeal. The provider must submit a detailed written grievance, including the desired resolution and all supporting documentation and correspondence to the PNO Director at L.A. Care. L.A. Care will respond with an acknowledgement letter within five (5) business days.

- A Provider Relations Subcommittee will convene within thirty (30) calendar days of receipt of the dispute to decide whether the committee has authority to address the issue. The grieving party will have the opportunity to address the issue in front of the committee, if L.A. Care's committee has deemed it applicable. A resolution will be made by the committee with notification to the provider within seven (7) business days of the decision.

All providers have the right to file a grievance with the Department of Managed Health Care (DMHC). The toll-free telephone number is (800) 400-0815. If you have a grievance against L.A. Care Health Plan, contact L.A. Care and use our grievance process.

9.0 HEALTH EDUCATION

Overview

Health education is the process of providing health information, skill training, and support to individuals to enable and empower them to modify their behaviors and improve their health status. L.A. Care Health Plan is responsible for the planning, implementation, and evaluation of member health education, health promotion, and patient education for our direct line of business members. Primary Care Providers (PCPs) are responsible for delivering individual education during member doctor visits, continually reinforcing positive health behavior change in patients, documenting the delivery of health education services in the patient's medical record and administering the Individual Health Education Behavioral Assessment Tool (IHEBA). PPG's are responsible for assisting L.A. Care in educating providers about health education requirements, services and available sources.

The mission of L.A. Care Health Plan's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve direct line of business member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care. This is achieved through assisting direct line of business members to:

- Effectively use the managed health care system, including primary and preventive health care services, obstetrical care, health education services and appropriate use of complementary and alternative care

- Modify personal health behaviors, achieve and maintain healthier lifestyles, and promote positive health outcomes

- Learn and follow self-care regimes and treatment therapies for existing medical conditions, chronic diseases or health conditions.

Health Education Services

***Health In Motion*™ L.A Care Members Only,** L.A. Care Health Plan's mobile health education program, brings health education directly to L.A. Care members in their communities. *Health In Motion*™ L.A. Care Members Only is for L.A. Care Health Plan's direct line of business members (MCLA, L.A. Care Healthy Kids and L.A. Care Medicare Advantage HMP SNP) . All classes are available at no cost to the member and are conducted in English and Spanish. Interpretation services (including ASL) are also available. Programs include:

Chronic Disease

- **Asthma 101**: (1 session) Educates children and parents on risk factors, asthma attack prevention, medication adherence, and the use of peak flow meters and spacers.
- **Diabetes 101 – Sugar in the Blood:** (1session) Teaches basic diabetes in easy-to-understand terms, risk factors for diabetes, symptoms of diabetes, the importance of knowing blood sugar numbers, and ways to prevent or control diabetes.
- **Healthier Living:** (6 session series) Teaches skills to help manage patient's chronic disease. Instruction includes nutrition, goal setting, and how to better communicate with providers and family members.
- **Love Your Heart, Lower Your Blood Pressure:** (1 session) Teaches skills to prevent and manage high blood pressure. Instruction includes nutrition and exercise information.
- **Take Action Against Cholesterol:** (1 session) Teaches skills to prevent and manage high cholesterol. Instruction includes nutrition and exercise education.
- **Living with Diabetes:** (5 session series) Teaches skills to help manage diabetes. Instruction includes awareness of disease complications, nutrition, and exercise education.

Wellness

- **Burn Rubber:** (1 session) An exercise program where participants will "burn" calories with the use of a "rubber" resistance band. Popular resistance band exercises have been modified to perform in a chair to meet the needs of the senior population. Eight different exercises are covered for a total body workout.
- **Cold or Flu? Antibiotics Won't Work for You!:** (1 session) Teaches participants the difference between a virus and bacteria, what antibiotics are used for and how to take them, awareness of the risk of antibiotic resistance, and ways to help relieve cold and flu symptoms without the use of antibiotics. **Know Your Medicine:** (1 session) Teaches adulds the different types of drugs and what makes them different, the difference between generic and brand-name drugs, ways to take medications safely and how to get the most of your personal pharmacist.
- **L.A. Care Weight Watchers Program:** Adult (18+ years) L.A. Care Medi-Cal (MCLA) members may participate **in limited Weight Watchers®** weekly meetings at no cost to the member. **(Weight Watchers may have restrictions and not all members will qualify.)**
- **Living Well With A Disability:** (8 session series) A peer support workshop for anyone with a health challenge or disability to build skills, and maintain a life of healthy independent living.
- **Stress Management:** (1 session) Teaches what stress is, its effect on health, signs/symptoms of stress, and ways to manage stress.
- **What To Do When Your Child Gets Sick:** (1 session) Using the Institute for HealthCare Advancement's low-literacy book and curricula, this class offers parents helpful "how-to" tips for when their newborns and young children get sick. Instruction includes how to use the book at home to care for a sick child and how to protect a child from accidents and injury. The class also discusses how to get the right medical care for a child.

Nutrition

- **Bust a Myth:** (1 session) Takes a closer look at common health myths. Each myth is "busted" as popular health beliefs regarding nutrition and exercise are examined. Topics include healthier selections with drinks and fast food options, dieting, and exercise.
- **Eat and Play in a Healthy Way:** (2 sessions) Teaches parents and caregivers of children ages 2-5 how developmental stages are linked to common mealtime behaviors, the "parent provides, child decides" principle for healthy nutrition and the importance of physical activity at a young age.
- **Healthy Eating Lifestyles Program 5-12 Years:** (5 session series) Teaches nutrition and exercise education for children and parents.
- **Snack Right!:** (1 session) Basic nutrition education for the entire family.

Primary care physicians may refer L.A. Care direct line of business members to health education by utilizing the online Health Education Referral Form located in L.A. Care Connect, L.A. Care's provider portal at http://www.LACare.org/providers/lacareconnect. Providers may alternately complete and fax a hard copy referral form to the Health Education Department. Health education staff will contact the patient and schedule the requested health education service(s). The outcome of the health education referral will be sent back to the member's PCP. The PCP must document health education referrals and outcome data in the patient's medical record.

L.A. Care Health Plan Family Resource Centers

L.A. Care Health Plan operates two community health education resource centers in the South Los Angeles communities of Lynwood and Inglewood. L.A. Care Health Plan partners with community organizations to offer no or low cost health education classes on asthma, diabetes, HIV, exercise, nutrition, parenting, smoking

cessation, weight management, senior wellness, and activities and services for people with disabilities. New member orientations, health screenings, and application and enrollment assistance are also provided. For more information go to: http://www.lacare.org/providers/familyresourcecenters

Nurse Advice Line - 1-800-249-3619
L.A. Care Health Plan offers a nurse advice line 24-hours a day, seven days a week to MCLA, Healthy Kids, and Medicare Advantage members.

Health Education Programs
L.A. Care Health Plan conducts several health education programs targeting specific vulnerable populations.

Adult Weight Management Program. The purpose of the adult weight management program is to encourage members to maintain a healthy weight by making healthy lifestyle changes. The program consists of screening members who are overweight and obese. Members who qualify for the program will receive up to 20 Weight Watchers® local meeting vouchers. During the course of receiving the local meeting vouchers, a Health Screen Form (HSF) must be completed by the participant's physician. The HSF serves as an evaluation form which tracks health outcomes due to weight loss. Members will receive additional local meeting vouchers once the HSF is sent back to L.A. Care.

L.A. Care's Weight Watchers® program is for L.A. Care Medi-Cal Direct (MCLA) members who are 18 years old or older. Providers are able to refer members to the program using the online Health Education Referral Form located in L.A. Care Connect, L.A. Care's provider portal at http://www.LACare.org/providers/lacareconnect.

Perinatal Health Education Outreach Program. The purpose of the program is to provide prenatal and post-partum educational material to our Medi-Cal direct pregnant members. L.A. Care Health Plan mails culturally appropriate educational material to our pregnant members relevant to their pregnancy stage. Materials include information on planning a healthy pregnancy, nutrition, caring for yourself after childbirth, and breastfeeding.

Tobacco Cessation Health Education Program. Adult L.A. Care Health Plan Members (MCLA and Medicare Advantage HMO SNP) who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, Buproprion, Varenicline) are mailed health education materials promoting available smoking cessation resources including "You Can Quit Smoking–*Support and Advice from L.A. Care Health Plan"* and a listing of free local smoking cessation resources. Outbound calls are made to members two weeks after the mailing to ensure receipt of the packet and to administer a phone survey to assess the resources used and their smoking status.

Health Education Materials and Resources

Health Education Materials
L.A. Care makes available health education materials in multiple topics and languages to meet the needs of direct line of business members. Health education topics includes: asthma, breastfeeding, dental, diabetes, exercise, family planning, HIV/STD prevention, hypertension, immunizations, injury prevention, nutrition, parenting, perinatal/pregnancy, substance abuse, tobacco prevention/cessation, and weight management and more.

Providers may order L.A. Care health education materials through the health education material order form online application located at: http://www.lacare.org/providers/resources/healtheducation. Written Health Education Materials provided by L.A. Care comply with the guidelines set forth by DHCS. Health education materials distributed to L.A. Care members by L.A. Care Health Plan and its provider network undergo review using the Readability and Suitability Checklist (RSC). The RSC refers to the form provided by Medi-Cal Managed Care Division (MMCD) to ensure health education materials developed, adapted, or used for members are systematically evaluated to assess their suitability for Medicaid populations.

Alternative Formats – L.A. Care Health Plan makes health education materials available in alternative formats (Braille, video, audio, accessible materials online or on CD, large size print, and/or other appropriate technologies and methods) upon request.

Community Resource Directory
L.A. Care Health Plan provides an online community resource directory focusing on health education/social services within Los Angeles County. The resource directory includes program topics, languages, location, fee and contact information. The resource directory is available online at http://www.lacare.org/providers/resources/crd.

Individual Health Education Behavioral Assessment Tool – "Staying Healthy"
PCPs are responsible for ensuring the use of the Individual Health Education Behavioral Assessment (also called "IHEBA" or "Staying Healthy.") The goals of the IHEBA are to:

- Identify high-risk behaviors of plan members
- Prioritize individual health education needs related to lifestyle, environment, and cultural and linguistic background
- Assist physicians in initiating and documenting focused health education interventions and follow-up.

The IHEBA is a DHCS requirement per MMCD Policy Letter 99-07. The IHEBA is designed to help open a dialogue between patients and providers about behavioral risk factors and health education needs.

"Staying Healthy" is currently available in five age categories (0-3; 4-8; 9-11; 12-17; 18+) and seven languages (English, Spanish, Chinese, Hmong, Laotian, Russian and Vietnamese). Hmong and Laotian are not required for Los Angeles County.

PCPs must ensure the "Staying Healthy" Behavioral Assessment Tool is administered to all new L.A. Care members as part of the Initial Health Assessment within 120 days of enrollment and within 60 days of enrollment for children under the age of 18 months.* It must also be administered to all existing members who present for a scheduled visit. These assessments must be reviewed at least annually and re-administered by the doctor at the appropriate age intervals.

L.A. Care Health Plan makes the "Staying Healthy" Assessment Tool and supporting resources available to network providers. "Staying Healthy" forms and "Staying Healthy" California tip sheets can be downloaded

from the L.A. Care Health Plan website http://www.lacare.org/providers/resources/stayinghealthyforms or ordered using the Health Education and Cultural & Linguistics Material Order application.

> *__NOTE:__ At the time of this print, DHCS is considering revising the initial timeframe of the IHA requirements in children under the age of 18 months. L.A. Care is operating on the above guidelines until DHCS has made their final decision at which point PPGs will be notified. Please verify with your Plan representative that your PPG has the most recent requirements.

Provider Education
The provider network must be regularly educated on health education requirements, services and available resources. L.A. Care health plan shares this responsibility with PPGs. Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and special trainings.

Content of provider education includes, but is not limited to:

- Communication of regulatory agencies' and L.A. Care Health Plan health education requirements
- Availability of health education services and resources
- Availability of health education materials and the process for obtaining materials

- Health education material requirements including qualified health educator oversight, reading level, field testing (if applicable), medical accuracy, availability of materials in alternative format, and cultural/linguistic appropriateness
- Individual Health Education Behavioral Assessment Tool (IHEBA) requirement
- Benefits and barriers of breastfeeding. Stipulation that formula samples, coupons and materials from infant formula companies should not be routinely distributed to pregnant and postpartum women as per MMCD Policy Letter 98-10

L.A. Care Health Plan PPGs are responsible for educating providers on health education requirements and available L.A. Care services as listed above. Methods may include, but are not limited to: provider mailings and newsletters; meetings, seminars or other trainings; on-site visits; blast-faxes; provider manual and policies and procedures; and website postings.

