



L.A. Care *Medi-Cal*TM

Provider Manual

2017



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1.0 Welcome To L.A. Care Health Plan

1.1 General Introduction

Thank you for participating in L.A. Care Health Plan's (L.A. Care) provider network and helping fulfill its mission to provide high quality health care services to L.A. Care's members in Los Angeles County.

We would like to welcome you to L.A. Care. As part of L.A. Care's Medi-Cal Direct (MCLA) network of providers; you play a very important role in the delivery of health care services to our members.

The purpose of this L.A. Care Medi-Cal Provider Manual (Provider Manual) is to furnish all Providers, including Participating Physician Groups (PPGs) and their affiliated Provider networks, specialty health plans, physicians or physician groups, hospitals, safety net providers, California Community-Based Adult Services (CBAS) centers, and other ancillary providers, with information on the important processes related to L.A. Care's Medi-Cal product. The Provider Manual is organized by substantive sections and provides information about applicable requirements for the Medi-Cal program, L.A. Care policies, general reference information, including minimum standards of care, and other responsibilities. Please read each section in this Provider Manual carefully in order to determine your contracted provider responsibilities.

1.1.1 Medi-Cal and the Two Plan Model

Medi-Cal is California's Medicaid program. It is a public health insurance program administered by the California Department of Health Care Services (DHCS). The Medi-Cal program was established in 1965 to provide the necessary health services for low-income individuals or people with disabilities. In California, the Medi-Cal program is governed by the California Welfare and Institutions Code and provisions of Title 22 of the California Code of Regulations. Since 1998, significant portions of the Medi-Cal population have been enrolled into managed care organizations on a mandatory basis. In 2014, as a result of the implementation of Affordable Care Act, Medi-Cal managed care enrollment expanded. In Los Angeles County, Medi-Cal is operated through a Two-Plan Model consisting of a "local initiative" health plan and a commercial plan. L.A. Care is the local initiative managed care plan in Los Angeles County. Currently, Health Net is the commercial plan.

1.1.2 Responsibility of Participating Providers

L.A. Care requires that its contracted Providers (including but not limited to medical groups, hospitals, Providers, PPGs, specialized health plans, physicians or physician groups, hospitals, community-based adult services (CBAS) centers, and other ancillary Providers) meet specific requirements. Many sections of this Provider Manual include a section entitled "Responsibility of Participating Providers." This section is provided to assist the contracted Provider with understanding which functions are the responsibility of L.A. Care, PPGs, hospitals, ancillary Providers, and/or other participating Providers, respectively.

1.1.3 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 product lines. To accomplish this goal, L.A. Care will work cooperatively with network Providers to ensure that they have timely access to information and the appropriate resources to meet service requirements.

1.1.4 Traditional and Safety Net Providers

L.A. Care considers the following provider types as some examples, but not all inclusive examples of Traditional or Safety Net Providers: Child Health and Disability Prevention (CHDP) Providers, Federally Qualified Health Centers (FQHCs), licensed community clinics, and Disproportionate Share Hospitals.

1.2 Website Information Available to Providers

The L.A. Care website has useful information for Providers. Please visit our website at www.lacare.org for information about the following:

- Provider Portal Sign In
 - Check Patient Eligibility
 - PCP Registration
- Provider Resources
 - Cal MediConnect Tools
 - Provider Manuals
 - Provider Forms
 - Utilization Management Forms
 - Pre-Authorization Request Form

- Hospital Authorization and Billing Reference Guide
- Care Management Forms
 - Care Management Referral Form
- Claims Forms
 - PM-160 Form
 - CMS 1500 Claim Form
 - Provider Dispute Resolution Request Form
- Managed Long Term Services and Supports
 - Long Term Care and CBAS Referral Request Form
 - LTSS Referral Form
- Prescription Drug Prior Authorization Request Form
 - Medicare (Cal MediConnect) Coverage Determination Form
 - Prior Authorization Request Forms
- Reference Guide
 - Coding Reference Guide for Acute Respiratory Conditions
 - Provider Authorization and Billing Reference Guide
 - SNF Authorization and Billing Guidance
- Provider Portal Resources
 - Provider Portal Reference Guide
- Additional Referral Forms
 - CA Pediatric WIC Referral Form
- Provider Policies
- Provider Toolkits
- Staying Healthy Forms
- Clinical Guidelines
- Skilled Nursing Resources
- Behavioral Health
 - Behavioral Health Services
 - Forms and Toolkits
 - Specialty Mental Health
 - Substance Use Disorder
- Pharmacy Services
 - Medication Adherence
 - Prior Authorizations
 - List of Covered Drugs
- HEDIS Resources
- Health Education Tools
- Social Services Directory
- Quality Improvement Program
- Provider FAQs
- Provider News

- Health Advisories
- Progress Notes
- The PULSE
- Newsletter Sign Up
- Claims and ICD-10
 - Submitting a Claim
 - ICD-10
- Provider Training
 - Classes & Seminars
 - Physician Leadership Program

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) and submit your request.

1.3 Notice to Providers

From time to time, L.A. Care amends Provider contracts and updates the Provider Manual and/or its Policies and Procedures. Updates are done to ensure Providers have necessary information on the most up-to-date laws, regulations, and revisions to provide the highest quality services to L.A. Care Members and ensure regulatory compliance. L.A. Care works to promptly notify all Providers of material changes in requirements. L.A. Care utilizes multiple communication avenues to advise providers of changes e.g. newsletters, e-mails, letters, and announcements on our website. For more information, please refer to the L.A. Care's website located at www.lacare.org.

1.4 L.A. Care Departmental Contact List

L.A. Care Health Plan
 1055 W. 7th Street
 Los Angeles, CA 90017
 1.213.694.1250

Department	Contact Information
Capitation	1.213.694.1250, x 4377
Care Management	1.844.200.0104
Claims	1.866.522.2736 Mail L.A. Care claims questions to: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081
Cultural and Linguistic Services	1.213.694.1250, x 4523
Eligibility Verification, Provider Service Line	Register for the Provider Portal to verify member eligibility at: lacare.org and click on Provider Sign in. 1.866.522.2736 or 1.866.LACARE6
Encounter Data	Provider Service Line; 1.866.LA.CARE6 or 1.866.522.2736
Health Education; Health in Motion	1.855.856.6943
Managed Long Term Services and Supports (MLTSS)	Provider Inquiry Line: 1.855.427.1223 Fax: 1.213.438-4866 mlts@lacare.org
Marketing/Sales	1.213.694.1250, x 5712
Member Services	General Information Line Medi-Cal – 888.839.9909 CMC – 1.888.522.1298
Pharmacy	1.877.795.2227
Prior Authorizations and Hospital Admissions	L.A. Care UM Department must be notified within 24 hours or the next business day following inpatient admission. To submit an Authorization request: Call Toll-Free: 1.877.431.2273 Fax: 1.213.623.8669 Written Requests: L.A. Care Health Plan 1055 W. 7 th Street, 10 th Floor Los Angeles, CA 90017 Attn.: Utilization Management/Authorizations

Department	Contact Information
Provider Credentialing, Performance, and Certification	1.844.530.7596
Provider Information/Data Issues	Provider Inquiry Line 1.866.LA.CARE6 or 1.866.522.2736
Provider Network Management	1.213.694.1250, extension 4719
Provider Inquiries	<p>Providers may communicate questions or concerns to their contracted PPG or to L.A. Care directly.</p> <p>Telephone: L.A. Care's Provider Services Unit: 1.866.LACARE6, (1.866.522.2736)</p> <p>In writing: L.A. Care Health Plan Attn: Provider Relations 1055 W. 7th Street, 10th Floor Los Angeles, CA. 90017</p> <p>E-mail: LACarePSU@lacare.org (Five to seven business-day turn-around response) Your assigned Provider Relations Representative</p>
Quality Improvement, Senior Director	1.213.694.1250, x 5744
Quality Improvement, Medical Director	1.213.694.1250, x 5315
Quality Improvement, Disease Management	1.213.694.1250, x 4768
Quality Management, Director	1.213.694.1250, x 5203
Regulatory Affairs and Compliance	1.213.694.1250, x 4292
Utilization Management, Director	1.213.694.1250, x 5181

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
DHCS	Department of Health Care Services
DOFR	Division of Financial Responsibility
FSR	Facility Site Review
HEDIS	Healthcare Effectiveness Data and Information Set
IBNR	Incurred But Not Reported
PASC-SEIU	Home Care Workers Union

Acronym or Word(s)	Definition
IPA	Independent Practice Association – In the L.A. Care Provider Manual, IPA will be referred to Participating Physician Groups (PPGs)
L.A. Care	L.A. Care Health Plan (Local Initiative Health Authority for Los Angeles County)
LTC	Long Term Care
LTSS	Long Term Services and Supports (a.k.a. Managed Long Term 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
PNM	Provider Network Management
QIP	Quality Improvement Plan
SED	Severely Emotionally Disturbed
SNF	Skilled Nursing Facility
WIC Program	Women, Infant & Children’s Nutritional Supplemental Program

2.0 Membership and Membership Services

This section covers L.A. Care Medi-Cal membership and Member Services. Topics include eligibility, enrollment and disenrollment, Primary Care Physician (PCP) assignment, complaint resolution, and member rights and responsibilities.

2.1 Responsibility of Participating Providers

L.A. Care Medi-Cal participating Providers are responsible for adhering to the Member Services provisions and guidelines specified in this section.

2.2 Program Eligibility

Individuals who wish to enroll in L.A. Care must have been determined eligible for the Medi-Cal program through a County, Department of Health Care Services (DHCS) state office, or the Social Security Administration.

DHCS basic Medi-Cal eligibility criteria include the following categories:

- Children under 21 years old
- Adults over 65 years old
- Low-income adults
- Families with children
- Individuals with disabilities
- Foster youth up to age 26
- Pregnant women

In addition, Medi-Cal applicants must meet income and asset levels, as established by the Medi-Cal program.

All beneficiaries who are determined eligible for the Medi-Cal program may enroll into L.A. Care's Medi-Cal product line. For further information, go to the DHCS' site at <http://www.dhcs.ca.gov/> or Covered California's site at <http://www.coveredca.com/medi-cal/>.