10.0 CULTURAL & LINGUISTIC SERVICES

Overview

The relationship between culture, language, and health is complex and inextricably linked to the health status of individuals and subsequently communities. L.A. Care Health Plan maintains a comprehensive Cultural and Linguistic Services program, which supports and works collaboratively with other L.A. Care Health Plan departments.

The mission of L.A. Care Health Plan's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care.

Within the HECLS department there are two units: Health Education and Cultural and Linguistic Services. The goals of the Cultural and Linguistic Services unit are to:

- Ensure that limited English proficient (LEP) members receive the same scope and quality of health care services that others receive.
- Ensure the availability and accessibility of cultural and linguistic services including quality interpreting services and written materials in members' preferred language and format.
- Improve health outcomes and decrease disparities.
- Continually evaluate and improve C&L programs and services.

Interpreting Services

L.A. Care Health Plan provides timely, 24-hour health care interpreting services, including American Sign Language (ASL), at medical and non-medical points of contact, at no cost to members.

Telephonic Interpreting Services

- To access L.A. Care's telephonic interpreting services, call one of the following numbers: **PPGs: 1-888-718-4366**
- **Network Practitioners: 1-888-930-3031**
- **Network Pharmacies: 1-888-942-7670**

Face-to-Face Interpreting Services

To request face-to-face interpreting services (including American Sign Language), call L.A. Care's Member Services Department at 1-888-839-9909 at least 5-10 business days prior to the patient's appointment.

Have the following information ready:

- Provider Name
- Language being requested
- Member's name and ID number
- Member's date of birth
- Requestor name and contact number
- Date, time, and duration of appointment
- Location of appointment
- Type of appointment
- Purpose of appointment
- Contact person at appointment site
- Other special instructions

California Relay Service (CRS) for Members with Hearing or Speech Loss
California Relay Service (CRS) is an exchange service that can be used to contact a member. A member can also use the services to contact his/her provider. CRS enables a person using a TTY to communicate with a person who does not use a TTY by phone. The service also works in reverse by allowing a non-TTY user to call a TTY user. Trained relay operators are on-line to relay the conversation as it takes place.

PPGs and network providers can call the CRS directly for members with hearing or speech loss. The statewide access for voice or Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) is 1-888-877-5379 voice (SPRINT) or 1-800-735-2922 voice (MCI).

Translation Services
L.A. Care provides limited English proficient (LEP) members with written member informing materials in the member's identified primary threshold language. Threshold languages for Medi-Cal are English, Spanish, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Threshold languages for Healthy Kids are English, Spanish, and Korean.

L.A. Care provides templates of translated notice of action (NOA) letters to PPGs.

Cultural and Linguistic Services Trainings
L.A. Care offers ongoing cultural competency trainings on a variety of topics to network providers and their staff. Trainings are conducted on an as needed basis and cover topics such as:

- Knowledge of L.A. Care's policies and procedures for language assistance
- Working effectively with LEP members
- Working effectively with interpreters
- Understanding cultural diversity and sensitivity to cultural differences relevant to the delivery of health care interpreting services
- Working with special needs populations, including seniors and people with disabilities
- Understanding health disparities and cultural awareness

Cultural and Linguistic Resources

Language Skills Assessment Tool
L.A. Care, Plan Partners, and the ICE collaborative have developed an Employee Language Skills Assessment Tool for provider offices to use in documenting language proficiency of providers and staff. The tool can be downloaded through L.A. Care's website at http://www.lacare.org/providers/resources/downloadableforms.

Interpreting Services Poster
L.A. Care makes available and routinely distributes translated signage promoting interpreting services to provider offices. Provider offices are required to post the signage prominently in the medical office. Copies of the translated poster can be ordered through the online Health Education, Cultural and Linguistic Services Materials Order Form at: http://www.lacare.org/providers/resources/healtheducation/order-form

Complaint/Grievance Forms
Grievance forms in threshold languages are available on the L.A. Care website at http://www.lacare.org/grievancelocalization. Members have the right to file a complaint or grievance if they've been denied interpreting services or if the member information was not available in their primary language in

written format or over the phone. All complaints are filed with L.A. Care's Member Services Department and are routed to the appropriate areas within the organization.

L.A. Care Community Resource Directory

L.A. Care ensures that members are referred to culturally and linguistically appropriate community services through use of the L.A. Care Community Resource Directory. L.A. Care staff, primary care physicians, and PPG staff may refer L.A. Care members to services by using the online Community Resource Directory accessible through the L.A. Care website: http://www.lacare.org/providers/resources/crd.

Cultural and Linguistic Requirements

Provider Education

The provider network must be regularly educated on cultural and linguistic requirements, services and available resources. L.A. Care Health Plan shares this responsibility with PPGs.

Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and special trainings.

PPGs are required to educate providers on the following topics:

- Upcoming C&L related trainings offered by L.A. Care
- C&L requirements, including:
  - Posting of the interpreter poster at provider office sites
  - Maintaining language proficiency and qualifications of bilingual staff on file
  - Ensuring 24-hour access to interpreting services at all points of contact, including after-hours services
  - Documentation of the member's preferred language in the medical record
  - Documenting request/refusal of interpreting services in the medical record
  - Processes for filing a grievance if a patient's language needs are not met
- C&L resources including:
  - The online searchable Community Resource Directory
  - The online Health Education, Cultural and Linguistic Services materials order form.

L.A. Care routinely makes promotional/educational materials available for PPGs to assist them in educating providers of C&L requirements, services, and resources. Additional provider tools can be found on L.A. Care's website under the "Provider Resources" section.

Interpreting Services

PPGs and network providers must utilize qualified interpreters when communicating with limited English proficient (LEP) L.A. Care members. Qualified interpreters can be accessed through L.A. Care Health Plan. PPGs may choose to contract with a professional interpreting services vendor to communicate with members. If a PPG chooses to contract with an interpreting services vendor, PPG must ensure that services are provided by qualified interpreters. In addition, PPG must submit an annual detailed tracking report of all interpreting services provided to L.A. Care members quarterly L.A. Care Health Plan providers shall not require, or suggest to, LEP members that they provide their own interpreter. A member may choose to use a relative or friend as an interpreter after they are informed of the right to free interpreting services. If a member refuses professional interpreting services, this refusal and the member's request to use a family member or friend must be

documented in the medical chart. Use of minors as interpreters is not allowed except in extraordinary circumstances such as medical emergencies.

Translation Services

PPGs are responsible for ensuring NOA letters are routinely sent to members in their preferred threshold language. If the PPG develops a member informing material, PPG is responsible for translating the material into threshold language(s) and sending it to the member in the appropriate language. Any material that is sent in English must include a notice that has been translated into the threshold language(s) informing the member of the availability of translation and interpreting services.

PPGs must ensure all translations are completed by qualified translators and follow the process outlined in MMCD policy letter 99-04. If the PPG translates materials, the PPG must obtain a signed form from the translator attesting to the accuracy and completeness of the translation. PPGs must keep the original (English) text, the translated document, and the attestation form on file for review. Quarterly, PPGs are required to submit a translation tracking report to L.A. Care.

Training

PPGs are required to inform network providers about upcoming trainings and available resources. PPG staff members are also required to attend L.A. Care Health Plan's cultural competency trainings.

Assessing Proficiency of Bilingual Staff

PPG and provider office staff members who communicate with members in a language other than English must be qualified and formally assessed for their capabilities. PPGs and provider offices must keep evidence of the results of formal language assessments on file. This information must be updated annually for provider office staff and every three years for providers, at a minimum.

If bilingual staff members are providing interpreting services for members, the following documentation must be available for review:

- Written or oral assessment of bilingual skills
- Documentation of the number of years of employment the individual has as an interpreter
- Documentation of successful completion of a specific type of interpreter training program
- Other reasonable alternative documentation of interpreter capability.

PPG Reporting

Annually, by January 31, PPGs must submit a report to L.A. Care containing the following information:

- A list of bilingual staff, including the following information:
  - Name
  - Title/Department
  - Language Spoken
  - Level of proficiency (using the ICE Employee Language Skills Assessment Tool)
  - Documentation of successful completion of an interpreter training program.

Quarterly, PPGs must submit reports to L.A. Care containing the following information:

- Log of interpreting services provided to L.A. Care members (if PPG chooses to utilize their own vendors)
- Tracking log of all documents translated, including document title, language(s) translated into, type of document, product line, and date sent to the member

PROVIDER EDUCATION/TRAINING

PPGs are responsible for educating network providers on cultural and linguistic requirements, programs, and services. PPGs are also required to attend and promote cultural competency trainings made available by L.A. Care.

Supporting documentation of provider education must be available for review and must include:

- Copies of program handouts or correspondence
- Sign-in sheets
- Agenda/ Training Outline
- Meeting minutes
- Evaluation

MONITORING/COMPLIANCE

PPGs are required to develop and distribute policies and procedures that outline all cultural and linguistic requirements listed in this provider manual. PPGs are also responsible for provider education and oversight to ensure full compliance with State and Federal regulatory requirements.

11.0 FINANCE (THE FOLLOWING GUIDELINES APPLY TO HEALTHY KIDS AND MEDI-CAL)

Under contractual agreement, each month L.A. Care and Participating Physician Groups (PPGs) accept capitated payments for the provision of health services to L.A. Care members, regardless of how frequently members access services. This section covers guidelines for financial reports requirements, capitation and other related issues.

CAPITATION PAYMENTS

One-hundred percent (100%) of capitation payments will be remitted to a PPG no later than the tenth (10th) business day after receipt of the funds by L.A. Care from the payer for that specific month of eligibility (except as defined in "Financial Security Requirements," and "Assumption of Financial Risk"). The payments will constitute payment in full for health care and administration services rendered under the PPG's L.A. Care Services Agreement.

For further information regarding PPG compensation, please refer to the Capitation Schedule of the L.A. Care Physician Capitated Services Agreement.

CAPITATION STATEMENT REPORT

A Capitation Statement Report will be placed on a protected PPG web site on or before the tenth (10th) business day of every month. The Capitation Statement Report will provide a summary of the capitation payment for each enrolled member assigned to each PPG, and will include the following information:

- Number of current active enrollees (initial eligibles)
- Number of retroactive disenrollments (decaps). This number represents the number of retroactive disenrollment months processed
- Capitation amount
- Capitation total

The Capitation Statement Report is also used to create the Group Capitation Payment Summary Report.

INSURANCE

Each PPG is responsible for total costs, except as provided herein, for care rendered to members enrolled with that PPG under the terms of its Services Agreement with L.A. Care. The PPG must maintain adequate insurance set forth in the following:

Professional Liability Insurance

The PPG has, and shall maintain at its expense throughout the term of this Agreement, Professional Liability Insurance for each employed physician with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate for the year of coverage or such other amount acceptable and permitted by Health Plan in writing. PPG shall provide copies of insurance policies within five (5) business days of a written request by Health Plan.

FTCA Alternative

In lieu of providing Professional Liability Insurance as set forth in Section 11.3.1, a PPG may provide Health Plan with evidence of liability protection under the Federal Tort Claims Act by the Bureau of Primary Health Care in accordance with Section 224(h) of the Public Health Service Act, 42 U.S.C. 233(h), as amended ("FTCA Coverage"). However, a PPG shall ensure that only those providers covered pursuant to section 11.3.1 or under FTCA Coverage may provide provider services to members.

Reinsurance/Stop-Loss Insurance

The PPG must maintain adequate stop-loss insurance to cover PPG's catastrophic cases in an amount

reasonably acceptable to L.A. Care, but in no event less than thirty thousand dollars ($30,000) plus fifty percent (50%) of any medically necessary billed charges. The cost of the PPG's reinsurance/stop-loss coverage is the PPG's sole financial responsibility.

General Liability Insurance
The PPG shall maintain general liability insurance in at least the minimum amounts acceptable to L.A. Care to cover any property loss that is not covered under any lease agreement with the landlord, or contract agreement with the management company. The limits of liability shall not be less than $100,000for each claim and $300,000 in aggregate under each policy period.

Errors and Omissions
The PPG shall maintain Errors and Omissions (E&O) Insurance that covers the claims made against managed care activities. The insurance policy shall be written on a claim made basis. The limits of liability shall not be less than $100,000 for each claim and $100,000 in aggregate for each policy period.

Directors and Officers
The PPG shall maintain Directors and Officers (D&O) that covers claims made against directors and officers of the company. The insurance policy shall be written on a claim made basis. The limits of liability shall not be less than $100,000 for each claim and $100,000 in aggregate for each policy period.

Independent Certified Public Accounting Firm Liability Insurance
PPG shall ensure that all Independent Certified Public Accounting Firm conducting audits on PPG's financial statements maintain at its expense throughout the Term of this Agreement, Liability Insurance with limits of not less than two hundred and fifty thousand dollars ($250,000.00) in aggregate for the year of coverage or such other amount acceptable and permitted by Health Plan in writing. PPG shall provide copies of such insurance policies within five (5) business days of a written request by Health Plan.

MINIMUM FINANCIAL SOLVENCY STANDARDS
Each PPG must maintain adequate financial resources to meet its obligations as they become due. PPGs contracted with L.A. Care shall be solvent at all times, and shall maintain the following minimum financial solvency standards:

- Prepare quarterly financial statements in accordance with Generally Accepted Accounting Principles (GAAP). These financial statements, including but not limited to, a Balance Sheet, a Statement of Income, and a Statement of Cash flow must be submitted to the Financial Compliance department of L.A. Care no later than forty-five (45) calendar days after the close of each quarter of the fiscal year.
- Process claims in a timely manner.
    - Medi-Cal Line of Business: Reimburse, contest, or deny at least ninety percent (90%) of all claims within thirty (30) calendar days, ninety-five percent (95%) within forty-five (45) working days, and ninety-nine percent (99%) of all clean claims within ninety (90) calendar days or in accordance with applicable law, regulation and contractual timeliness requirements.
    - Healthy Kids: Reimburse, contest, or deny at least ninety-five percent (95%) of all claims within forty-five (45) working days or in accordance with applicable law, regulation and contractual timeliness requirements.
- Estimate and document, on a monthly basis, the organization's liability for incurred, but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method as stipulated by Title 28, California Code of Regulations, Section 1300.77.2.
- Maintain, at all times, a positive Working Capital (current assets net of related party receivables less

current liabilities).

- Maintain, at all times, a positive Tangible Net Equity (TNE) as defined in Title 28, California Code of Regulations, Section 1300.76(e).
- Maintain a "Cash to Claims ratio" (cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within 60 days divided by the organization's unpaid claims) unpaid claims are payable and incurred but not reported (IBNR) claims) as listed per SB 260 Title 28, California Code of Regulations, Section 1300.75.4.2. Maintain at all times a "cash to claims ratio" of .60 as of January 1, 2006, .65 as of July 1, 2006 and .75 as of January 1, 2007.
- On an annual basis, submit to the Financial Compliance department of L.A. Care, financial statements, including but not limited to a Balance Sheet, a Statement of Income, and a Statement of Cash Flow, audited by an independent Certified Public Accounting Firm within one-hundred fifty (150) calendar days after the close of the fiscal year.

Each PPG must actively monitor its providers to measure their financial stability. Copies of all reports, including findings, recommendations, corrective action plans, and other information regarding these reviews must be provided to L.A. Care upon request.

On a discretionary basis, the Financial Compliance department of L.A. Care will have the right to periodically schedule audits to ensure compliance with the above requirements including all regulations per SB 260 Title 28, California Code of Regulation requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the line(s) of business contracted with L.A. Care. Representatives of the PPGs shall facilitate access to records necessary to complete the audit.

Collaboration of Financial Auditing Activities:
To reduce the duplication of the annual financial audit(s) and ER delegation audits of PPGs by the Plan(s), L.A. Care Health Plan andCare 1st Health Plan (Participating Plan Partners) have agreed to conduct only one financial audit and one ER delegation audit annually per PPG. The audits will be conducted by the designated Plan, as detailed in L.A. Care Policies and Procedures, and the audit results and work papers shall be made available for review by the Plans.

If the PPG is contracted with one or more of the Participating Plan Partners, the PPG agrees to: (a) allow the sharing of the audit results among the participating Plan Partners; (b) give L.A. Care the authority to use the ER delegation audit results of our participating Plan Partner to delegate/de-delegate the PPG with all the participating Plan Partners; (c) give L.A. Care the authority to use Medi-Cal Emergency Services (ER) claims payment audit results as a criteria to delegate or de-delegate the ER claims payment function for its Medi-Cal line of business, Healthy Kids programs.

REIMBURSEMENT SERVICES AND REPORTS

In accordance with the provisions of a PPG's Subcontracts, the PPG will provide all normal reimbursement services, including those relating to the payment of capitation, processing and payment of any claims on a fee-for-service basis, administration of any stop-loss and risk-sharing programs, and any other payment mechanisms. Claims processing may be delegated to PPGs in cases where utilization management is delegated.

Upon request, the PPG will provide to L.A. Care a copy of payment records, summaries and reconciliations with respect to L.A. Care members, along with any other payment compensation reports which the PPG customarily provides to its providers.

RECORDS, REPORTS, AND INSPECTION

Records

Each PPG will maintain all books, records, and other pertinent information that may be necessary to ensure the PPG's compliance with its L.A. Care Services Agreement, and the requirements of regulatory agencies which included the DMHC, for a period of five (5) years from the end of the fiscal period in which its Services Agreement with L.A. Care terminates. These books, records, and other information must be maintained in accordance with generally accepted accounting principles, applicable state law and regulations, MRMIB, DHCS and DMHC requirements.

These books and records will include, without limitation, all physical records originated or prepared pursuant to the performance under this contract including but not limited to:

- Working papers
- All reports submitted to DMHC
- Financial records
- All books of account
- Encounter data
- All medical records
- Hospital discharge summaries
- Medical charts and prescription files
- Any other documentation pertaining to medical and non-medical services rendered to members
- Records of Emergency Services and other information as reasonably requested by L.A. Care and DMHC to disclose the quality, appropriateness, and/or timeliness of health care services provided to members under the PPG's Physician Capitated Services Agreement
- PPG subcontracts
- Reports from other contracted and non-contracted providers
- Any reports deemed necessary by L.A. Care, regulatory agencies and DMHC to ensure compliance by L.A. Care with the requirements of the regulatory agencies and DMHC

Each PPG will maintain all books and records necessary to disclose how the PPG is fulfilling and discharging its obligations under their L.A. Care Services Agreement, and their responsibilities as defined by the regulatory agencies and DMHC. These books and records will be maintained to disclose the following:

- Quantity of covered services provided.
- Quality of those services.
- Method and amount of payment made for those services.
- Persons eligible to receive covered services.
- Method in which the PPG administered its daily business.
- Cost of administering its daily business.

Inspection of Records

PPGs will allow L.A. Care, DMHC, and any other authorized state and federal agencies to inspect, evaluate, and audit any and all books, records, and facilities maintained by the PPG and its providers as they pertain to services rendered under the PPG's Physician Capitated Services Agreement, at any time during normal business hours, subject to the confidentiality restrictions discussed in the PPG's Physician Capitated Services Agreement.

Records Retention Term

The PPG's books and records must be maintained for a minimum of five (5) years from the end of the fiscal year in which the PPG's contract with L.A. Care expires or is terminated. However, in the event the PPG has been duly notified that DMHC or other applicable regulatory agency has initiated an audit or investigation of L.A. Care, the PPG, or the Physician Capitated Services Agreement, the PPG will retain these records the greater of the above timeframe or until the matter under audit or investigation has been resolved.

Financial Statements
As required by Section 11.4 above, each PPG must provide L.A. Care with a copy of its Quarterly Financial Statements and Annual Audited Financial Statements. If requested, these financial documents, as well as any other reports required by DMHC, will be made available to DMHC and any other regulatory agencies.

This section is subject to change pursuant to receipt of supplemental regulations under Title 10.

12.0 CLAIMS

This section covers guidelines for claims processing and other claims related issues for Direct Line of Business Contracted Providers.

RESPONSIBILITY OF PARTICIPATING PROVIDERS

Contracted Providers, PPG's and Hospitals that have an agreement with L.A. Care are responsible to perform certain tasks for claims under the terms of their agreement in L.A. Care's Medi-Cal, and Healthy Kids Programs. PPG's and hospitals must be in compliance with Title 28 of the California Code of Regulations (CCR), Section 1300.71 Claims Settlement Practices (and with 42 U.S.C. Section 1396a(a)(37)(A) and Title 22 of the CCR, Section 51008 for the Medi-Cal program), and other applicable Federal and State regulations.

After reviewing this section, please refer to "Exhibit B – Division of Responsibility" in the agreement between the Provider, PPGs or Hospital and L.A. Care, to determine what entity is responsible for specific claims. Exhibit 14 specifies which health care services are the financial responsibility of L.A. Care, and which are the financial responsibility of the Provider, PPG's or Hospital. The Provider, PPG or Hospital is responsible for handling all claims for those services they have financial responsibility.

COLLECTION OF CHARGES FROM MEMBERS

Balance billing of L.A. Care members is prohibited by law in most circumstances. Neither the contracted Provider, PPG, Hospital nor any of its providers will in any event submit a demand or otherwise collect reimbursement from an L.A. Care member or persons acting on behalf of a member for any services provided pursuant to their L.A. Care Participating Physician Group Services Agreement, Section 3.11 Reimbursement/Subrogation, except to collect any authorized co-payments.

THIRD PARTY LIABILITY/ESTATE RECOVERY

Neither the contracted Provider/Hospital nor any of its providers will attempt recovery in circumstances involving third party tort liability (TPL) or estate recovery for a Medi-Cal member. The PPG or Hospital will notify L.A. Care immediately upon discovery of a potential TPL case and coordinate its recovery activities with L.A. Care for Healthy Kids members.

Accidents or illnesses, which may result in third party tort liability/estate recovery will be reported to L.A. Care within five (5) business days of discovery by the PPG. If L.A. Care requests details of the services provided, the PPG will deliver the following information within ten days of the date of the request and will include the following information:

- Member name
- Complete CIN # (Client Identification Number)
- Social Security number
- Date of birth
- PPG provider name
- Date(s) of service
- Diagnosis code and/or description of illness/injury
- Procedure code and/or description of services rendered
- Amount billed by a subcontractor or out-of-plan provider to PPG (if applicable)
- Amount paid by other health insurance to PPG or subcontractor Amount and date paid by PPG to subcontractor out-of-plan provider (if applicable)
- Date of denial and reasons (if applicable)

Finally, if the provider, PPG or hospital receives any request by subpoena from attorneys, insurers, or beneficiaries for copies of bills, they will provide L.A. Care with a copy of any document released, and will

provide the name, address, and telephone number of the requesting party within five days of compliance with the request.

- For Medi-Cal TPL or estate recoveries, the State Department of Health Care services retain lien/claim rights over any recoveries for Medi-Cal members.

- For Healthy Kids, L.A. Care retains lien/claim rights over third party tort liability and estate recovery for Healthy Kids members.

L.A. Care's Participating Physician Group Services Agreement, Section 3.11 Reimbursement/ Subrogation, covers all other instances.

IMPLEMENTATION GUIDELINES:

- When a claims is received and it is determined that the injuries are a result of a third party, the claim will be processed and paid normally. After L.A. Care is informed of a TPL case, it will notify the member or legal representative that reimbursement be made upon receipt of any payments from the third party, whether by action at law, settlement or otherwise.
- If the member or their legal representative is unresponsive or uncooperative, the decision will be made whether legal action must be pursued.

CLAIMS SUBMISSION

Submitted claims must be completed with all required information to ensure timely processing and payment as stipulated in the provider's contract.

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 forms for facility services.

Claim Filing Limit

The provider shall bill using appropriate forms and in a manner acceptable to L.A. Care within the filing limit specified in the provider's Participating Physician Group Services Agreement.

L.A. Care's Claims Submission Address

In order to determine who is responsible for paying a claim, please refer to Exhibit B, the Division of Financial Responsibility, in your company's contract with L.A. Care. The Division of Financial Responsibility specifies what entity is responsible for paying a claim.

If you have a question about where to send a claim, please call L.A. Care's Provider Information Line. You will access our Interactive Voice Recognition (IVR) system that will guide you to one of our Provider Network Representatives that can assist.