2.2.1 Conditions of Enrollment

At the time of enrollment, L.A. Care provides new enrollees with a Summary of Benefits, a Provider Directory, a Pharmacy Directory, a copy of the Pharmacy Formulary, and an enrollment date.

Member materials as well as other helpful resources are available on the L.A. Care website at www.lacare.org.

2.2.2 Disenrollment

Members who do not meet the Medi-Cal eligibility requirements may be disenrolled from L.A. Care by DHCS.

2.3 Member Enrollment, Assignment, and Disenrollment

L.A. Care informs Members about their enrollment rights, responsibilities, plan benefits and rules.

L.A. Care uses multiple methods to meet the cultural and linguistic needs of Members as well as to communicate with them in their own language, including, but not limited to, the following:

- Translation of Member materials into threshold languages
- Referral to physicians who can provide services in the Member's preferred language
- Use of qualified bilingual staff contracts for telephonic and face-to-face interpreting services, including American Sign Language (ASL) at medical and non-medical points of contact
- Hearing or speech impaired members can contact L.A. Care through the California Telecommunications Relay Services at TTY 711

L.A. Care publishes access information for People with Disabilities for each contracted Provider in the L.A. Care Provider Directories, which is updated monthly. Updated Provider Directories are sent to new Members upon enrollment with the "New Member Welcome Kit" and then annually thereafter, based on Member eligibility.

Providers should notify L.A. Care immediately of changes to their language capabilities and access information.

2.3.1 Medi-Cal Guidelines

There are two types of Medi-Cal programs in Los Angeles County, i.e. "fee-for-service" and "managed care." Most Medi-Cal beneficiaries in Los Angeles 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.

2.3.2 Medi-Cal Expansion

Under the Affordable Care Act, Medi-Cal has been expanded to include low-income adults without

children. Coverage under the expansion began January 1, 2014.

Medi-Cal currently provides health coverage for low-income individuals including families with children, Seniors and People with Disabilities (SPD), foster care youth, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. The Medi-Cal program now covers low-income adults up to 138% of the federal poverty level.

2.3.3 Mandatory Medi-Cal Managed Care Members

DHCS is in charge of administering the Medi-Cal Program. DHCS states that in Los Angeles County, most Medi-Cal members must enroll in a health plan and be in managed care. Members who must enroll in a health plan are commonly known as “mandatory members.” A mandatory member may disenroll from Medi-Cal managed care only if the member:

1. Has a complex medical condition (such as HIV/AIDS or cancer)
2. Has been in Medi-Cal managed care less than 90 days, and
3. Is being treated by a physician who does not work with any Medi-Cal managed care health plan.

Otherwise, the mandatory member must choose a managed care health plan, like L.A. Care.

2.3.4 Voluntary Medi-Cal Managed Care Members

In Los Angeles County, people with Medi-Cal may choose to enroll in a health plan. Members who choose to enroll in a health plan are called “voluntary members.” A voluntary member can choose to leave his or her health plan and return to fee-for-service Medi-Cal at any time. Voluntary members include:

- American Indians; who are eligible to get services from an Indian Health Center or Native American Health Clinic
- Children in foster care or in the Adoption Assistance Program
- Members with an HIV/AIDS diagnosis
- Some individuals with disabilities or elderly persons receiving Supplemental Security Income (SSI)
- Those 65 years or older

2.3.6 Member Enrollment

2.3.6.1 Enrollment into Medi-Cal is administered by DHCS using the State-contracted enrollment vendor, Health Care Options (HCO). Eligible Prospective Enrollees complete a CMS/DHCS approved enrollment form that is processed through HCO.

2.3.6.2 Dual members are eligible beneficiaries under the Medicare and Medi-Cal programs. All Dual-Eligibles have a Medicare Special Election Period, which allows them to enroll in and disenroll from a Medicare-Advantage plan on a monthly basis. Dual-Eligibles may join a Medicare-Advantage plan outside of their Initial Election Period and Medicare’s Annual Election Period.

2.3.6.3 All Dual-Eligibles who do not enroll in a managed care plan are required to enroll in a managed care Medi-Cal plan for their Medi-Cal benefits, with some exceptions.

2.3.7 Selection, Assignment, and Change of Primary Care Provider (PCP) and/or Participating Provider Group (PPG)

2.3.7.1 Selection and Assignment

2.3.7.1.1 At the time of enrollment, eligible Medi-Cal enrollees should select a PCP and PPG. Enrollees may choose to keep their current doctors or clinics as long as the doctors or clinics participate with L.A. Care. Enrollees may choose a new doctor or clinic from Providers in L.A. Care’s Provider Directory, which lists all contracted L.A. Care PPGs, PCPs, specialists, and hospitals. The Provider Directory also has helpful information about each doctor and clinic. Enrollees may choose a specialist as a PCP as long as the specialist is listed as a PCP in the provider directory.

2.3.7.1.2 Enrollees who do not choose a PCP and PPG will be assigned to a PCP and PPG by L.A. Care.

2.3.7.1.3 Health Care Options (HCO) will send a confirmation enrollment letter. L.A. Care will send a Welcome Packet that includes a welcome letter, Provider Directory, Evidence of Coverage/Member Handbook, and an identification card to an enrollee no later than ten (10) calendar days from receipt of confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later. The selected or assigned PCP and PPG will be stated on the Member’s identification card.

2.3.7.1.4 The PCP is responsible for coordinating, supervising, and providing primary health care services, including but not limited to, initiating specialty care referrals and maintaining continued care. Specialists who also meet the requirements for PCP participation and are willing to assume the responsibilities of a PCP may also request designation as a PCP in L.A. Care’s network.

2.3.7.2 Change of PCP and/or PPG

2.4.2.2.1 Members may change their PCP and/or PPG on a monthly basis by calling L.A. Care Member Services at 1.888.839.9909 (CRS TTY: 711). The change will occur on the first of the following month, provided the request is received by L.A. Care Member Services by the 20th of the month.

2.4.2.2.2 Changes in the L.A. Care provider network may also result in changes to the members' PCP and/or PPG. L.A. Care will notify the members of the change, the effective date of the change, and the members' right to request a different PPG and/or PCP assignment.

2.3.7.3 Disenrollment

2.3.7.3.1 Disenrollment refers to the termination of a member's enrollment with Medi-Cal L.A. Care. Disenrollment does not refer to a member transferring from one PCP and/or PPG to another.

2.4.2.3.2 Voluntary disenrollment refers to a member initiated termination from enrollment in L.A. Care. A member may disenroll from L.A. Care by calling Health Care Options (HCO) at 1.800.430.4263. HCO enrolls or disenrolls Medi-Cal beneficiaries in or out of a Medi-Cal managed care health plan. HCO will send the member a disenrollment form via mail. Membership will end on the last day of the month in which HCO approves the member's request for disenrollment. Disenrollment takes from 15 to 45 business-days. The member must continue to receive services through L.A. Care until the member is disenrolled from L.A. Care.

2.4.2.3.3 Involuntary disenrollment means the Medi-Cal member will lose managed care coverage with L.A. Care, but not necessarily their Medi-Cal benefits, if any of the following happens with a member:

- Member moves out of Los Angeles County permanently
- Member requires medical health care services not provided by L.A. Care (for example, some major organ transplants)
- Member has other non-government or government-sponsored health coverage
- Member is in prison or jail

2.4.2.3.3.1 A member may be involuntarily disenrolled from L.A. Care if there is a loss of Medi-Cal eligibility. This may occur under multiple circumstances including lack of eligibility renewal.

2.4 Member Identification Card

Members who are enrolled in L.A. Care Medi-Cal will be issued an identification card like the example below. This card contains their Health Plan (or PPG) number and their PCP's name and telephone number. The card also provides other telephone numbers to assist

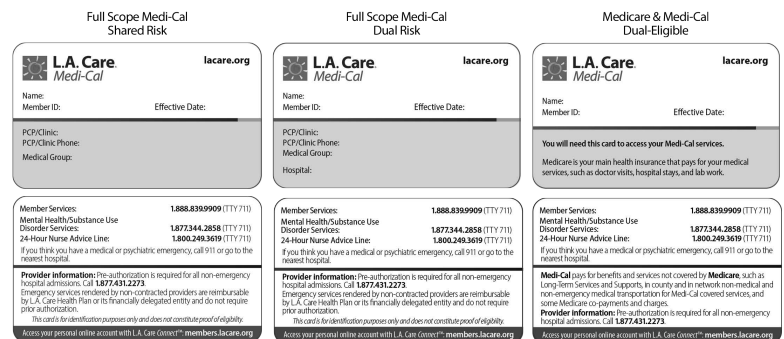
2.5 Eligibility Verification

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

2.5.2 To verify member eligibility, providers can log into the L.A. Care Provider Portal through L.A. Care site at www.lacare.org, under the "For Providers" tab, Provider Sign In/Check Patient Eligibility or call L.A. Care's Provider Services Line at 1.866.LA.CARE6 (1.866.522.2736).

2.6 Evidence of Coverage

An L.A. Care Evidence of Coverage/Member Handbook (EOC) is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and



2.8 Member's Rights and Responsibilities

2.8.1 L.A. Care Medi-Cal Members have specific rights and responsibilities that are fundamental to the provision and receipt of quality healthcare services, as follows:

- Respectful and courteous treatment. Members have the right to be treated with respect, dignity and courtesy by their provider and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.
- Privacy and confidentiality. Members have the right to have their medical records kept confidential. Provider offices must implement and maintain procedures that protect against disclosure of confidential patient information to unauthorized persons. Members also have the right to receive a copy of and request corrections to their medical records.
- Providers must abide by California minor consent laws. Members have the right to be counseled on their rights to confidentiality, and members' consent is required prior to the release of confidential information unless such consent is not required.
- Choice and involvement in their care. Members have the right to receive information about their health plan, services, and providers. Members have the right to choose their PCP from L.A. Care's provider directory. Members also have the right to obtain appointments within access standards. Members have the right to talk with their provider about any care provided or recommended. Members have the right to discuss all treatment options, and participate in making decisions about their care. Members have the right to a second opinion. Members have the right to speak candidly to their provider about appropriate or medically necessary treatment options for their condition. Members have the right to decline treatment. Members have the right to decide in advance how they want to be cared for in case of a life-threatening illness or injury. Members also have the right to assist with the formulation of their advanced directives.
- Voice concerns. Members have the right to file a complaint about L.A. Care and/or its affiliated providers. They also have the right to receive care without fear of losing their benefits. L.A. Care will help members with the grievance process. If members don't agree with a complaint resolution, they have the right to appeal. Members have the right to disenroll from L.A. Care whenever they want. As a Medi-Cal member, members have the right to request a State Hearing.
- Service outside of L.A. Care's provider network. Members have the right to receive emergency

or urgent services as well as family planning and sexually transmitted disease services outside of their health plan's network.