For all claims for which L.A. Care is financially responsible, please mail the claims to:

L.A. Care Health Plan
Attn: Claims Dept.
P.O. Box 811580
Los Angeles, CA 90081

Claim Status Inquiries

Please be advised that you may inquire about the status of a claim, including the date of receipt, for which L.A.

Care is financially responsible by calling **1-866-LA-CARE6.**

CLAIMS PROCESSING

Claims processing by PPG (delegated or otherwise) must meet L.A. Care's Claims requirements and procedures and including but not limited to the specifications described below:

Fee-For-Service Claims System

The PPG's claim processing system must be designed so that data for all claims received for reimbursement on a fee-for-service basis are maintained and accounted for in a way that allows for the determination of the date of receipt, date and amount of paid, the status or resolution of any claim, the dollar amount of unpaid claims, and the rapid retrieval of any claim.

Claim status or resolution categories include, but are not limited to:

- To be processed
- Processed, waiting for payment
- Pending, waiting for approval for payment or denial
- Pending, waiting for additional information
- Denied
- Paid
- Other, if appropriate

The system used could involve either a claims log, claims numbering system, electronic data processing records, and/or any other method approved by L.A. Care.

Payment for Out-of-Plan and Emergency Services

If a PPG is delegated to pay such claims, PPGs must ensure the timely and appropriate payment for all authorized and non-authorized emergency services that meet the definition of "Emergency Services" as defined Article I of the Services Agreement and by the California Code of Regulations, Title 22, Division 3, Chapter 4, Article 7, Section 53622. Please be aware that balance billing of L.A. Care members is prohibited by law in most circumstances.

Provider Claims

Each PPG must operate its claims processing system in a manner which ensures the timely payment of claims to providers of authorized health care services, including contracted providers and non-contracted providers, within regulatory requirements.

Medi-Cal Claims must be paid within thirty (30) calendar days of the receipt of a complete claim.

Healthy Kids claims must be paid within the State requirement of forty-five (45) working days.

A PPG's claims processing payments systems must also reasonably determine the status of received claims and calculate provisions for Incurred But Not Reported (IBNR) claims.

All records regarding fee-for-service reimbursement must be maintained in accordance with the provisions of California Code of Regulations, Title 28, Chapter 2, Article 9, Section 1300.77.4.

If a claim is contested, the PPG must give notice to providers within thirty (30) calendar days of receipt. In addition, the PPG must retain a file copy of the notices sent and make them available for review upon request by L.A. Care.

Member Claims

PPGs will pay uncontested claims for emergency services or other health care services for which a member has been billed within thirty (30) calendar days. If a claim is contested by the PPG, the PPG must notify the member that the claim is being contested within thirty (30) calendar days of the date the claim was received by the PPG. The notice will identify the portion of the claim that is being contested and the specific reasons for contesting the claim. Upon request, PPGs will provide L.A. Care a copy of the notice.

L.A. Care, at its option, may monitor the claim resolution process and facilitate the resolution of any member claim disputes.

The PPG shall process and pay claims for emergency services, as appropriate, for all services medically necessary to diagnose and stabilize the patient without prior authorization pursuant to California Code of Regulations, Title 28, Division 1, Chapter 2, Article 8, Section1300.71.4.

Hospital Emergency Departments (ED) under Federal and State laws are mandated to perform a Medical Screening Examination (MSE) on all patients presenting to the ED and to treat all patients with emergency conditions. The PPG is required to reimburse the ED and the emergency physician for the MSE without prior authorization regardless of the outcome of the MSE.

Aging Schedule of Outstanding PPG Member Claims

Upon request, PPGs will provide an aging schedule of outstanding/unpaid claims from contracted and non-contracted providers submitted for payment, and from subscribers and enrollees for reimbursement. This report will include a brief summary explanation of the reason(s) any claim remains unpaid for longer than thirty (30) calendar days.

PROVIDER AND MEMBER CLAIMS DISPUTE, GRIEVANCE, AND APPEALS PROCESS

If delegated for grievance, and appeals processing, the PPG will implement a grievance and appeals process for review of provider and member claims disputes that comply with the time limits and other requirements of California Code of Regulations, Title 28, Division 1, Chapter 2, Article 8, Section 1300.68. This dispute procedure, and any amendments, must be approved by L.A. Care and meet State Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) regulatory requirements, as appropriate. If not delegated for grievance, and appeals processing, the PPG will promptly forward any grievances or appeals relieved at their office to L.A. Care's Grievance and Appeals Coordination Unit.

L.A. Care provides an additional level of grievance appeal above that which exists at the PPG level. Claim disputes which are unresolved or for which the disposition of the PPG is unsatisfactory to the provider or member may be submitted to L.A. Care for further consideration. (In cases of delegation, they should first be considered by the PPG, and in turn by L.A. Care if the provider or member chooses). Claims grievance appeals must be submitted to the Member Services department of L.A. Care. Claims will be triaged by an appropriate health care professional and subsequently considered by clinical, member services or provider network operations staff, as appropriate. Resolving claims grievance appeals may take up to forty-five (45) calendar days. L.A. Care has the ability to pay and deduct for claims not paid or inadequately by a PPG when a service is the PPG's financial responsibility or when the PPG or its contracted providers improperly authorize a service that would otherwise be L.A. Care's financial responsibility.

Claim denial or Notice of Decision letters issued by PPGs must fully describe the grievance and grievance appeal process. This must include a description of timelines as well as higher levels of consideration, including L.A. Care and DMHC. The address for such reconsideration is:

Grievance and Appeals Coordination Unit
P.O. Box 811640
Los Angeles, CA 90081

When L.A. Care is processing a provider dispute or a grievance or an appeal involving the actions or inaction of the PPG, the PPG will respond to L.A. Care's requests for information within 10 working days or sooner if required for compliance with regulatory requirements. If the PPG does not respond within that time-frame or the response is inappropriate, L.A. Care retains the right to pay and deduct from the PPG's capitation whatever amount is necessary to satisfy any member or provider claims, which are the subject of the dispute, appeal or grievance. Further, unless the PPG provides to L.A. Care a copy of its provider contract showing a lower amount in advance of such claims payment, then L.A. Care will pay the provider the either L.A. Care's contracted rate for that provider or the amount required to satisfy state payment requirements for non-contracted providers.

CLAIMS TIMELINESS REPORTS

PPGs shall provide an aging schedule of provider and member claims disputes, no later than twenty-five (25) business days following the end of each fiscal quarter. This report will include a brief summary explanation of the reason(s) any claim remains unpaid for longer than thirty (30) business days. The information should be mailed to:

L.A. Care Health Plan
Attn: Financial Compliance
1055 West 7th Street – 10th Floor
Los Angeles, CA 90017

In addition to submitting these Claims Timeliness Reports, PPG's must provide L.A. Care appropriate reports, findings, recommendations, corrective action plans, and other pertinent

13.0 MARKETING

The following guidelines apply to the Healthy Kids and Medi-Cal lines of business

RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs) must receive prior approval from L.A. Care's Marketing Department to design and implement Medi-Cal marketing materials and activities.

PPG MARKETING MATERIALS AND ACTIVITIES

L.A. Care must approve all PPG-created marketing materials and activity plans that:

- Mention Medi-Cal or Healthy Kids
- Include the L.A. Care name or logo

Submission should be made to the Provider Networks Operations department. Provider Networks Operations will secure Marketing leadership approvals and forward to the Regulatory Affairs & Compliance department for submittal of materials and activity plans to the Department of Health Care Services (DHCS) and to the Legal department for submittal of materials and activity plans to the Department of Health Care Services (DHCS) or the Managed Risk Medical Insurance Board (MRMIB) for approval when applicable. Upon receipt of approvals, the Provider Networks Operations department will notify the PPG regarding implementation and use of materials.

Violation of regulatory guidelines and L.A. Care approval policy will not be tolerated.

By distributing this manual, L.A. Care is providing all PPGs with written policies and procedures for obtaining approval on provider-created Medi-Cal marketing materials. PPGs shall be held responsible for ensuring marketing materials and activities of their contracted providers are reviewed and approved prior to use. L.A. Care Marketing Department will ensure that Provider Network Operations has access to the L.A. Care's Corporate Brand and Identity Guidelines to make organizational requirements easy to understand and to ensure compliance.

GUIDELINES

PPGs must adhere to the guidelines set forth below prior to engaging in marketing activities:

- All marketing materials must identify L.A. Care as L.A. Care Health Plan. Notice that there is no space after the period in "L."
- PPG marketing directed at members or potential members must be at the 6th grade reading level or below and include the L.A. Care logo containing the ® mark and must adhere to the specific graphic standards provided by L.A. Care.
- PPGs will ensure that all materials are ethnically and culturally sensitive, and linguistically competent. (See Section 10 of this manual, Cultural & Linguistic Services) This will be verified by the Marketing Department to ensure that materials meet the graphic standards and requirements for all languages.

Continuous monitoring of marketing activities by PPGs shall be the responsibility of L.A. Care's Marketing Department in collaboration with Provider Network Operations, whereas continuous monitoring of marketing activities by the PPG's contracted providers shall be the responsibility of the PPGs within the guidelines as set forth by L.A. Care.

Any discovered acts of marketing abuse (fraud) will result in immediate penalties that may include, but are not limited to, sanctions up to and including an inability to use L.A. Care's name, logo and branding.

MATERIAL SUBMISSION

Provider Responsibilities

Contracted providers must submit a set (copy) of the proposed materials for review and approval to their PPG(s) using these guidelines:

- Materials that do not reference a PPG's name or logo, but do mention L.A. Care's Medi-Cal and/or Healthy Kids programs, can be submitted to one PPG.
- Materials referencing PPG(s) or including their logo(s) must be submitted to those PPGs for approval.
- Contracted provider submissions sent directly to L.A. Care for approval will not be accepted.
- All material submissions must be in final composition, be legible and contain actual copy and photos. Rough drafts or incomplete ideas will not be accepted.
- All submissions must include a brief material description including the intended use(s),distribution and readability score.
- Materials should be submitted at least two (2) months in advance of intended use.
- Once materials have been approved, they can be reused as long as there are no material changes in the content. Dates and locations are not considered material.
- Providers should allow at least two (2) months for a response to submissions which takes into account regulatory reviews.

PPG Responsibilities:

PPGs are responsible for informing their providers that no marketing materials are to be used and/or activities engaged in without prior consent from L.A. Care.

The procedures are as follows:

- Upon receiving provider material submissions, PPGs should review documents for clarity and accuracy of information. Upon completing review and before final authorization is given to the provider, PPGs shall forward materials to L.A. Care's Provider Network Operations department for submission to Marketing for review and approval. A signature of approval by the PPG should be included.
- PPGs shall review all responses from L.A. Care and communicate in writing; within seven (7) calendar days should they disagree with the findings.
- PPGs must maintain all responses received from contracted providers and L.A. Care for future reference.
- PPGs are responsible for monitoring provider outreach activities as well as marketing material development, usage and distribution.
- PPGs shall immediately provide written notification to L.A. Care's Communication and Marketing department regarding any marketing violations, and should supply documentation when possible.
- Materials that must be approved include but are not limited to: − General advertising used to reach prospects and patients. − Tactical advertising with PPG names and/or logos. − Collateral items such as brochures, pamphlets, fliers and promotional items.

L.A. Care Responsibilities

L.A. Care shall provide PPGs with L.A. Care's Corporate Brand and Identity Guidelines. In addition, L.A. Care shall maintain oversight accountability for marketing materials and activities implemented by PPGs and contracted providers.

L.A. Care's Provider Network Operations department shall provide initial review and those materials that pass their review shall be forwarded to Marketing with a requested date of return. Organizationally, all submitted

materials shall be responded to within one (1) month of receipt. All applicable materials will then be forwarded to the appropriate regulatory agency for final approval. Material review responses shall be based on the following:

PPG Submissions

- Proposed materials have not been produced and/or used prior to receiving necessary approvals.
- Submissions of proposed materials that mention L.A. Care include the L.A. Care logo.
- Materials referencing other PPGs or organizations, by name or logo, must include authorized signatures from those providers confirming approval to use their name, etc.
- All material submissions must be in final composition, be legible and contain actual copy and photos. Rough drafts or incomplete ideas will not be accepted.
- All submissions must include a brief material description including the intended use(s), distribution and readability testing score.

Contracted Provider Submissions

- L.A. Care's Marketing Manager will review contracted provider submissions only after they have been reviewed by contracted PPGs.
- Contracted provider submissions sent directly to L.A. Care will not be accepted.
- Upon receipt of contracted provider submissions from PPGs, the Marketing Manager will review and determine whether further action is required to bring materials into compliance.
  Within two (2) months of receiving a PPG's materials for contracted providers, a written response of approval/non-approval (with explanation) shall be sent to the PPG. All materials will be stamped or identified with date of receipt to ensure compliance with turnaround timelines committed to.
- If a PPG disagrees with L.A. Care's findings, a written rebuttal should be submitted for reconsideration within seven (7) calendar days of receipt.
- L.A. Care's Marketing Manager will contact and provide written notification to PPGs found to be in violation of policies, requesting a cease of material or activity use, and warning of impending action for failing to adhere to policy.
- L.A. Care will investigate and forward violation information to the appropriate parties at L.A. Care or to the regulatory agencies (as needed) to determine liable party and if penalty is to be levied.

MEMBER EDUCATION

L.A. Care will develop and coordinate the distribution of educational materials focused on program benefits as well as improving members' overall health status and disease management. Materials will also be designed to increase awareness and choice for L.A. Care. Also see Section 9, Health Promotion and Education.

All materials will be culturally sensitive and linguistically competent and produced in the necessary threshold languages. See Section 10, Cultural & Linguistic Services for details.

MARKETING STAFF

Marketing managed care services to prospects and members is strictly regulated and monitored by regulatory agencies. Therefore, PPGs must adhere to the L.A. Care requirements, stated below, regarding their marketing staff:

L.A. Care and PPG staff who have regular contact with prospects and members should also be knowledgeable, principled and skilled in marketing, including material development, approval processes, marketing ethics and regulatory agencies' marketing guidelines. In addition, L.A. Care, PPG and contracted provider staff working as marketing representatives shall adhere to all regulatory agency guidelines related to appropriate marketing activities and solicitation of eligible applicants, as well as marketing violations.

MARKETING GUIDELINES FOR CONTRACTED PROVIDERS

Do's	Don'ts
Submit all potential marketing materials and planned activities to L.A. Care's Provider Networks Operations department to secure necessary approval priors to implementation.	Engage in marketing activities or use materials without prior written approval from L.A. Care and the appropriate regulating agency*.
Provide L.A. Care at least two months for review of materials submissions. Ensure that materials accurately describe the program and your involvement.	Misrepresent your business, yourself, Medi-Cal, L.A. Care or any health care agency or health plan through false statements or claims, or misrepresent or disparage the program or other health plans.
Ensure the language and information used in marketing materials is clear, simple (6th grade reading level) and communicates that enrollees have choices.	Mislead enrollees to entice them to select a specific doctor or medical facility. Make disparaging written/oral statements aimed at competitors – including the use of false performance data for comparison.
Ensure that staff who come in contact with Medi-Cal members have had appropriate marketing training and understand guidelines, set forth by L.A. Care and regulatory agencies.	Use information that has derogatory language, comments or implications or that makes misleading comparisons. Also, do not use any satisfaction or "Best Plan" data that is not substantiated by a credible third party and that is solely based on the contracting plan's assessment of itself and competitors.
Ensure that L.A. Care Health Plan marketing materials given to you are consistently available for distribution to members or prospective members.	Make any claims that a health plan or medical facility has been endorsed or recommended by L.A. Care, a governing agency or organization that has not certified its endorsement in writing.
Forward L.A. Care an MOU (Memorandum of Understanding) or a letter of agreement regarding intended marketing activities taking place on your premises or any other facility which you may be participating in.	Offer monetary or like incentives to prospects as an enticement to enroll with a contracted health plan or to become a patient at your medical facility. Engage in marketing activity on any unauthorized premises.
Review and follow marketing policies and procedures located in the Provider Manual.	Coerce, intimidate or threaten prospects into enrolling with a health plan or to choose your medical facility
Ensure marketing efforts are done appropriately within outlined guidelines and do not violate governing regulations.	Allow staff or pay independent agents to engage in door-to-door marketing, solicit via phone or mail to enroll with a health plan or to select your facility

Make sure staff involved in marketing material development and activities are trained and have a copy of the marketing policies and procedures and adhere to the L.A. Care Corporate Branding and Identity Guidelines.	Engage in marketing practices that discriminate against prospective members based on race, creed, color, marital status, religion, age, sex, national origin, sexual orientation, ancestry, pre-existing physical or mental handicap or health status

*Providers: Applicable prior authorization of materials by DHCS, DMHC and/or MRMIB as needed.

14.0 ENCOUNTER DATA

THE FOLLOWING GUIDELINES APPLIES TO THE HEALTHY KIDS, MEDI-CAL AND MEDICARE PRODUCT LINES

Participating Physician Groups (PPGs) are responsible for gathering, processing, and submitting encounter data on all L.A. Care members.

Encounter Data is the primary source of information about the delivery of services provided by practitioners to L.A. Care members. Encounter data is utilized by the State to validate services provided and will be used by the state to determine future reimbursements to providers. Therefore, not reporting accurate Encounter Data may result in decreased rates paid by the State. When PPGs contracted with L.A. Care submit encounter data that is timely, accurate, and complete, L.A. Care staff is able to track utilized services and analyze the validity of capitation rates. This is a very important source of information for determining needed changes and improvements in health related programs administered at L.A. Care. L.A. Care will also use encounter data for monitoring and oversight functions including HEDIS reporting and meeting various regulatory requirements.

L.A. Care has contracted with Diversified Data Design (DDD), a data clearinghouse company, to assist PPGs with the proper formatting timely and accurate submission of encounter data. PPGs must submit encounter data directly to Diversified Data Design.

REQUIREMENTS

PPGs are required to submit encounter data for encounters between its providers and L.A. Care members to L.A. Care within sixty (60) business days after the end of the month in which the encounter occurred.

The encounter data must be submitted in an electronic format in accordance with the encounter data specifications established by Diversified Data Design. When a PPG uses Diversified Data Design to process its encounter data, Diversified Data Design will convert the PPG's encounter data into the appropriate format to meet L.A. Care's specifications. If a PPG is contracted with L.A. Care for more than one product, the encounter data needs to be submitted separately by product line.

PPGs must use Diversified Data Design's services under the below mentioned terms and conditions free of charge. L.A. Care will reimburse Diversified Data Design for services rendered to all contracted PPGs. Listed below is Diversified Data Design's contact information.

Diversified Data Design
5875 Green Valley Circle
Culver City, CA 90230
(310) 973-2880
Contact: Noelle Clark Porter or Horace Clark

USE OF DIVERSIFIED DATA DESIGN SERVICES

PPGs are required to:

- Submit data to Diversified Data Design within the parameters required by Diversified Data Design.
- Submit data to Diversified Data Design within timeframes to ensure routine and timely submission of encounter data to L.A. Care.
- Provide a completed encounter data batch cover sheet, which is designed to facilitate an accurate accounting of encounter data submissions, to Provider Network Operations' Business Analyst concurrently with the submission to Diversified Data Design.

15.0 COMPLIANCE

L.A. Care's Compliance Program is designed to ensure the provision of quality health care services to all L.A. Care members. This is achieved through a variety of compliance activities. L.A. Care's Compliance Program activities include:

- Auditing Oversight of Delegated Responsibilities
- Fraud & Abuse Prevention (through L.A. Care's Program Integrity Plan and the Special Investigation Unit discussed below)
- HIPAA Compliance (Privacy, Information Security and Electronic Transactions)
- Ongoing monitoring of quality health care services
- Education for PPGs about new legislation and other health care compliance requirements.

GOALS AND OBJECTIVES

The goal of L.A. Care's Compliance Program is to ensure that all L.A. Care Health Plan members receive appropriate and quality health care services through the provider network in compliance with all applicable California and federal rules and regulations as well as L.A. Care contractual requirements.

L.A. Care's Compliance Program:

- Provides oversight of delegated responsibilities to provider network.
- Implements corrective action plans with PPGs to address deficiencies in provision of health care services.
- Identifies and investigates potential fraud & abuse activities. Takes appropriate actions to resolve all fraud & abuse activities.
- Provides education and other available resources to assist PPGs in becoming compliant with HIPAA and Fraud and Abuse requirements.
- Conducts ongoing monitoring of provider network to assess quality of health care services provided to health plan members.
- Implements corrective actions as necessary to address identified deficiencies.
- Provides new legislation updates to PPGs that specify required actions to ensure contract compliance. Makes available additional information about compliance activities and requirements to PPGs on an on-going basis.
- Provides L. A. Care's latest Code of Conduct online training program at

http://www.lachp.org/compliance/coc_2010_ppg.nsf/coc_login

(When taking the online training, please log-in with your name, as well as the name of the organization before beginning.)

AUTHORITY AND RESPONSIBILITY

L.A. Care's Compliance Program strives to ensure compliance with California and federal rules and regulations, L.A. Care's payer contracts, and other standards as required by applicable regulatory agencies. This includes, but is not limited to, the following requirements as applicable to each PPG's contract with L.A. Care:

- Rules and regulations promulgated by and for the Department of Managed Health Care and the Department of Health Care Services.
- All applicable federal rules and regulations that apply to the provision of health care services.
- Federal and California governing law and legal rulings.
- Terms and conditions as set forth in L.A. Care's contracts with California and federal agencies, private foundations, and other payer organizations for the provision of health care services.
- Requirements established by L.A. Care and implemented with the PPG as stated in the PPG's contract with L.A. Care.

DELEGATION OF COMPLIANCE PROGRAM

L.A. Care does not delegate its Compliance Program responsibilities to a PPG. L.A. Care staff works with PPG staff to administer compliance activities and implement corrective actions to rectify deficiencies. PPG staff is encouraged to work with L.A. Care's compliance staff to ensure compliance with all program requirements.

AUDIT & OVERSIGHT ACTIVITIES

To ensure that all L.A. Care health plan members receive quality and appropriate health care services, L.A. Care staff performs an annual audit of contract responsibilities and services delegated by L.A. Care to the PPG. L.A. Care's audit program for delegated PPGs, includes but is not limited to, the following activities:

- Annual on-site visit to delegated PPGs to ensure that all delegated responsibilities and services are in compliance with program requirements.
- Ad-hoc on-site visits to review PPG activities to ensure compliance with program requirements.
- Ongoing monitoring through review of periodic reports and data required as outlined in the delegation agreement.
- PPGs shall maintain and provide to L.A. Care all books, records and information as may be necessary to demonstrate compliance with California, federal, and L.A. Care contractual requirements. Records include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and nonmedical services rendered to members, and such other information as reasonably requested by L.A. Care.

L. A. CARE'S PROGRAM INTEGRITY PLAN

L.A. Care Health Plan ("L.A. Care") recognizes the importance of preventing, detecting and investigating fraud and abuse. L.A. Care is committed to protecting and preserving the integrity and availability of health care resources for our Members, stakeholders, and business partners by maintaining a comprehensive Program Integrity Plan.

These responsibilities are delegated to the Special Investigation Unit (SIU), whose mission is to maintain adherence to the Program Integrity Plan to ensure the integrity of publicly funded programs.

What are Fraud and Abuse?

- **Fraud** is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Abuse** is defined as practices that are inconsistent with sound fiscal or business practices and sound medical practices and result in unnecessary cost to the federal Medicaid and Medicare programs.

Examples

Examples of fraud and abuse include:

Member/Beneficiaries:

- Changing, forging or altering a prescription
- Changing medical records
- Changing referral forms
- Letting someone else use their I.D. card to get medical services
- Misrepresentation of eligibility status
- Identity theft
- Prescription drug diversion and inappropriate use
- Resale of medications on the black market

- Prescription stockpiling
- Doctor shopping.

Prescriber/Provider:

- Lying about credentials
- Billing for services that were not done
- Billing a balance that is not allowed
- Double billing, upcoding, and unbundling
- Underutilization – not ordering services that are medically necessary
- Forging a signature on a contract
- Pre- or post-dating a contract
- Intentionally submitting false claims

Reporting Potentially Fraudulent Activities to L.A. Care

Under the terms of the contract between L.A. Care and the PPG, the PPG is required to report suspected cases of fraud and abuse.