- Members may also have access to Federally Qualified Health Centers and members that meet certain criteria may access Indian Health Services Facilities.
- Service and information. Members have the right to request an interpreter at no charge and not use a family member or a friend to translate for them.
- Members have the right to access the Member Handbook and other information in another language or format, including braille, large size print, and audio format upon request.
- Know their rights. Members have the right to receive information about their rights and responsibilities. Members have the right to make recommendations about their rights and responsibilities. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

2.8.2 L.A. Care informs Members of their responsibilities, which are to:

- Act courteously and respectfully. Members are responsible for treating providers and staff with courtesy and respect. Members are responsible for being on time for their visits or calling your office at least 24 hours before the visit to cancel or reschedule.
- Give up-to-date, accurate and complete information. Members are responsible for giving correct information and relevant information to all of their providers. L.A. Care. Members are responsible for getting regular check-ups and telling their provider about health problems before they become serious.
- Members should follow their provider's advice and participate in their care. Members are responsible for talking about their health care needs with their provider, developing and agreeing on goals, doing their best to understand their health problems, and following the treatment plans and instructions they both agree on.
- Use the Emergency Room only in an emergency. Members are responsible for using the emergency room in case of an emergency or as directed by their provider.
- Report wrong doing. Members are responsible for reporting health care fraud or wrong doing to L.A. Care. Members can do this anonymously by calling the L.A. Care Fraud and Abuse Hotline toll-free at 1.800.400.4889.

2.9 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) calendar 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) calendar days prior to changes, or as soon as possible.

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

2.10 Member Grievances and Appeals

L.A. Care Members have the right to file a grievance and/or appeal through a formal process. Members may elect a personal representative or a provider to file the grievance or appeal on their behalf (See Section on Acting as an Appointed Representative).

2.10.1 Member Grievances

A Grievance is defined as any complaint or dispute, expressing dissatisfaction with the manner in which L.A. Care or delegated entities provide health care services, regardless of whether any remedial action can be taken. A Grievance may include concerns about the operations of L.A. Care or its Providers such as: wait time, the demeanor of health care personnel, the adequacy of facilities, and the lack of courteous service. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

2.10.2 Participating Physician Group Responsibility

L.A. Care does not delegate the grievance or appeal process to Participating Physician Groups (PPGs) or any of its contracted providers. Therefore, any expression of dissatisfaction by the member and or any denial that has been protested must be forwarded to the L.A. Care Appeals and Grievances Department within 24 hours of receipt by telephone at: 1.888.839.9909 by Fax at: 1.213.438.5748 or by mail at:

L.A. Care
Appeals & Grievances Department
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

Electronic grievances or appeals may be filed online at www.lacare.org, under the "For Members" tab, "Member Rights/File a Complaint" section.

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

The PPG is expected to cooperate with all requests from the L.A. Care Appeals and Grievances Department. The PPG should provide a contact person for communication with the Appeals and Grievances Department.

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

2.10.2.1 Acting as an Appointed Representative

A member may have any individual, including a provider, act as his or her representative as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before Center for Medicare and Medicaid Services (CMS), or is otherwise prohibited by law.

The member and representative must complete the Appointment of Representative Form, in order to act as a representative. A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation.

Providers may contact the Provider Service Line to request an Appointment of Representative Form via mail.

2.10.3 L.A. Care's resolution process for Standard and Expedited Grievances includes the following basic steps:

2.10.3.1 Standard Grievance

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

L.A. Care acknowledges, thoroughly investigates, and resolves standard member grievances within 30 calendar days of the oral or written request. However, if information is missing or if it is in the best interest of the member, L.A. Care may extend the timeframe by an additional 14 calendar days.

2.10.3.2 Expedited Grievance

L.A. Care provides expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function (“urgent grievances”).

A member or a member’s representative may request an expedited grievance.

L.A. Care responds to expedited grievances within 72 hours of receipt of the oral or written request.

2.10.4 Member Appeals

A member may file an appeal when he or she does not agree with L. A. Care’s decision to: stop, suspend, reduce, deny a service, or deny payment for services provided. The member must submit the appeal to L.A. Care. Upon review of the appeal, L.A. Care will make a determination and notify the member in writing of the decision.

2.10.4.1 Member Appeal Procedure – Medi-Cal

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

If a delegated PPG’s appeal process results in a denial, deferral, and/or modification with which the member is still dissatisfied, the member or Authorized Representative, may request a formal appeal to L.A. Care for a higher-level review.

Members and providers, on behalf of members, may also appeal L.A. Care’s decision to modify or deny a service request. The appeal request is reviewed by a physician or physician reviewer not involved in the prior determination. (This does not apply to the retrospective claims review/provider dispute resolution process.)

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.

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 acknowledgment and a determination notification will be sent to the member and provider via mail, within 72 hours after the receipt of the reasonably necessary information and requested by L.A. Care 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 phone number, as applicable
- The phone number and extension of the L.A. Care physician reviewer

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

2.10.5 State Hearings

Additional requirements specific to the management of Medi-Cal Member Appeals.

Medi-Cal Members and/or their representative may contact the California Department of Social Services to request a State Hearing or an Expedited State Hearing within **120 calendar days** from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary the Adverse Benefit Decision has been upheld. ***Medi-Cal Members must exhaust all levels of the Plan’s internal appeal process prior to initiating a State Hearing.***

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

Contact information for the Medi-Cal Managed Care Ombudsman is as follows:

Medi-Cal Managed Care Ombudsman

1.888.452.8609 (many languages)

To submit the request in writing, a member may send a letter to the following address:

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

To access the online site go to:

<http://www.dhcs.ca.gov/services/medi-cal>

2.10.6 Independent Medical Review

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 following:

- 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 requesting an IMR is always included with the L.A. Care's appeal response notification letter resulting from upholding a denial or modification of a request for service.

For assistance regarding an IMR, the DMHC has a toll-free telephone number (1.888.466.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired.

The DMHC Internet Website has IMR application forms and instructions online.

To access the online site go to the DMHC, Independent Medical Review page:

<https://www.dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaint.aspx>

2.10.7 Member Appeal Procedure – Overlapping Benefits

For benefits covered by both Medicare and Medi-Cal, the Member retains the right to a State Fair Hearing, regardless of the designated pathway.

Medi-Cal issues follow the Medi-Cal Appeals procedure. The final available determination possible is that made in a State Fair Hearing.

Medicare issues follow the Medicare Appeals procedure. Members, or their authorized representative, who want to appeal the outcome of the appeal decision may contact the DHCS, to request a State Fair Hearing or an Expedited State Fair Hearing.

3.0 Access to Care

This section summarizes the access to care requirements for L.A. Care’s Providers in the participating provider network, including Participating Physician Groups (PPGs) and their affiliated provider networks.

3.1 Responsibility of Participating Providers

All Providers are responsible for fulfilling the access to care standards outlined in this section. L.A. Care monitors the ability of its Members to access each service type (left column) according to the specified L.A. Care Access Standard (right column).

3.2 Access to Care Requirements (Primary Care and Specialty Care Physicians, Behavioral Health and Ancillary Providers)

Primary Care Provider (PCP) Appointment Standards:	
Type of Service	Standard
Routine Primary Care Appointment (Non-Urgent) Services for a symptomatic patient who does not require immediate diagnosis and/or treatment.	≤ 10 business days of request
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
Emergency Care 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
Preventative health examination (Routine)	≤ 10 business days of request
First Prenatal Visit A health evaluation for a pregnant member with no acute medical problems	≤ 14 calendar days of request
Staying Healthy Assessment Initial Health Assessment and Individual Health Assessment and Individual Health Education Behavioral Health Assessment (IHEBA)	Members >18 months of age: ≤ 120 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.

Primary Care Provider (PCP) Appointment Standards:

Type of Service	Standard
In-Office Waiting Room Time The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.	Within 30 minutes

Specialty Care Provider (SCP) Appointment Standards:

Routine Specialty Care Physician Appointment	≤ 15 Business days of request
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

Ancillary Care Appointment Standards:

Non-Urgent Ancillary Appointment	≤ 15 business days of request
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Behavioral Health Care Appointment Standards:

Routine Appointment (includes non-physician behavioral health providers)	< 15 Business days of request (Physicians) ≤ 10 business days of request (Non-Physicians)
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
Life Threatening Emergency Services for a life-threatening condition where the member is at immediate risk of self-harm or harm to others	Immediately
Non-Life Threatening Emergency Services for a non-life threatening condition where the risk of self-harm or harm to others is not imminent but requires a safe environment	≤ 6 hours of request

Primary Care Provider (PCP) Appointment Standards:

Type of Service

Standard

Emergency Services

Immediate, 24 hours a day, 7 days per week

After Hours Care Accessibility Standards:

After Hours Care

Physicians (PCP, Behavioral Health Provider and Specialists, or covering physician) are required to provide 24 hours a day, 7 days per week coverage to members.

Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to member, upon request within 30 minutes.

*Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.

- Automated systems must provide emergency 911 instructions
- 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, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician **within 30 minutes**
- If process does not enable the caller to contact the PCP, Behavioral Health Provider, Specialist or covering practitioner directly, the “live” party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.

Practitioner Telephone Responsiveness:

Speed of Telephone Answer (Practitioner’s Office)

The maximum length of time for practitioner office staff to answer the phone.

Not to Exceed (NTE) 30 seconds

Call Return Time (Practitioner’s Office)

The maximum length of time for PCP, Behavioral Health Provider, Specialist offices, covering practitioner or triage/screening clinician to return a Member call.

< 30 minutes

*Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.

3.3 Monitoring

L.A. Care regularly monitors and audits the appointment and access standards identified in this Section, and others per applicable rules, regulations, contracts, and guidance. The PPG and/or Provider, as applicable, are responsible for responding to any appointment and/or access deficiencies identified by L.A. Care Health Plan review methods, including the following:

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

4.0 Scope of Benefits

Principal Benefits and Coverages

The below listed benefits and services are available for prevention, diagnosis, and treatment of illness or injury (including ancillary services). Please refer to the Prior Authorization section of this Provider Manual for authorization requirements to understand benefits and service coverage according to the contract and service area or contact the **L.A. Care Provider Services line at 1.866.522.2736**.

- Provider/Practitioner Services
- Preventive Health Services
- Family Planning
- Maternity Care
- Hospital Services
- Outpatient Mental Health Services
- Substance Use Disorder Preventive Services/ Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Prescription Drugs and Medications
- Vision Services
- Laboratory X-ray, and Prescribed Services
- Cancer Clinical Trials
- Durable Medical Equipment
- Therapeutic Formulas
- Enteral Nutrition Products
- Diabetic Equipment and Supplies
- Long Term Services and Supports (LTSS)
- Home Health Care

Hospice Care

- Emergency Care
- Medical Transportation

In Los Angeles County, L.A. Care Health Plan is responsible for Long Term Care (LTC) coverage. Additional information can be found in the LTSS section.

For custodial authorization or outpatient services needed while in custodial level of care, please fax all requests to the Prior Authorization Department at 1.213.438.5777

Principal Exclusions and Limitations

Services that are not covered by L.A. Care Health Plan or Medi-Cal

These services will not be provided by L.A. Care or Regular Medi-Cal (fee-for-service program) and are excluded from coverage:

- Experimental or investigational drug, device, or procedures (unless approved)
- Over-the-counter (OTC) drugs (unless approved)
- Cosmetic surgery, except when required to repair trauma or disease-related disfigurement
- Personal comfort or convenience items
- Private duty nurses (except when medically necessary)
- Elective circumcisions
- Audiology Services not performed/prescribed by a provider in a provider office
- Speech Therapy Services
- Podiatry Services
- Services outside the United States, except Emergency services requiring hospitalization in Canada and Mexico

Excluded (Carve-Out) Services

Medi-Cal beneficiaries enrolled in a managed care plan obtain most of their benefits from their health plan. Medi-Cal services not covered by a health plan are referred to as “excluded” or as “carve-out.”

Excluded services can only be rendered by a Medi-Cal enrolled Provider/Practitioner and must be billed through the Medi-Cal Fee-for-Service (FFS) system. In most cases, beneficiaries remain enrolled in their health plan while receiving these excluded services. Coordination of carved out services is part of the role of the primary care provider. Below is a list of excluded services that may be obtained while a beneficiary remains enrolled in a managed care plan:

- California Children’s Services (CCS)
- Mental Health
 - L.A. Care does not cover hospital care and specialty mental health care. Medi-Cal FFS or the County Department of Mental Health (DMH) provides these services.
- Alcohol and Drug Treatment
- Dental Services
- Directly Observed Therapy for Tuberculosis (TB)
- Women, Infants, and Children Supplemental Food Program (WIC)
- Local Education Agency Services
- End of Life Services
 - Contact the Medi-Cal Member and Provider Helpline at 1.800.541.5555 (outside of California, please call 1.916.636.1980 to learn about these services.

Exceptions for Services Not Covered by L.A. Care Health Plan or Regular Medi-Cal

Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) added Section 14131.10 of the Welfare and Institutions Code (W&I Code) to exclude several optional benefits from coverage under the Medi-Cal Program for members 21 years and older, effective July 1, 2009. Please refer to the Medi-Cal Provider Manual on the Department of Health Care Services website (http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp) for a description of optional benefit exclusions and exemption criteria.

Nurse Advice Line (NAL)

L.A. Care provides a Nurse Advice Line (NAL) free of charge. Members can call **1.800.249.3619 (TTY 711) 24 hours a day, 7 days a week**. Providers are encouraged to share this number with L.A. Care members. The NAL is intended to provide members with general health advice and information, understand health concerns, understand prescriptions, health test results, and seek the appropriate level of care. The line is staffed with RNs who follow medical doctor reviewed algorithms when triaging symptomatic calls. An audio library of more than 1,000 easy to follow health topics is provided through this service. Members can also chat live with a nurse by logging into their L.A. Care Connect online member account.

Other Important Numbers

Hearing or speech impaired members can contact L.A. Care NAL through the California Telecommunications Relay Service at TTY 711.

Medi-Cal Members with one of our Plan Partners can call the Nurse Advice Line at:

- Anthem Blue Cross: 1.800.224.0336 or TTY/TDD 1.800.368.4424
- Care 1st Health Plan: 1.800.609.4166 or TTY/TDD 1.800.735.2929
- Kaiser Permanente: 1.888.576.6225

Non-Emergency Medical Transportation

L.A. Care Medi-Cal members can access Non-Emergency Medical Transportation (NEMT) when they cannot get to their medical appointment by car, bus, train, or taxi, and the plan pays for your medical or physical condition.

NEMT is an ambulance, litter van or wheelchair van. NEMT is not a car, bus, or taxi. L.A. Care Health Plan allows the lowest cost NEMT for the member's medical needs when they need a ride to their appointment. That means, for example, if a wheelchair van is able to transport the member, L.A. Care Health Plan will not pay for an ambulance.

NEMT can be used when:

- Medically needed;
- The member can't use a bus, taxi, car or van to get to their appointment;
- Requested by a L.A. Care Health Plan provider; and
- Approved in advance by L.A. Care Health Plan.

Scheduling NEMT

To request NEMT, please call **L.A. Care Health Plan Member Services 1.888.839.9909 (TTY 711)** at **or LogistiCare at 1.866.529.2141** at least **five (5)** business days (Monday-Friday) before the appointment. Or call as soon as you can when you have an urgent appointment. Please instruct the member to have their member ID card ready when you or they call.

Services can be requested directly by calling **LogistiCare at 1.866.529.2141** at least **five (5)** business days (Monday-Friday) before the appointment 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 1.866.529.2142

Limits of NEMT

There are no limits if you meet the terms above.

What Doesn't Qualify for NEMT?

Getting to your medical appointment by car, bus, taxi, or plane. Transportation will not be provided if the service is not covered by the health plan. A list of covered services is in this member handbook (or also called an EOC).

Cost to Member

There is no cost when transportation is authorized by L.A. Care Health Plan.

5.0 Utilization Management

This section summarizes L.A. Care's Medical Management Utilization Management (UM) processes for its direct contract Provider network, including direct contract Participating Physician Groups (PPGs), direct contract physicians, hospitals and ancillary providers, as applicable.

L.A. Care UM functions and activities vary depending on specific contractual agreements with each contracted PPG, provider, and hospital. Please review your Medi-Cal Program contract with L.A. Care which outlines the Division of Financial Responsibility (DOFR). You may contact L.A. Care's Provider Services Unit (PSU) line at 1.866.522-2736 to connect you with the appropriate department to respond to your UM questions. You may also contact the Medical Management/UM Department at 1.877.431.2273.

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

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

L.A. Care UM department is staffed with professional registered nurses and paraprofessionals who are available

to provide support to PPGs and Providers with UM activities including but not limited to the following:

- Benefit interpretation
- Outpatient and inpatient referral management
- Coordination of care and services for linked programs (California Children's Services, Department of Developmental Services, Early Start, Local Education Agency, etc.)
- Coordination of benefits
- Targeted case management (comprehensive and catastrophic)
- Complex case management
- Education of PPG and/or contracted providers on policies, procedures and legislative updates

5.1 Goal And Objectives

Goal

The goal of L.A. Care's UM 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 the quality of member medical care provided to L.A. Care Members.

Objectives

The UM 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 the following:

- 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 PPGs, Providers, Practitioners, Members and L.A. Care.
- Developing and implementing programs to encourage preventive health behaviors that can 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 (COC) for L.A. Care Members within and outside of L.A. Care's network.

- Integration with Quality Improvement
 - The UM Program has multiple quality operations processes to ensure that quality of care service-oriented interventions are initiated and carried out. Linkage between the UM Program and the 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 Quality of 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 the following:
 - Inter-Rater Reliability (IRR)
 - Member and Provider Satisfaction with the UM Experience
 - Referral of identified potential quality issues for review to the QI Department for follow-up in accordance with established procedures (including sentinel or adverse event reporting)
- 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. L.A. Care's Policy Prohibiting Financial Incentives for Utilization Management Decision-makers states that 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.
- Monitoring the provision of health assessments and basic medical case management to all Members, PPGs, Providers, and Practitioners.

5.2 Scope of Service

The scope of L.A. Care's Medi-Cal UM Program includes all aspects of health care services delivered at all levels of care to L.A. Care Medi-Cal members.

L.A. Care 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 administers the delivery of health care services to its members through different contractual agreements. L.A. Care's services are administered through different contractual arrangements with 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 L.A. Care's contracted networks, contracts with non-participating provider 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:

- Delivers medically necessary services at the appropriate level of care, including inpatient and ambulatory settings
- Provides services consistent with the benefits provided by the Plan's Medi-Cal Program
- Provides a comprehensive analysis of care by identifying under and overutilization patterns by network contracted PPGs, hospitals and ancillary providers
- 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
- Defines, adopts and distributes evidence based criteria utilized in the utilization management process as well as instruct contracted institutions, physicians, and other health care clinicians regarding

the criteria and 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 the provision of health care services by network institutions, physicians, and other health care clinicians unless otherwise mandated by regulatory standards
- Ensures coordination and COC for members receiving linked and carved out services/programs including, but not limited, California Children's Services (CCS), Regional Centers, 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
- L. A. Care Health Plan by offering feedback to the PPGs and 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

5.2.1 Policy Prohibiting Financial Incentives for Utilization Management Decision-makers

UM 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 UM decision-makers to encourage decisions that would result in underutilization.