There are four (4) ways in which PPGs can do this:

1. Through the Compliance Helpline
   - Call **1-800-400-4889 or file a report online at – www.lacare.ethicspoint.com.**. The Compliance Helpline is available 24 hours a day, 7 days a week and can be used by L.A. Care Board members, employees, contractors, providers , members and other interested persons to report all violations or suspected violations of law and/or the compliance program and/or questionable or unethical conduct or practices including, without limitation, the following:
     - Incidents of fraud and abuse
     - Criminal activity (fraud, kickback, embezzlement, theft, etc)
     - Conflict of interest issues
     - Code of Conduct violations
2. Through the Special Investigation Unit (SIU)
   - The Special Investigation Unit (SIU) is set up to handle all types of potentially fraudulent activities. You can access this by calling L.A. Care's Compliance Officer directly at **213-694-1250, ext. 4292.**
3. In Writing
   - You can mail a written letter regarding potentially fraudulent activities to L.A. Care at:

L.A. Care Health Plan Attn: Compliance Officer
Regulatory Affairs & Compliance
c/o Special Investigation Unit (SIU)
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

4. Call the Provider Inquiry Line:

If, for whatever reason, you are not able to report a potential fraud case by calling these phone numbers, please call L.A. Care's Provider Inquiry Line at 1-**866-522-2736.**

Referral Requirements

Regardless of what method you choose to use to report fraud or abuse to us, you should include the following:

- Name of Person Reporting Fraud (Optional, but highly recommended)
- Name, Address, License or Insurance ID of Subject (if known)
- Nature of Complaint
- Date of Incident(s)
- Supporting Documentation (Optional)

If fraud or abuse is found, the fraudulent incident or activity is reported to the appropriate outside law enforcement and/or regulatory agency.

To learn more about Fraud and Abuse or how to report it to the government, please go to:
www.stopmedi-calfraud.dhs.ca.gov or call the Medi-Cal Fraud Hotline at **1-800-822-6222**.
You can also visit www.stopmedicare.fraud.gov.

Communication of L.A. Care's Fraud and Abuse Detection Efforts
L.A. Care uses various means to educate its provider network and membership about its fraud and abuse detection and prevention efforts. Information about L.A. Care's fraud and abuse detection activities is communicated in some of the following ways: provider bulletins; provider mailings; provider trainings; member newsletters; New Member Handbook, and other sources which may include L.A. Care's Regional Community Advisory Committee (RCAC) meetings.

THE FEDERAL FALSE CLAIMS ACT
The federal False Claims Act is the Government's primary weapon in the fight against health care fraud. The majority of funds recovered come from False Claims Act suits or settlements. The federal False Claims Act permits a person who learns of fraud against the United States Government, to file a lawsuit on behalf of the **g**overnment against the person or business that committed the fraud. If the action is successful, the person filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery. These persons are often referred to as whistleblowers. Successful whistleblowers can receive anywhere from fifteen percent (15%) to fifty percent (50%) of the total amount recovered.

Who can be a plaintiff?
Any person may bring a lawsuit called a "*qui tam action*" regardless of whether he or she has "direct" or first-hand knowledge of the fraud. However, if substantially the same allegations or transactions alleged in the claim were publicly disclosed, the court may dismiss the claim.

What types of fraud qualify?
When a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he or she is not otherwise entitled, that person has committed fraud. This usually -- although not always -- involves money. However, under the False Claims Act, fraud has a much wider and more inclusive meaning.

Under the Act, the defendant need not have actually known that the information it provided to the government was false. It is sufficient that the defendant supplied the information to the Government either: (i) in "deliberate ignorance" of the truth or falsity of the information; or (ii) in "reckless disregard" of the truth or falsity of the information.

Thus, if a defendant should have known that its representations to the government were not true or accurate, but did not bother to check, such recklessness may constitute a violation of the Act. Likewise, if a defendant deliberately ignores information which may reveal the falsity of the information submitted to the government, such "deliberate ignorance" may constitute a violation of the Act.

What are the penalties for violations of the False Claims Act?

Persons who violate the False Claims Act can be liable for civil monetary penalties of not less than $5,500 but no more than $11,000, plus three times the government's damages, with respect to each false claim, and the costs of the civil action (e.g., attorneys' fees, etc.). However, under new health care reform laws, certain types of violations can also carry a civil penalty of up to $50,000 per claim. Additionally, the government may opt to include other civil and criminal laws in the suit which impose monetary penalties for submitting false claims.

What protection is there for a plaintiff who brings an action?
The False Claims Act provides protection to employees, agents or contractors who are retaliated against by an employer because of the employee's, agent's or contractor's participation in a *qui tam* action. The protection is available to any employee, agent or contractor who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee, agent or contractor investigates, files or participates in a *qui tam* action.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

California has a False Claims Act that is similar to the federal False Claims Act.

ANNUAL FRAUD AND ABUSE (FAA) AWARENESS TRAINING REQUIREMENT
On an annual basis, all providers are required to take one of the trainings numbered below or administer their own "In-house" FAA training program which shall include, but not be limited to, the topics listed below. All Providers are required to submit an executed FAA Awareness Attestation confirming their organization's compliance with this requirement.

However, at L.A. Care's discretion, if the organization's Medicare Certification can be verified, the annual requirement to submit an executed L.A. Care FAA Training Attestation will be waived.

1. **ICE/Health Industry Collaboration Effort**
2. **NHCAA/ National Health Care Anti-Fraud Association (www.learnsomething.com)**
3. **L.A. Care Health Plan Fraud and Abuse Awareness Training Program**
   http://www.lachp.org/compliance/fraud_abuse_trn.nsf

- **"In-house" FAA training shall include the following elements:**
  - Definitions of fraud and abuse;
  - Overview of laws & regulations related to Medicare Advantage and Part D fraud and abuse, including a brief description of main requirements and criminal & civil penalties related to each of the following:
    - Federal False Claims Act and State False Claims Act
    - Anti-Kickback Statute/Stark Law
    - HIPAA Privacy & Information Security Requirements;
  - Entities/individuals excluded from doing business with the Federal Government-Office of Inspector General (OIG) exclusion lists:
  - Obligations of the first tier, downstream, and related entities to have appropriate policies and procedures to address fraud and abuse;
  - Process for reporting to L.A. Care suspected fraud and abuse in first tier, downstream, and related entities;
  - Protections for employees and first tier, downstream, and related entities who report suspected fraud and abuse.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA is the Health Insurance Portability & Accountability Act of 1996 (August 21, 1996), Public Law 104-191. Also known as the Kennedy-Kassebaum Act, the Act includes a section, Title II, entitled Administrative Simplification, requiring:

- Improved efficiency in health care delivery by standardizing electronic data interchange, and
- Protection of confidentiality and security of health data through setting and enforcing standards.

More specifically, HIPAA called upon the Department of Health and Human Services (DHHS) to publish rules that ensure:

- Standardization of electronic patient health, administrative and financial data.
- Unique health identifiers for individuals, employers, health plans and health care providers.
- Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information (ePHI) the covered entity creates, receives, maintains, or transmits. It also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers and other electronic devices.

The Security Standard is intended to be scalable; in other words, it does not require specific technologies to be used. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

Privacy Rule

The Privacy Rule is intended to protect the privacy of all individually identifiable health information in the hands of covered entities, regardless of whether the information is or has been in electronic form. The Privacy standards:

- Give patients new rights to access their medical records, restrict access by others, request changes, and to learn how patient's health information has been accessed
- Restrict most disclosures of protected health information to the minimum needed for healthcare treatment , payment and business operations
- Provide that all patients are formally notified of covered entities' privacy practices
- Enable patients to decide if they will authorize disclosure of their Protected Health Information (PHI) for uses other than treatment or healthcare business operations
- Establish criminal and civil sanctions for improper use or disclosure of PHI
- Establish requirements for access to records by researchers and others
- Require that business associate agreements with business partners and vendors contain language that safeguard their use and disclosure of PHI.
- Implement a comprehensive compliance program, including:
  - Conducting an impact assessment to determine gaps between existing information practices, policies and HIPAA requirements
  - Reviewing functions and activities of the organization's business partners to determine where Business Associate Agreements are required
  - Developing and implementing enterprise-wide privacy policies and procedures to implement the regulations
  - Assigning a Privacy Officer who will administer the organizational privacy program and

enforce compliance
- Training all members of the workforce on HIPAA and organizational privacy policies
- Updating systems to ensure they provide adequate protection of patient data

The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH")
The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") made a number of significant changes to HIPAA. The following are the most significant changes impacting covered entities such as Providers:

Breach Notification Rules
Prior to HITECH, the HIPAA Privacy Rule required that a Provider only "mitigate" harmful effects known to the Provider from an improper release of Protected Health Information ("PHI"). HITECH has expanded what a Provider must do in the event of the "**breach"** of the security or privacy of an individual's PHI, requiring both the patient involved, and media outlets in certain cases, to be notified of the breach. HITECH also created requirements that apply directly to a Provider's business associates ("BA") in the event of such a breach.

How do the Breach Notification Regulations Apply?
The Regulations only apply to "unsecured" PHI. PHI that is "secured" is not subject to the Regulations, which means that the requirements discussed below do not apply to such secured PHI. For PHI to be secured, it must be either "encrypted" in accordance with standards specified under the HIPAA Security Rule or the media on which the PHI is stored must be destroyed in one of several ways.

PHI that does not meet these standards is "unsecured." The Regulations are triggered in the event of a "breach," which means a use or disclosure of PHI that is not permitted under the Privacy Rule.

What Must a Covered Entity or Business Associate do if a Breach Occurs?
The Provider must provide written notification to the affected individuals within a sixty (60) day period following the discovery of the breach. If a BA learns of a breach, it is required to notify the Provider so that the Provider can notify the individuals involved. The 60-day timeframe begins when the Provider, in the exercise of reasonable diligence, should have known of the breach.

In addition to notifying affected individuals, the following items are important:
- If a breach affects more than 500 people, Providers must inform the media about the breach.
- Providers are also required to provide notice to Department of Health and Human Services ("DHHS"), which will publicize the breach on its web site.
- For breaches affecting less than 500 people, Providers are required to keep an annual log of any breaches and provide a log to DHHS within 60 days of the start of the next calendar year.

Business Associates Directly Regulated Under HIPAA
Business associates have historically had to comply with certain HIPAA requirements solely as a result of their agreements with Providers. If a BA breached its obligations, it would only be liable to the Provider under that contract and it would not be subject to direct oversight or penalties by DHHS. HITECH has increased the stakes for compliance for BAs.

As a result of this change, BAs are subject to a host of obligations:

- In addition to the breach notification obligations, they are directly subject to parts of the HIPAA Security Rule requiring the use of technical, physical and administrative safeguards to ensure the confidentiality of electronic PHI.
- Understanding the requirements of the Security Rule, what types of safeguards are acceptable and how the safeguards should be implemented will be required of the BAs.

- BAs must directly comply with a host of standards found in the Privacy Rule, including using and disclosing PHI only as permitted under the Privacy Rule.
- Providers can be penalized directly by DHHS and other enforcement agencies.

Enhanced Enforcement Options and Increased Penalties for Noncompliance
HITECH significantly expanded options for HIPAA enforcement. For example, State Attorney Generals have been empowered, since February 2009, to bring civil actions against persons who violate HIPAA if the Attorney General believes the violation threatens state residents. DHHS will also be conducting audits of Providers and BAs to ensure their compliance with the Privacy and Security Rules.

In addition, HITECH increased the penalties against Providers and BAs for violating HIPAA.

- HITECH expanded regulators' ability to impose criminal penalties for violating HIPAA.
- HITECH imposed increased penalties. For example, while the maximum fine that could be imposed for identical violations in a one year period was $25,000 under the previous rule, HITECH permits fines of up to $1.5 million for identical violations within the same year. The enhanced civil penalties are linked to the Provider's level of culpability.
- HITECH has eliminated certain defenses that could be raised in the past against HIPAA violations. No longer can parties avoid penalties by claiming that they did not have actual or constructive knowledge of the violation. Together with the new obligations discussed above, these enhanced penalties have increased the risks of noncompliance.

Other Notable Points about HITECH
- HITECH has expanded the disclosures for which Providers must maintain an accounting to include disclosures for treatment, payment and health care operations, if the disclosures for those purposes are made through an electronic health record.
- Providers will be required to agree to an individual's restriction on disclosures of their PHI to a health plan if the disclosure is for payment or health care operations purposes and it pertains solely to services for which the Provider involved was paid in full out-of-pocket.
- Significantly less leeway exists for Providers to engage in marketing or fundraising activities.