5.2.2 Required Reporting from UM

L.A. Care contracted PPGs' UM departments shall monitor, report, and address the following services to L.A. Care and its appropriate committee structures. The services include, but are not limited to:

- Potentially fraudulent or abusive practices
- Potential under and overutilization
- Coordination of care for results or facilitation
- Opportunities for improvement
- Breaches of adherence to confidentiality and Health Insurance Portability and Accountability Act (HIPAA) policies (these are referred to L.A. Care's Compliance, Privacy Officer)
- Potential quality issues identified through UM activities
- Identified barriers to accessibility and availability of services

5.3 Delegation of Utilization Management

L.A. Care has a formal process by which specific Utilization Management functions are delegated to other organizations including PPGs/Specialty. [See **PPGs Service Agreement — Delegation of UM Functions by National Committee for Quality Assurance (NCQA) UM Standards**].

L.A. Care's Clinical Assurance Department 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 Delegation Agreement.

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 delegation is defined as delegation to perform UM activities defined in the delegation agreement and noted in the PPG Division of Financial Responsibility (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 License or other regulatory status and NCQA accreditation or certification status and includes conducting oversight activities, reporting results, developing Corrective Action Plans (CAPs) and monitoring progress in implementation of the CAPs.

L.A. Care's Clinical Assurance Department is responsible for making sure that the delegated activities are performed in a manner consistent with the delegation agreement, L.A. Care criteria, 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 withholds or withdraws delegated status for Utilization Management from a PPG/Specialty Provider, L.A. Care's UM Department shall assume the level of UM activity appropriate to the new non-delegated PPG/Specialty Provider. L.A. Care reserves the right to continue to delegate UM to the PPGs/Specialty Providers if they meet L.A. Care's standards for delegation. L.A. Care's Clinical Assurance Department will provide consultation to the PPG/Specialty Provider and may actively participate with the PPG/Specialty Provider to assist the PPG/Specialty Provider to come into compliance with a UM delegated function prior to L.A. Care's revocation of a UM delegated status.

5.4 Utilization Management Delegation Status

PPG/Specialty Provider 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.

5.4.1 Delegates with NCQA accreditation

If the delegate or delegate's sub-delegates are NCQA Accredited or NCQA Certified or NCQA-Recognized, the delegate is eligible for automatic credit if it meets all other automatic credit criteria for the those areas specific to NCQA. This does not apply to, or relieve the delegates from, L.A. Care's oversight process.

5.5 Utilization Management Delegation Monitoring and Oversight

L.A. Care's Clinical Assurance Department is responsible for evaluating the PPGs/Specialty Providers ability to perform the delegated activities including an initial review to assure that the PPG/Specialty Provider has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

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

5.6 Utilization Management and Case Management Reports

PPGs will submit UM and Case Management (CM) reports as defined in the delegation agreements, via the Clinical Assurance Secure File Transfer Protocol (SFTP) site, and email a screen shot of uploaded reports to **clinicalassurance@lacare.org**. Specialty Providers will submit reports as defined in the delegation agreements, via the Provider Vendor Management SFTP site, and email a screen shot of uploaded reports to **clinicalassurance@lacare.org**.

L.A. Care will utilize encounter data, summary reports, and supplemental reports provided by PPGs/Specialty Providers to track, trend, and report UM activities as required by regulatory entities, contracted requirements, and accreditation standards. These reports, combined with information obtained via site visits and audits, will be used to accomplish UM delegated oversight functions. Additional oversight reporting may be required to be sent to the Delegation Oversight Unit for ongoing monitoring. L.A. Care reviews PPGs/Specialty Providers 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 L.A. Care's Clinical Assurance Department upon request via the SFTP site, with a screen shot of the uploaded letters to **clinicalassurance@lacare.org**.

L.A. Care will analyze the reports and present the results to the PPGs/Specialty Providers via quarterly feedback provided by L.A. Care's Clinical Assurance Performance Monitoring Nurse Specialists. 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 committee/sub-committee meetings, and periodically at the QOC and Internal Compliance Committee for recommendations.

A list of the reporting requirements can be found in each PPGs/Specialty Providers Delegation Agreement. The following table shows a complete description of required reports, due dates, and required format. PPGs with Medi-Cal L.A Care (MCLA) line of business are required to submit the following reports (**Certain Specialty Providers with MCLA line of business are required to submit reports with asterisk*):

Report	Due Date	Submit To	Required Format
<p><i>Applicable to All Lines of Business (LOB)</i></p> <p>*UM Program Description The UM Program describes UM, CM, Care Coordination Programs and Processes, and the medical and behavioral health aspects of the Program.</p>	<p>Annually Feb 15 <i>Report Previous Year</i></p>	<p>via Clinical Assurance SFTP Site Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Narrative</p>
<p><i>Applicable to All LOB</i></p> <p>*UM WorkPlan Work Plan goals and planned activities.</p>	<p>Annually Feb 15 <i>Report Current Year</i></p>	<p>via Clinical Assurance SFTP Site Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Quarterly ICE Reporting template provided by L.A. Care</p>
<p><i>Applicable to All LOB</i></p> <p>*UM Program Evaluation Report that provides a detailed description of utilization activities, delegated activities, and strategic initiatives accomplished during the past year. This report is incorporated into the Q4 UM ICE Report, no need to submit a separate report.</p>	<p>Annually Feb 15 <i>Report Previous Year</i></p>	<p>via Clinical Assurance SFTP Site Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Quarterly ICE Reporting template provided by L.A. Care</p>

Report	Due Date	Submit To	Required Format
<p>Applicable to All LOB</p> <p>*UM ICE Quarterly Report Report that provides a detailed description of utilization activities, delegated activities, and strategic initiatives accomplished during the quarter</p>	<p>Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15</p>	<p>via Clinical Assurance SFTP Site Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Quarterly ICE Reporting template provided by L.A. Care</p>
<p>Applicable to All LOB</p> <p>*QI Continuity & Coordination of Care Report (COC-TOC) Number of terminated primary care and specialty care providers; number of members requesting assistance for COC (COC) with terminated providers</p> <p>COC (NCQA NET 5 Element A & B) Tracking log of members requesting COC due to provider termination:</p> <ul style="list-style-type: none"> • Total # of termed Primary Care Physicians (PCP)/ SCP • Total # of members requesting assistance for COC with termed PCP/SCP • Total # of members allowed to continue access to termed PCP/SCP <p>Tracking log of members requesting COC when benefits end: (NCQA QI 8 Element D)</p> <ul style="list-style-type: none"> • Total # of members whose benefit coverage ended while still needing care • Total # of members assisted in transition to other care when benefit coverage ended. 	<p>Quarterly 1st Qtr – April 15 2nd Qtr – July 15 3rd Qtr – Oct 15 4th Qtr – Jan 15</p>	<p>via Clinical Assurance SFTP Site Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Reporting template provided by L.A. Care</p>

Report	Due Date	Submit To	Required Format
<p><i>Applicable to All LOB</i></p> <p>*UM Monthly Activity Report and Logs</p> <p>*UM Monthly Activity Report: Delegates are required to complete our UM Monthly Activity Report</p> <p>*UM Monthly Activity Logs:</p> <ol style="list-style-type: none"> 1. *Referral/Authorization Approval Log: Delegates have the option of using our template or adding the fields found in our template (if missing) to their own reporting log. Submitted log must contain fields found in our template, as these fields will be needed for NCQA. 2. *Denial/Modification/Termination Log: Delegates have the option of using our template or adding the fields found in our template (if missing) to their own reporting log. Submitted log must contain fields found in our template, as these fields will be needed for NCQA. 3. Bed Days Report- Acute Inpatient Log, includes LTAC: Delegates may use their own template, as long as they report member information. 4. Bed Days Report- Inpatient Admissions Greater than 10 days LOS: Delegates have the option of using our template or adding the fields found in our template (if missing) to their own reporting log. Submitted log must contain fields found in our template. 5. Bed Days Report-Sub-Acute SNF Log: Delegates may use their own template, as long as they report member information. 6. ESRD/Dialysis Log: Delegates may use their own template, as long as they report member information. 7. HIV/AIDS Encounters Log: Delegates may use their own template, as long as they report member information. 8. Major Organ Transplant Requests Log: Delegates may use their own template, as long as they report member information. 9. Case Management/Care Coordination Log: Delegates need to use our template, do not make any modifications to our template. <p><i>Service Logs to be maintained, but to be submitted only upon request:</i></p> <ul style="list-style-type: none"> • Sterilization Log • TB (New Diagnosis) Log • CPSP (Pregnancy) Log • Drug-Alcohol Referral • Hospice Referral • Standing Referrals • Specialty Referrals <p><i>Linked Services Logs to be maintained, but to be submitted only upon request:</i></p> <ul style="list-style-type: none"> • CCS** • New TB Referrals to Direct Observed Therapy (DOT)** • Non-CCI SNF admissions, Custodial (Long Term) Care Log** • AIDS In-Home & Community Based Waivers** • Medi-Cal Waivers** <p><i>**Not applicable with CMC Line of Business</i></p>	<p>Monthly</p> <p>Every 15th of the month</p> <p><i>Previous month's data</i></p>	<p>via Clinical Assurance SFTP Site</p> <p>Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Reporting template provided by L.A. Care</p> <p><i>Logs need to be submitted in excel format, L.A. Care needs to be able to filter and sort through fields</i></p>

Report	Due Date	Submit To	Required Format
<p><i>MCLA LOB ONLY</i></p> <p>COC with FFS Provider for Transitional SPDs Report (COC-SPD):</p> <p>COC requests related to members transitioning from MediCal Fee for Service (FFS) to MediCal Managed Care. Aid codes: 10, 14, 16, 20, 24, 26, 36, 60, 64, 66, 1E, 1H, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V</p>	<p>Quarterly</p> <p>1st Qtr – April 15</p> <p>2nd Qtr – July 15</p> <p>3rd Qtr – Oct 15</p> <p>4th Qtr – Jan 15</p>	<p>via Clinical Assurance SFTP Site</p> <p>Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Reporting template provided by L.A. Care</p>
<p><i>MCLA LOB ONLY</i></p> <p>Dental General Anesthesia Services Report (DGAS):</p> <p>Dental general anesthesia services provided by a physician in conjunction with dental services for managed care beneficiaries in hospitals, ambulatory medical surgical settings, or dental offices.</p>	<p>Quarterly</p> <p>1st Qtr – April 15</p> <p>2nd Qtr – July 15</p> <p>3rd Qtr – Oct 15</p> <p>4th Qtr – Jan 15</p>	<p>via Clinical Assurance SFTP Site</p> <p>Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Reporting template provided by L.A. Care</p>
<p><i>MCLA LOB ONLY</i></p> <p>COC for Optional Targeted Low Income Children Report (COC-OTLIC):</p> <p>COC for members requesting FFS providers through plan. Aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9</p>	<p>Quarterly</p> <p>1st Qtr – April 15</p> <p>2nd Qtr – July 15</p> <p>3rd Qtr – Oct 15</p> <p>4th Qtr – Jan 15</p>	<p>via Clinical Assurance SFTP Site</p> <p>Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Reporting template provided by L.A. Care</p>
<p><i>MCLA LOB ONLY</i></p> <p>COC for Medical Exemption Requests Report (COC-MER):</p> <p>COC requests for returning member in the middle of care with a non-participating provider</p>	<p>Quarterly</p> <p>1st Qtr – April 15</p> <p>2nd Qtr – July 15</p> <p>3rd Qtr – Oct 15</p> <p>4th Qtr – Jan 15</p>	<p>via Clinical Assurance SFTP Site</p> <p>Email screen shot of uploaded reports to clinicalassurance@lacare.org</p>	<p>Reporting template provided by L.A. Care</p>

On monthly and quarterly basis, Clinical Assurance Performance Monitoring Coordinators will email report reminders, and attach the required reporting templates. For required reporting templates, please contact your assigned Performance Monitoring Coordinator or send request to **clinicalassurance@lacare.org**. If your organization requires additional training or assistance with a particular report, please contact your assigned Performance Monitoring Coordinator to set-up a training.

5.7 Utilization Management Delegation Oversight Audits

Oversight for L.A. Care's directly contracted PPGs/Specialty Providers 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 departments to improve efficiencies and decrease duplication. The primary objective of the oversight audit is to ensure compliance with L.A. Care's policies and procedures, standards of care, local, State, and Federal regulatory requirements, accreditation standards, and provisions of the purchaser contracts (e.g. Department of Health Care Services (DHCS), Centers for Medicare & Medicaid (CMS)). The oversight audit consists of document review and staff interviews to verify that policies/procedures/processes have been implemented, applied, and are in compliance.

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

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

- Credentialing
- Financial Compliance

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

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

5.8 Supplemental Audits

Focused supplemental audit topics may be identified by the Utilization Management Committee, Chief Medical Officer or Medical Director. Focused supplemental audit topics may also be identified by a mid-year assessment, 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's department's policies and procedures, standards of care, regulatory requirements, and provisions of contracts with a specific issue. The supplemental audit may consist of document review, file review and/or medical record review and staff interviews; in addition to follow-up on identified deficiencies or areas of concern.

A sampling methodology used to select member records ensures a representative sample from the PPG/Specialty Provider for the supplemental audit. Supplemental audit tools are scored according to the methodology approved by the UM Committee. The supplemental audit may address any UM and coordination of care category as identified by L.A. Care UM Program.

5.9 Continuous Monitoring Activities

Continuous monitoring activities are used to further supplement the basic oversight activities. These activities include annual/focused audits and supplemental report submission review in order to provide more comprehensive and timely oversight

in selected areas where episodic audits/reviews have not been adequate in ensuring compliance with regulations. A sampling methodology appropriate to each continuous monitoring activity is defined to ensure representative sampling, and approved by the UM Committee. Examples of continuous monitoring may include, but are not limited to:

- Referral Management – Timeliness, Clinical Decisions, Member/Provider Notification, benefits, and medical necessity determinations
- 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

5.10 Continuous Monitoring of Un-appealed Denials

The L.A. Care Clinical Assurance Department reviews denials issued and submitted by the PPGs/Specialty Providers. Delegated PPGs/Specialty Providers are required to submit all denial letters with any supporting documentation current to the denial upon request or on schedule defined in L.A. Care's Delegation Oversight Monitoring Policy upon request. Plan Partner and PPG denial letters are evaluated for compliance in the following areas:

- Appropriate template
- 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

If deficiencies are found in the initial review, the Plan or delegated PPG is notified of the areas of deficiencies for immediate correction. Continued non-compliance issues are reported to the Utilization Management Committee (UMC), Quality of Care (QOC), and/or Internal Compliance Committee (ICC) for recommendations in corrective action planning or disciplinary action. Delegated PPGs/Specialty Providers letters are also audited during the annual oversight audits. Corrective Action Plans (CAPs) are required for those PPGs/Specialty Providers with less than 90% compliance. PPGs/Specialty Providers with deficiencies or CAPs will be monitored according to L.A. Care policy. If a PPG/Specialty Provider remains non-compliant, the findings

will be reported to the Delegation Oversight Group for a decision regarding continued delegation.

The Plan will provide delegated PPGs/Specialty Providers with the approved CMS, DHCS, or L.A. Care letter templates that need to be utilized as the member communication during the utilization management process. Documents will be shared at least once every year or more often as the need arises. The utilization on the approved templates ensures that the PPG/Specialty Provider is using approved standard regulatory language to explain member's rights.

5.11 Benefits

The DHCS mandates benefits for Medi-Cal Members.

Member Handbooks for the Medi-Cal MCLA LOB 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.

5.12 Continuity of Care (COC)

COC provisions related to any member who is:

- New member transitioning into L.A. Care and who is in the middle of care
- Members assigned to a contracted provider who is terminated from the network
- New Medi-Cal enrollees transitioning into Medi-Cal Managed Care
- Dually eligible beneficiaries (beneficiaries eligible for Medi-Cal and Medicare) in the Cal MediConnect program
- New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption

L.A. Care and its Delegates must provide COC with an out-of-network provider when:

1. L.A. Care is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
2. The provider is willing to accept the higher of the L.A. Care or its Delegates contract rates or Medi-Cal FFS rates; and
3. The provider meets applicable professional standards and has no disqualifying quality of care issues.

Beneficiaries, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request for COC. When this occurs, the L.A. Care and its Delegates must:

- begin to process the request within five working days after receipt of the request.
- the request must be completed in three calendar days if there is a risk of harm to the beneficiary. For the purposes of this APL, “risk of harm” is defined as an imminent and serious threat to the health of the beneficiary.

The COC process begins when L.A. Care and it Delegates starts the process to determine if the beneficiary has a pre-existing relationship with the provider. L.A. Care and it Delegates shall accept requests for COC over the telephone, according to the requester’s preference, and shall not require that the requester complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, L.A. Care and it Delegates may take any necessary information from the requester over the telephone.

L.A. Care and it Delegates shall accept and approve retroactive requests for COC that meet all COC requirements noted above, and in 1-3 below. The services that are the subject of the request must have occurred after the beneficiary’s enrollment into the

L.A. Care, and L.A. Care and it Delegates must have the ability to demonstrate that there was an existing relationship between the beneficiary and provider prior to the beneficiary’s enrollment into L.A. Care. L.A. Care and it Delegates shall only approve retroactive requests that meet the following requirements:

1. Have dates of services that occur after the effective date of this APL;
2. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, COC retroactive reimbursement; and
3. Are submitted within 30 calendar days of the first service for which retroactive COC is being requested.

L.A. Care and it Delegates should determine if a relationship exists through use of data provided by DHCS to L.A. Care, such as Medi-Cal FFS utilization data. A beneficiary or his or her provider may also provide information to L.A. Care or it Delegates which demonstrates a pre-existing relationship with a provider. A beneficiary may not attest to a pre-existing relationship (instead, actual documentation must be provided) unless the L.A. Care or it Delegates makes this option available to him or her.

Following identification of a pre-existing relationship, L.A. Care or it Delegates must determine if the

provider is an in-network provider. If the provider is not an in-network provider, L.A. Care and it Delegates must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the beneficiary.

5.12.1 COC Request Completion Timeline

Each COC request must be completed within the following timeline:

- Thirty calendar days from the date of the received the request;
- Fifteen calendar days if the beneficiary’s medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the beneficiary.

A COC request is considered completed when:

- The beneficiary is informed of his or her right of continued access;
- L.A. Care or it Delegates and the out-of-network FFS or prior managed care health plan provider are unable to agree to a rate;
- L.A. Care or it Delegates has documented quality of care issues; or
- L.A. Care or it Delegates makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

5.12.2 Requirements after the COC Request Process is Completed

If L.A. Care or it Delegates and the out-of-network FFS provider are unable to reach an agreement because they cannot agree to a rate or L.A. Care or it Delegates has documented quality of care issues with the provider, L.A. Care or it Delegates will offer the beneficiary an in-network alternative. If the beneficiary does not make a choice, the beneficiary will be referred or assigned to an in-network provider. If the beneficiary disagrees with the result of the COC process, the beneficiary maintains the right to pursue a grievance and/or appeal.

If a provider meets all of the necessary requirements including agreeing to a letter of

agreement or contract with L.A. Care or it Delegates, the L.A. Care or it Delegates must allow the beneficiary to have access to that provider for the length of the COC period unless the provider is

only willing to work with L.A. Care or its Delegates for a shorter timeframe. In this case, L.A. Care or its Delegates must allow the beneficiary to have access to that provider for the shorter period of time. At any time, beneficiaries may change their provider to an in-network provider regardless of whether or not a COC relationship has been established.

When the COC agreement has been established, L.A. Care or its Delegates must work with the provider to establish a care plan for the beneficiary. Upon approval of a COC request, L.A. Care or its Delegates must notify the beneficiary of the following within seven calendar days:

- The request approval;
- The duration of the COC arrangement;
- The process that will occur to transition the beneficiary's care at the end of the COC period; and
- The beneficiary's right to choose a different provider from L.A. Care or its Delegates provider network.