GOVERNMENTAL AND HIPAA-RELATED RESOURCES & WEB SITES

U.S. Department of Health and Human Services, Administrative Simplification
http://aspe.hhs.gov/admnsimp/index.shtml
U.S. Department of Health and Human Services - Office of Civil Rights, HIPAA
http://www.hhs.gov/ocr/hipaa/
Workgroup for Electronic Data Interchange (WEDI)
http://www.wedi.org
National Committee on Vital and Health Statistics
http://www.ncvhs.hhs.gov/
National Council for Prescription Drug Programs
http://www.ncpdp.org
Electronic Healthcare Network Accreditation Commission
http://www.ehnac.org
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov/hipaageninfo/01_overview.asp

16.0 PHARMACY

Overview

The Outpatient Prescription Drug Formulary is used to administer the pharmacy benefits for our members. L.A. Care Health Plan uses a Formulary (Preferred Drug List) which is a list of preferred drugs for prescribing practitioners to prescribe. The goal of the Formulary is to enhance the prescribing practitioners and pharmacist's abilities to provide optimal cost effective drug therapy for our members. L.A. Care has a Pharmacy, Therapeutics and New Technology (PT&T) Committee to develop, maintain and improve the Formulary. The PT&T committee, comprised of practicing physicians and pharmacists in Los Angeles County, meets at least quarterly to review and revise the Formulary. L.A. Care highly encourages our network practicing prescribing practitioners and pharmacists to provide suggestions and comments for formulary additions and changes.

The L.A. Care PT&T Committee uses the following criteria in the evaluation of drug selection for its Formulary:

- Drug safety profile
- Drug efficacy
- Drug effectiveness
- Comparison of relevant drug benefits to current formulary agents of similar use, while minimizing duplications
- Equitable cost and outcomes of the total cost of drug and medical care

To view our latest Formulary, Formulary updates and Formulary Drug Review Request Form, please go to our website at www.lacare.org/providers/pharmacy
Follow these steps to view the Formulary, Formulary Updates, Formulary Drug Review Request Form, and the Prior Authorization Form:

- To access the Formulary, under Provider, selectFormulary & Pharmacy, on the left hand side of the page
- Under Formulary select "click on this sentence to print a copy of our L.A. Care Medi-Cal Formulary, Healthy Family and Healthy Kids Formulary"
- To access the Formulary Updates, select Formulary Updates on the left hand side of the page.
- Select the links, Updates will be listed by effective date from most recent to oldest.
- To access the Formulary Drug Review Request Form, select Formulary Updates on the left hand side of the page.
- Select, "Click on this sentence to print our Formulary Drug Review Request Form."
- To access the Formulary Prior Authorization Request Form, select Prior Authorization on the left hand side of the page.
- Select, "Click on this sentence to print a copy of our Prior Authorization Form"
- Certain formulary medications and all non-formulary medications require a written Prior Authorization (PA) request to be submitted by the prescribing practitioner for our L.A. Care members.
- Each PA request will be reviewed based on the individual member's need. All PA requests will be reviewed within one (1) business day. Determination will be based on documentation of existing medical need.

Medi-Cal Healthy Kids members: Certain formulary medications and all non-formulary medications require the prescribing provider to submit a written Medication Request Form to MedImpact for prior authorization review.

Benefit Coverage and Limitations

Depending upon a member's specific benefit parameters, the following topics may apply:

1. ***Generic Substitution***

The pharmacy benefit for our Medi-Cal, Healthy Kids Program members is a mandatory generic program. The intent of this mandatory generic program is to promote utilization of appropriate generic alternatives as first line therapies when medically appropriate. If a member or physician requests a brand name product in lieu of an approved generic due to documented medical need, a written request for coverage needs to be submitted on the Medication Request Form for consideration. Procedures and timeframes will follow our Prior Authorization process.

2. ***Step Therapy***

L.A. Care uses Step Therapy to promote cost-effective pharmaceutical management when there are multiple effective drugs to treat a medical condition. Drugs that are listed in the Formulary as Step Therapy (ST) require one or more "prerequisite" first step drugs to be tried before progressing to the second step drug. When a prescription for a Step Therapy drug is filled at the dispensing pharmacy, the pharmacy benefits claims processor will search past claims for the first step drugs. If medically necessary a Step Therapy drug can be obtained without first trying first step drug by submitting a completed Medication Request Form with documentation of the medical need for consideration. Each request will be reviewed on an individual member need. Procedures and timeframes will follow our Prior Authorization process.

To view a copy of our Step Therapy medication list, please go to our website at
www.lacare.org/providers/pharmacy/priorauthorizations

3. Quantity Limits

L.A. Care has identified a select number of medications to be subjected to quantity limits. A quantity limit establishes the maximum amount of medication that L.A. Care will cover within a defined period of time. If a member has a medical condition that requires a quantity of medication that exceeds our limit, a written request on a Medication Request Form will be required with documentation of medical need for consideration. Procedures and timeframes will follow our Prior Authorization process.

To view a copy of our Quantity Limits medication list, please go to our website at
www.lacare.org/providers/pharmacy/priorauthorizations

4. Prior Authorization (PA)

Depending upon plan benefit design, a medication request process for prior authorization review may apply as follows:

A. **Formulary Agents**
Drugs that are listed in the Formulary as Prior Authorization (PA) require evaluation prior to dispensing at a network pharmacy. Each written request on the Medication Request Form will be reviewed based upon the individual member needs for consideration. Procedures and timeframes will follow our Prior Authorization process.

B. **Non-Formulary Agents**
Any available drug not found in the Formulary listing shall be considered a Non-Formulary drug. Coverage for non-formulary agents may be applied for in advance by the prescribing practitioner. Each written request on the Medication Request Form will be reviewed based upon the individual member needs for consideration. Procedures and timeframes will follow our Prior Authorization process.

All PA requests will be reviewed within one (1) business day. Determination will be based on documentation of medical need. To print a copy of our Medication Request Form, please go to our website at www.lacare.org/provider/pharmacy/priorauthorizations:

Coverage questions or information regarding the medication request or formulary process may be obtained by:

- Faxing a completed Medication Request Form to MedImpact at1-800-681-7651.
- Contacting MedImpact at (800) 788-2949 and providing all necessary information requested.
- MedImpact will provide an authorization number, specific for the medical need, for all approved requests.
- Request(s) not approved by MedImpact are forwarded to L.A. Care for plan review and consideration.

Non-approved requests may be appealed. The prescribing provider must provide information to support the appeal on the basis of medical necessity.

5. *Therapeutic Interchange*

L.A. Care may use Therapeutic Interchange to promote rational pharmaceutical therapy when evidence suggests that outcomes can be improved by substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. Therapeutic Interchange protocols are never automatic; a dispensing provider may not substitute a therapeutically equivalent alternative drug for the prescribed drug without the knowledge and authorization of the prescribing practitioner.
Drugs may be considered for Therapeutic Interchange if they are:

- High risk,
- High volume,
- High cost, or
- Overused in routine conditions.

In designing Therapeutic Interchange protocols, drug characteristics are considered including:

- Efficacy,
- Effectiveness,
- Dosage formulation,
- Safety,
- Cost, and
- Pharmacoeconomic variables.

Over-the-Counter Medication Coverage
L.A. Care Health Plan may offer select over-the-counter (OTC) medications to be covered when approved by the Pharmacy, Therapeutics and New Technology (PT&T) Committee and prescribed by a licensed practitioner as a cost effective alternative to prescription drugs.

The following categories are covered for treatment and monitoring of diabetes by **Medi-Cal**, **Healthy Kids**:

- Blood glucose monitors (preferred brand is TrueResults)
- Blood glucose test strips (preferred brand is TrueResults)
- Ketone urine test strips
- Lancets and lancet puncture devices
- Pen delivery systems for giving insulin
- Insulin products
- Insulin syringes

For our **Medi-Cal** members only, other select OTC medications are covered by a written prescription and as follows:

- Analgesics
- Antacids
- Anti-diarrheals
- Anti-histamines (includes generic loratadine & generic cetirizine)
- Anti-inflammatories
- Anti-ulcer medications (includes Prilosec OTC)
- Benzoyl peroxide
- Calcium replacement
- Contraceptives (spermicidal foams and creams, condoms)
- Hematinics
- Hydrocortisone
- Laxative/stool softeners
- Prenatal vitamins
- Select vitamins
- Smoking cessation products (generic nicotine patches & gums)
- Topical anti-fungal products
- Topical antibiotics
- Topical anti-parasites
- Vaginal anti-fungal preparations

To view our complete OTC coverage list for our **Medi-Cal** members, please go to our website at www.lacare.org/providers/pharmacy

For our **Healthy Kids** members, a very limited number of OTC medications are covered by a written prescription and as follows:

- Calcium replacement
- Cetirizine
- Cetirizine/pseudoephedrine
- Loratadine
- Loratadine/pseudoephedrine
- Ketotifen ophthalmic drops
- Omeprazole OTC (Prilosec OTC)

To view our complete OTC coverage list for our **Healthy Kids** members, please go to our website at www.lacare.org/providers/pharmacy

Devices

L.A. Care Health Plan provides coverage on the pharmacy benefit for the following devices for Medi-Cal and Healthy Kids members:

- Spacers
- Peak flow meters

Excluded Medications

L.A. Care Health Plan does not cover the following medications on its pharmacy benefit:

- Experimental or investigational drugs

- Weight-loss medications, except as medically necessary for morbid obesity
- Fertility medications
- Drugs or medications for cosmetic purposes
- Over-the-counter medications not covered by L.A. Care
- Dietary or nutritional products, except when medically necessary or for the treatment of phenylketonuria
- Compound medications with formulary alternatives or those with no FDA-approved indications
- Non self-administered injectable drug products are not covered unless otherwise specified in the Formulary listing.
- Drugs for Erectile Dysfunction or lifestyle drugs.

Formulary Updates and Feedback

The Formulary is a tool to promote cost-effective prescription drug use. The PT&T Committee has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. L.A. Care welcomes the participation of prescribing practitioners, pharmacists, and ancillary medical providers, in this dynamic process. Please refer to "Formulary Updates" and "Pharmacy and Therapeutics Committee Updates" at: http://www.lacare.org/providers/pharmacy/formularyupdates.

Prescribing practitioners and pharmacists are highly encouraged to direct any suggestions, comments or formulary additions to L.A. Care via e-mail to PharmacyandFormulary@lacare.org or by mail at the following address:

Chairperson, Pharmacy & Therapeutics Committee
L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

Pharmacy Co-payments

L.A. Care's **Medi-Cal** members are responsible for the following pharmacy co-payments:

- No co-payment per generic prescription for up to a 30-day supply at a participating retail pharmacy
- No co-payment per brand name prescription for up to a 30-day supply at a participating retail pharmacy
- No co-payment per prescription for contraceptive drugs/device up to a 90-day supply at a participating Choice90 retail pharmacy
- No co-payment per prenatal vitamins for up to a 90-day supply at a participating Choice90 retail pharmacy
- No co-payment per maintenance medication prescription for up to a 90-day supply at a participating Choice90 retail pharmacy or mail order pharmacy

Medicare Part D (applies to **Medi-Cal** ONLY)

On January 1, 2006, Medicare Part D, a federal prescription drug benefit, will pay for most prescription drugs for Medicare/Medi-Cal dual-eligible recipients. L.A. Care will not cover Medicare Part D prescription drug claims for these dual-eligible Medi-Cal members. Dispensing providers must submit most prescription drug claims to the dual-eligible's Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PDP).

There are three (3) categories of non Medicare Part D drugs that will be covered by L.A. Care for these Medicare/Medi-Cal dual eligibles:

- Over-the-Counter medications (except for insulin & syringes which are covered by

PDP or MA-PDP)
- Barbiturates
- Prescription vitamins and minerals

NOTE: Prescription co-payments are associated with PDP or MA_PDP for these Medicare/Medi-Cal dual-eligibles.

Pharmacy Benefit Manager (PBM) Services

L.A. Care subcontracts select pharmacy services through MedImpact Healthcare Systems, Inc. (MedImpact) to administer the pharmacy benefits network, which includes over 1680 pharmacies in Los Angeles County.

MedImpact's role for L.A. Care includes:

- Processing pharmacy claims
- Processing initial prior authorization requests
- Managing the pharmacy network
- Monitoring and reporting drug utilization patterns
- Conducting online DUE programs at the point of sale

Prescriptions by Mail

L.A. Care offers members the option of getting up to a 90-day supply of maintenance medications mailed to their home or alternate address through our prescription mail order program. Please remember to write a 30-day supply, as well as a 90-day supply plus refills prescription, for their maintenance medications. They can locate the mail order form on L.A. Care's website or call L.A. Care Health Plan Member Services (1-888-522-1298) for the mail order form. This mail order service is free for members.

E-Prescribing/Electronic Health Records (EHR)

L.A. Care strongly encourages all prescribing practitioners to adopt e-prescribing and electronic health records. As of 2011, the Centers for Medicare & Medicaid Services (CMS) will begin paying bonuses to prescribing practitioners who use an e-prescribing system (and show "meaningful use") to manage Medicare patients. These prescriptions are managed through Surescripts (RxHub). E-prescribing allows providers to:

- Enhance formulary compliance and
- Verify alternatives and generic substitutions
- Check drug quantity limits
- Avoid drug-drug interactions/medication errors
- Improve patient safety (Reduce Adverse Drug Events)
- Enhance efficiency

Please refer to L.A. Care's website (**http://www.lacare.org/aboutlacare/hitec-la**) for information to assist you with adopting e-prescribing/EHRs.

17.0 Long Term Services and Supports (LTSS)

Note: This section applies to Medi-Cal only (not HK)

What is LTSS?

- ***Long Term Services and Supports*** (LTSS) typically refers to a wide range of services that support people living independently in the community. In Medi-Cal, LTSS also includes long-term care services provided in a skilled nursing facility.

LTSS Department Contact Information;

- E-mail MLTSS@lacare.org
- Call 855-427-1223, or
- Call 213-694-1250, ext. 5422
- Fax 213-438-4877

LTSS Department philosophy

- ***Our vision:*** A coordinated service delivery system that improves the well-being of members while giving them an opportunity to remain living safely at home or other setting of their choice.
- The various LTSS are a continuum, and patients may require assistance in moving among different services and coordinating their care.

What Long Term Services and Supports are included in the Medi-Cal benefit?

- There are 4 LTSS included in the Medi-Cal benefit. Additional information about each service is included in the section below.
    - Long Term Care (LTC)
    - Community-Based Adult Services (CBAS)
    - In-Home Supportive Services (IHSS)
    - Multipurpose Senior Services Program (MSSP)
- L.A. Care can also assist with referrals to community-based services outside of Medi-Cal benefits. These services are generally provided by community-based organizations like:
        - Independent Living Centers
        - Regional Centers
        - Area Agencies on Aging

What can the LTSS department provide to physicians and their patients?

- Assist members in finding the right combination of services through assessment and staff expertise.
- Coordinate access to LTSS services, including both L.A. Care benefits and community services and supports.
- Act as LTSS subject matter experts on care teams.
- Facilitate participation of LTSS providers on care teams.
- Report on LTSS usage, trends, grievances and appeals.
- Work with LTSS agencies to design and implement system improvements.

When should physicians contact the LTSS department?

- Identification of a member who has LTSS needs which may include:
    - social support
    - needs assistance with Activities of Daily Living (ADLs) or Independent Activities of Daily Living (IADLs), i.e., personal care or household chores

    - needs caregiver support
- Member qualifies for nursing home placement, but wants to stay home.
- Member currently receives LTSS services, but has unmet needs.
- Member whose condition indicates possible need for LTSS in the future.
- Member is experiencing difficulty with a particular LTSS service (LTC, IHSS, CBAS, or MSSP) and could benefit from assistance and coordination.
- Help a member prepare for a transition into long term care or from long term care into the community.
- Obtain authorization for LTC custodial services or for CBAS services.
- Request L.A. Care LTSS staff member participation in care team, or assistance in reaching out to LTSS service provider to join care team.

What is care coordination?

- Care coordination can include case management services for members with increased service needs:
    - Receiving episodic care
    - Requires increased resources
    - Receiving multiple services along the continuum
    - May be accessing LTSS services

What are the benefits of L.A. Care's care coordination process for members accessing LTSS services?

- Central point of contact at Health Plan level and with member, family, legal representatives, physicians/providers to accomplish care plan goals.
- Targeted assessment of identified member needs
- Creation of individualized care plan (ICP)
- LTSS Providers assess and develop care plans that contribute to the ICP
- Facilitation of identified referrals
- Facilitation of continuity of care with non-contracted providers
- Development of short term goals
- Follow up communications
- Discussion of ICP with Interdisciplinary Care Team (ICT)
- LTSS providers participate in the ICT
- Care teams and LTSS Providers work together to ensure member gets needed & unduplicated services

How can physicians' access care coordination services for members receiving LTSS?

- Contact the LTSS department (see contact info above).

Long Term Care (LTC)

- What is Long Term Care (LTC)?
    - Care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs which is not specific therapy for an illness or injury and is not skilled care.
    - Custodial care to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.
    - Personal care that does not require the continuing attention or supervision of trained, medical or paramedical personnel.

- Who is eligible for LTC?

- Medi-Cal recipients who require 24-hour long or short-term medical care eligible to receive services in a skilled nursing facility
- Criteria for LTC are contained in state regulations (Title 22, CCR, Section 51335)

- LTC Referral & Authorization Process:
  - Verify that patient is an LA Care member.
  - For referrals from a PCP, the LTC Custodial Referral Form is submitted to LA Care LTSS for review.
    - The form is accessible via the Provider Portal.at www.lacare.org.
    - PCP must prescribe services for LTC authorization
  - Note that PCPs should contact the L.A. Care utilization management team (not LTSS dept.) for referrals to skilled level of care.
    - Phone: 1-877-431-2273
  - L.A. Care will notify referral source of LTC referral outcome within:
    - 5 business days for routine
    - 72 hours for urgent
  - Referral outcome:
    - If the referral meets custodial LTC criteria, L.A. Care will issue authorization to nursing facility and notify referral source.
    - If the referral does not meet custodial LTC criteria, request will be referred to appropriate LTSS team within L.A. Care (PASC-SEIU, CBAS, MSSP) and/or to L.A. Care Case Management (Social Work, Complex Case Management, Disease Case Management).

- LTC Concurrent Review Process:
  - A custodial LTC member will be assigned to appropriate physician or physician group.
  - LA Care LTC Nurse Specialist will support assigned physician on facilitation and coordination of care needs.
  - LA Care LTC Nurse Specialist will conduct regular on-site or telephonic clinical review of members in nursing facilities

- Case Management, Utilization Management, and Care Coordination for Individuals in LTC:
  - L.A. Care Nurse Specialist is responsible for Case Management, Utilization Management and coordination of services for members in LTC facility
  - L.A. Care Nurse Specialist will authorize and facilitate specialty services such as, but not limited to the following:
    - Specialty physician referrals (i.e. Behavioral Health, Podiatry)
    - Labs
    - Diagnostics
    - Transportation
    - DME
    - Home Health
    - Hospice and Palliative care

- How can L.A. Care LTSS department assist members with LTC?
  - Recommending LTC services
  - Authorizing LTC Services
  - Monitoring member progress
  - Assisting with transitions outside of LTC services
  - Coordinating LTC services with other health plan benefits

Community Based Adult Services (CBAS)

- What is CBAS?
  - CBAS is a program where members can go to a center during the day for assistance with their daily needs. The goal is to delay the placement of eligible members into nursing homes or more expensive care settings.
  - L.A. Care plan benefit since 2012 (replacing adult day health care).

- Services available through CBAS include:
  - Core Services:
    - Professional nursing and medication management
    - Therapeutic activities
    - Social services and/or personal care services
    - One meal offered per day
  - Additional Services:
    - Physical, occupational or speech therapy
    - Mental health/psychiatric services
    - Registered dietician services
    - Transportation (to/from center to member residence)

- Who is eligible for CBAS?
  - CBAS services may be provided to Medi-Cal beneficiaries over 18 years of age who:
    - Meet nursing facility A or B requirements
    - Have organic/acquired or traumatic brain Injury and/or chronic mental health conditions
    - Have Alzheimer's disease or other dementia
    - Have mild cognitive impairment
    - Have a developmental disability

- Physician role in CBAS
  - CBAS services must be ordered by the PCP
  - Orders are made by completing an L.A. Care CBAS Request for Services Form
  - Completed request forms can be submitted to L.A. Care's CBAS Team via fax: ***213-438-5739***

- How can L.A. Care LTSS department assist members with CBAS?
  - Referring eligible members to local CBAS centers
  - Authorizing CBAS services
  - Coordinating CBAS services with other benefits

In Home Supportive Services (IHSS)

- What is IHSS?
  - IHSS is a state entitlement program that provides homecare services to low-income seniors and persons with disabilities, allowing them to continue living safely at home.

- Services available through IHSS include:
  - Domestic and Related Services (i.e., house cleaning & chores, meal preparation & clean-up, laundry, grocery shopping)

- Personal Care (i.e., bathing & grooming, dressing, feeding)
- Paramedical Services (i.e., administration of medication, puncturing skin, range of motion exercises)
- Other Services (i.e., accompaniment to medical appointments, yard hazard abatement, protective supervision)

- Who is eligible for IHSS services?
  - All IHSS beneficiaries must:
  - be a CA resident and a U.S. citizen/legal resident, and be living in their own home ;
  - receive or be eligible to receive Supplemental Security Income/State Supplemental Payment (SSI/SSP) or Medi-Cal benefits ;
  - be 65 years of age or older, legally blind, or disabled by Social Security standards ;
  - submit a health care certification form (SOC 873) from a licensed health care professional indicating that they need assistance to stay living at home.

- How do members access IHSS services?
  - Los Angeles County Department of Public Social Services conducts assessment and authorizes IHSS.
  - Member hires, trains, and supervises their IHSS worker.
  - L.A. Care is financially responsible for IHSS and works to assist members (e.g. help navigating IHSS grievance process) and coordinate with other care member is receiving.

- Physician role in IHSS
  - To assist members needing IHSS, physicians should:
    - Refer members who need IHSS to either the L.A. County IHSS Application Hotline (888-944-4477) or the L.A. Care LTSS department (855-427-1223).
    - Assist with completion of required IHSS forms and provide members with other documentation to support their need for IHSS services.
  - Refer members who have questions about their IHSS to L.A. Care.

- How can L.A. Care LTSS department assist members with IHSS?
  - Coordinating and navigating the IHSS assessment and re-assessment process
  - Resolving IHSS-related issues
  - Navigating the DPSS grievance & appeals processes
  - Coordinating IHSS benefits with other health plan benefits

Multipurpose Senior Services Program (MSSP)

- What is MSSP?
  - MSSP is an intensive case management program for seniors who are certified for nursing home placement, but wish to remain at home

- Services available through MSSP include:
  - Care Management (i.e., needs assessments, care plan development, monitoring of care)
  - Care Management Assistance (i.e., assistance accessing services, personal advocacy)
  - Purchased Services (i.e., supplemental chore & personal care services, diet & nutrition, handyman services, respite care, transportation, appliance assistance)
  - **Note that total cost of services must not exceed the cost of SNF placement.**

- Who is eligible for MSSP services?
    - In order to be eligible for the MSSP services, a member must:
        - be >65 years of age
        - live within an MSSP service area
        - be eligible for Medi-Cal
        - be certified for nursing home placement
    - If the member does not meet the eligibility requirements for MSSP:
        - LTSS staff will work with the ICT and member to identify alternative services

- How do members access MSSP services?
    - MSSP sites are contracted with L.A. Care.
    - Six MSSP service sites in L.A. County provide services to 3,400 individuals.
    - MSSPs assess for and provide both social and health care management services.
    - There are a limited number of statewide waiver slots. If an L.A. Care member is eligible, but the MSSP does not have an open slot:
        - The MSSP will conduct a full assessment and notify the MLTSS department of services that would be authorized
        - L.A. Care is responsible for providing MSSP-like services if there is no slot available.
        - These services will be coordinated by the MLTSS Department.

- How can L.A. Care LTSS department assist members with IHSS?
    - Identifying members eligible for MSSP services
    - Referring eligible members to the appropriate MSSP site for assessment
    - Coordinating MSSP benefits with other Health plan benefits

- Physician role in MSSP
    - If a physician believes a member might benefit from MSSP services, they should refer the member to L.A. Care's LTSS department.