L.A. Care or its Delegates shall also notify the beneficiary 30 calendar days before the end of the COC period about the process that will occur to transition the beneficiary's care at the end of the COC period. This process shall include engaging with the beneficiary and provider before the end of the COC period to ensure continuity of services through the transition to a new provider.

5.12.3 Extended COC Option

L.A. Care or its Delegates may choose to work with the beneficiary's out-of-network provider past the 12-month COC period, but L.A. Care or its Delegates is not required to do so to fulfill its obligations under the regulatory guidance.

An approved out-of-network provider must work with L.A. Care or its Delegates and its contracted network and cannot refer the beneficiary to another out-of-network provider without authorization from L.A. Care or its Delegates. In such cases, L.A. Care or its Delegates will make the referral, if medically necessary and if L.A. Care or its Delegates does not have an appropriate provider within its network.

5.12.4 Covered California to Medi-Cal Transition

This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination. These requirements are limited to these transitioning beneficiaries.

As part of the process to ensure that COC and coordination of care requirements are met, L.A. Care or its Delegates shall ask the beneficiary if there are upcoming health care appointments or treatments scheduled and assist the beneficiary to initiate the COC process at that time, if the beneficiary chooses to do so, according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new beneficiary enrolls in Medi-Cal, L.A. Care or its Delegates shall contact the beneficiary by telephone call, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph shall be included in this initial beneficiary contact process. L.A. Care or its Delegates shall make a good faith effort to learn from and obtain information from the beneficiary that will assist L.A. Care or its Delegates to honor active Prior Treatment Authorizations and/or establish out-of-network provider COC as described below.

L.A. Care or its delegated provider network shall honor any active Prior Treatment Authorizations for up to 60 days or until a new assessment is completed by L.A. Care or its Delegates. A new assessment has been completed by L.A. Care and its delegated provider network if the member has been seen by a L.A. Care-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active Prior Treatment Authorization. The Prior Treatment Authorizations must be honored without a request by the beneficiary or the provider.

L.A. Care or its delegated provider network shall, at the beneficiary's or provider's request, offer up to 12 months of COC with out-of-network providers, in accordance with the DHCS policy requirements for other transitioning populations regarding out-of-network COC.

5.12.5 Senior and Persons with Disabilities Fee For Service Treatment Authorization Request Continuity Upon Enrollment with L.A. Care

For a newly enrolled Seniors and Persons with Disabilities (SPDs), L.A. Care or its Delegates must honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by L.A. Care or its Delegates. A new assessment has been completed by L.A. Care or its Delegates if the member has been seen by a L.A. Care-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-

transition active Prior Treatment Authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the provider.

5.12.6 Behavioral Health Treatment Coverage For Children For Children Diagnosed with Autism Spectrum Disorder

L.A. Care or its Delegates are responsible for providing Early and Periodic Screening, Diagnosis, and Treatment services for beneficiaries ages 0 to 21. Effective September 15, 2014, the services include medically necessary Behavioral Health Treatment (BHT) Services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of the beneficiaries diagnosed with Autism Spectrum Disorder (ASD). In accordance with the requirements listed in this APL and APL 14-011, L.A. Care or its Delegates shall provide continued access to out-of-network BHT providers for up to 12 months beginning September 15, 2014. The beneficiary must have an existing relationship with the BHT provider. An existing relationship means a beneficiary has seen the out-of-network BHT provider at least twice during the 12 months prior to September 15, 2014, or the date of his or her initial enrollment in the L.A. Care if enrollment occurred on or after September 15, 2014. Retroactive requests for BHT services are limited to services that were provided after September 15, 2014 or the date of the beneficiary's enrollment into L.A. Care or its Delegates if the enrollment date occurred after September 15, 2014.

L.A. Care or its Delegates must continue ongoing BHT services until L.A. Care or its Delegates have conducted a comprehensive diagnostic evaluation and assessment, and established a treatment plan. L.A. Care or its Delegates may refer to the COC section of APL 14-011 for additional requirements and information regarding COC for BHT services for beneficiaries diagnosed with ASD.

5.12.7 Existing COC Provisions under California State Law

In addition to the protections set forth above, L.A. Care beneficiaries also have rights to protections set forth in current State law pertaining to COC. In accordance with W&I Code §14185(b), L.A. Care or its Delegates must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect

for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by L.A. Care, until the prescribed therapy is no longer prescribed by the L.A. Care-contracting provider.

Additional requirements pertaining to COC are set forth in Health and Safety (H&S) Code § 1373.96 and require all health plans in California to, at the request of a beneficiary, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment. L.A. Care's continues obligation to fully comply with the requirements of §1373.96. In addition to the requirements, L.A. Care or its Delegates must allow for completion of covered services as required by §1373.96, to the extent that doing so would allow a beneficiary a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. L.A. Care or its Delegates must allow for the completion of these services for certain timeframes which are specific to each condition and defined under H&S Code § 1373.96.

5.12.8 Medical Exemption Requests

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into L.A. Care only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to a L.A. Care provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from Medi-Cal Managed Care enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to an Medi-Cal Managed Care Plan. A MER should only be used to preserve COC with a Medi-Cal FFS provider under the circumstances described above in this paragraph. L.A. Care or its Delegates are required to consider MERs that have been denied as an automatic COC request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider.

5.12.9 PPG Responsibility for COC Coordination

Delegates are responsible for the initial assessment and care coordination for COC determinations. L.A. Care will provide reporting instructions, templates and documentation requirements for the various regulatory reporting needs. Delegates are also responsible for

ensure the necessary financial arrangements are made with providers who agree to the provision on continued services to our members. Delegates must ensure:

- The request for COC is managed within the defined timelines.
- The appropriate documentation of the request is maintained as defined by regulatory requirements
- Written communication explaining the provision of the services within timeframes of the provision of services is provided to the Member, the Requested Provider, the assigned Primary Care Physician and the PPG.
- The Member is assigned to a care coordination program to assist in care coordination while the member is receiving care with a non-participating provider
- A care transition plan is developed to ensure communication to the member and providers on understanding the COC services and the plan for transitioning back into the network provider.

If the COC is not approved or the non-participating provider does not accept the conditions of the COC process, L.A. Care would support transitioning the member in-network when there is:

- Documentation to ensure an in-network physician has spoken with the treating physician, agreed to accept the member and agreed that the services needed can be provided within the assigned network
- There is an acceptable transition plan notifying the member of where to receive services, contact information and a scheduled appointment
- There is a written Notification of Action letter, containing their appeal rights, to the member regarding the denial of services
- The member is assigned to a PPG care coordination program

5.12.10 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.

5.13 New Medical Technology

L.A. Care evaluates the inclusion of new technologies and new applications of existing technologies in the benefit plans. The Utilization Management and Pharmacy and Therapeutics Committee are responsible for evaluating and recommending coverage status for 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 L.A. Care's UM administrative staff at 1.877.431.2273.

5.14 Responsibility of Participating PPGs and Contracted Providers – Coordination of Health Care Services

PPGs are responsible for assisting participating providers with the provision and coordination of health care services, referral management and payment of services for which the PPG has financial responsibility for members enrolled with their primary care physicians. PPGs are also responsible for primary (basic) medical case management and care coordination.

The PPG agrees and is required to:

- Provide health care services as defined by L.A. Care policy, regulatory requirements, clinical practice guidelines or associated medical professional guidance.
- 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

A full description of these services are defined in the PPG contract, the contract Division of Financial Responsibility (DOFR) and a delegation agreement.

5.14.1 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 UM 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 are required within 30 minutes or the service is deemed approved in accordance with DHCS contractual regulations
- Respond to expedited UM 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

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

L.A. Care and PPGs must provide members and practitioners access to UM staff when they are seeking information regarding the Utilization Management process and the authorization of care as defined in L.A. Care policies.

- L.A. Care contact information:
- 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

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

5.14.3 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.

5.14.4 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. Please note: If you do not provide abortion/pregnancy termination
- services, you must refer the member to L.A. Care Member Services line.
- 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

5.14.5 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.

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 section of this manual)
- Durable Medical Equipment (DME)
- Home Health Services
- Hospice
- Non-Emergent/Non-Urgent Hospital or Skilled Nursing Facility (SNF) 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

5.14.6 Utilization Management Services Not Delegated To PPGs:

Referrals for:

- Power Wheelchairs (shared risk only)
- Coagulation Factors (see Pharmacy section)
- Early Periodic Screening Diagnosis and Treatment (EPSDT) Supplemental Services – In Home Shift Nursing Care/Private Duty Nursing (See Section: EPSDT Supplemental Services)
- Managed Long Term Services and Supports (MLTSS)
- Clinical Trials
- Experimental/Investigational
- Non-emergency Transportation
- Behavioral Health
- Chemical Dependency
- Transgender Health Services

5.14.7 Referral Management Processes:

Types of referrals:

- Pre-Service Review (also called prior authorization, pre-certification)
- Concurrent Review (A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care)

- 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

5.14.7.1 Classification of Referral Management Requests

L.A. Care uses the definitions below to classify UM cases:

5.14.7.1.1 Expedited (Urgent) request. A request for medical care or services where application of the time frame for making routine or non-life threatening 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 member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

5.14.7.1.2 Routine (Non-urgent) request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

5.14.7.1.3 Timelines for UM determinations

All authorization requests submitted to L.A. Care will be responded to within the defined timeframes as follows:

- Expedited – 72 hours from the receipt of the request for service
- Routine – 5 working days from receipt of the information necessary to make the decision, not to exceed 14 calendar days from receipt of the request
- Urgent concurrent- 24 hours of receipt of the request
 - The request to approve additional days for urgent concurrent care is related to care not previously approved. The organization must document that it made at least one attempt to obtain the necessary information within 24 hours of the request, but was unable to. The organization has up to 72 hours to make a decision

- Post-service or Retrospective - 30 calendar days of the request
- Extending timeframes – see Attachment A, for the most recent version of L.A. Care's Timeliness Standards for the appropriate documentation requirements and timelines for extensions

NOTE: Referral requests submitted as expedited/urgent must meet the regulatory definition for urgent care (see above). Referrals submitted as such will be reviewed by clinical staff to ensure the service requested meets this definition. Referrals that DO NOT meet the definition will be modified to the appropriate determination status, e.g. routine, and processed accordingly. The modification will be referred to a 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.

5.14.7.1.4 UM determinations are made in accordance with the standard regulatory requirements for referral management and include:

- Approved
- Modified
- Denial
- Deferred/Pended/Delayed

Occasionally referral requests are submitted with clerical or eligibility errors or the requesting provider has made a decision to withdraw the request. Additional determinations may be utilized to identify the scenario, such as withdrawn or void. In either case, the identified issue must be documented in the case to identify why the determination was made.

5.14.7.2 Pre-service Review (Prior Authorization)

Pre-service Review or Prior Authorization is 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.

5.14.7.3 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.

5.14.7.4 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.

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 1.877.431.2273.

5.14.7.5 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

5.14.8 Member Eligibility Verification

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

5.14.8.1 Authorizations and Member Eligibility

L.A. Care and its delegates authorize services for extended time periods (up to 12 months) when the member's condition is not likely to change and the service is expected to be required into the future. Examples of such authorizations are standing referrals, specialty referrals, wheelchairs, incontinence supplies, CBAS services and Long Term Care services. These extended authorizations offer convenience and operational efficiency to the Provider because

it eliminates the need for monthly submission of authorization requests. However, every authorization is issued with the expectation that members will continue coverage under L.A. Care and the process requires Provider to verify eligibility.

5.14.8.1.1 Provider Responsibility for Authorizations and Member Eligibility

Notwithstanding the authorization, the provider is required to verify the member's eligibility prior to providing the services authorized. Failure to confirm eligibility prior to providing the services may result in nonpayment of your claim. L.A. Care recommends that member eligibility be verified on the date services are to be rendered. Daily eligibility may be checked through L.A. Care's IVR system. If you have any questions regarding a member's eligibility, please contact L.A. Care's Provider Information Line at 1.866.522.2736.

5.14.8.1.2 Delegate Responsibility

Delegates are required to provide the disclaimer language in notices of authorization to facilities, practitioners, and other providers. Delegates are responsible to inform individual providers or practitioners of the requirement to verify member eligibility prior to providing services.

5.14.8.1.3 Claim Denied for Lack of Member Eligibility

If a claim is denied for lack of member eligibility, and rendering provider believes the member's eligibility was verified and the service was provided in good faith, the provider may submit a Provider Dispute Request Form. Provider is to include all documentation relative to verification of eligibility in the provider dispute request. Providers may access a form at <http://www.lacare.org/providers/provider-resources/provider-forms>.

5.14.8.2 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

5.14.8.2.1 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

5.14.8.2.2 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 L.A. 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.

5.15 Medical Necessity Definitions

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 is 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.

5.15.1 Clinical Criteria For Decision Making Decision Support Tools

The appropriate use of criteria and guidelines require

strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed nursing review staff apply professional judgment during all phases of decision-making regarding L.A. Care members.

“Decision Support Tools” are intended for use by qualified licensed nursing review staff as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for important professional judgment. The Medical Director evaluates cases that do not meet review criteria/guidelines, and is responsible for authorization/denial determinations.

UM staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. In the event that a provider questions a medical necessity/appropriateness determination, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following describes the approved Department “Decision Support Tools” that have been implemented, and are evaluated and updated at least annually.

5.15.1.1 UM Review Criteria, Guidelines and Standards

L.A. Care, Plan Partners, PPGs, and Vendors delegated for UM functions must utilize evidenced based nationally recognized criteria for UM decision making. UM criteria are used to determine medical necessity in the referral management Authorization Request review process.

Standards, criteria and guidelines are the foundation of an effective UM Program. The tools are utilized to assist during evaluation of individual cases to determine the following:

- Services are medically necessary
- Services are rendered at the appropriate level of care
- Quality of care meets professionally-recognized industry standards
- UM decision-making is consistent

The following standards, criteria, and guidelines are utilized by UM staff and Medical Directors as resources during the decision making process:

- UM Medical necessity review criteria and guidelines
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Referral Guidelines
- Policies and Procedures

5.15.1.2 Application of UM Criteria

L.A. Care requires 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. For use in determining the appropriateness of UM determinations at the L.A. Care Plan level for the MCLA direct requests for authorization, L.A. Care adopts and maintains approved criteria with current versions of the following UMC approved UM Criteria Auto Authorization UM Criteria as approved by the UM Committee in the following hierarchy:

- UM Auto Authorization Criteria as approved by the UM Committee
- Other Utilization Management Committee Approved Criteria
- Pharmacy Therapeutics Committee Approved Criteria
- DHCS and CMS UM Criteria -- to be determined by Primary Payer for the request
 - DHCS Medi-Cal UM Criteria is available and updated on Department of Health Care Services (DHCS) Web Site
 - CMS Medicare UM Criteria as available and updated on CMS Web Site
- When none of the above criteria are applicable, consider the following and two (2) or more of the following criteria are applicable, then MCG Health care guidelines criteria are to be used as the first choice.
 - MCG Health Guidelines
 - Apollo® Managed Care Criteria
 - Uptodate® (uptodate.com)
- Hayes, Inc.
- Definition of Medical Necessity (Product Line specific when the above criteria does not apply to a specific request for a UM decision)
- Other resources

Due to the dynamic state of medical/health care practices, each medical decision must be case specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition, or the need for a referral.

5.15.1.3 Inter-rater Reliability Requirements (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 Inter-rater Reliability (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. Required 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.

5.15.1.4 Criteria Based on Individual Need

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 service 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.

5.16 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.

5.17 Criteria for Use in L.A. Care Review of Appeals and Other Requested Clinical Reviews (e.g. Clinical Grievance Review, PQIs, etc.

- MCG Criteria is used by L.A. Care as the first choice in review of appeals and other requested clinical reviews (e.g. Clinical Grievance Review, Potential Quality Incidents, 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.

5.18 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 or UM processes; practitioners, providers, members, 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. The PPG shall maintain a log for requests of UM Criteria and report the number and types of UM Criteria requests annually to their UM Committees.

5.19 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.

5.20 Notification Process for UM Decisions (See Attachment A, L.A. Care UM Timeliness Standards)

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 (pending) 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 financial responsibility of the PPG hospital shared risk pool is managed by 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 hold 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 attachment A, L.A. Care UM Timeliness standards matrix
 - PPG will notify L.A. Care as defined in the PPG contract agreements (i.e. electronic file exchange or Excel file logs).

5.21 L.A. Care’s CAPitation Deduction Process for PPGs:

Should a Standard delegated 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 monthly capitation (See PPG contract Section 1.22 E). L.A. Care will notify the PPG and L.A. Care’s Provider Network Management Department when a determination is made that a service is eligible for capitation deduction, commonly known as CAP deduct.

5.22 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.

5.23 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 Medi-Cal. Copies of the template letters are provided to the PPG or may be obtained by contacting the L.A. Care UM Department.

5.24 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

Providers 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.

5.25 Contacting the Peer Reviewer (Reconsideration)

All UM Notice of Action correspondences sent to the requesting PCP or specialist 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.

5.25 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. 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

5.26 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. Hospital inpatient care may be pre-planned/pre-authorized (elective), urgent or an emergency admission. 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.

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. Generally:

- 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 Standards matrix; see attachment A of this Section.
- 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

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. 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

These reviews will be conducted utilizing accepted guidelines for acute levels of care, such as intensity of service and severity of illness criteria, MCG Health, Interqual® or other care 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 – 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.

Concurrent Review/In-patient Hospital Care

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

NOTE: 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.

ADMISSIONS TO NON-CONTRACTED HOSPITALS (MEDI-CAL ONLY)

- Members admitted to non-contracted hospitals 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 with a discharge within a total of five (5) days from the admission date, the member should be maintained in the same facility
- If the facility is requesting a transfer and the member will not be discharged within five (5) days from the admission, or the services needed to care for the member cannot be met in the current facility, L.A. Care and its delegates will transfer to an in-network provider or the most appropriate facility to manage the care

California Children's Service (CCS)

L.A. Care will ensure timely referrals are made to and for CCS specialists, hospitals and specialty centers for Members under the age of 21 years who have conditions eligible for services through CCS.

- 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.

NOTE: 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 (TOC) – 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 Programs

Successful transition programs include:

- A standardized TOC program elements to reduce variability in processes and outcome
- Use of an readmission risk stratification tool designed for this population is essential
 - Perform early in the admission (within 1 business day)
 - Must assess for social determinates
 - Ability to focus intense resources where they are most needed
- Medication reconciliation at discharge is essential
- For highest risk, form a TOC team to closely follow the member until care is fully transitioned to the receiving provider
 - At a minimum, include hospitalist, case manager and PCP or receiving physician in TOC team

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 Admission Notification

PPGs that are not Dual Risk, Full Risk or 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: 1.213.438.5777

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:

- Postpartum stay of 48 hours following normal vaginal delivery
- Postpartum 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 include 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 (Medi-Cal)

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.

Retrospective Claim reviews determination is made within 30 calendar days of the request or the regulatory requirement for claims processing.

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 Medi-Cal members at no cost.

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 its 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 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 determinations for specialty referral/ services shall be processed in accordance with

L.A. Care and/or its delegated entity 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 entity 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, PPG 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 PPG contract with L.A. Care. NOTE: Requests for standing referrals will be processed in accordance with state regulatory requirements.

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

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.

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. NOTE: 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.

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.

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

PPGs Dual or Full Risk

PPG is responsible for the decision making, care coordination and financial reimbursement for the wheelchair. PPG will approve, modify or deny the request for a standard wheelchair in accordance with L.A. Care Policies.

PPGs – Shared Risk 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.

PPGs – Shared Risk with Extended Delegation:

PPG process the request using a L.A. Care contracted ancillary provider in accordance with L.A. Care Policies.

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

HOW TO REQUEST AUTHORIZATION OF A CUSTOM WHEELCHAIR

L.A. Care does not delegate the UM decision making for customized wheelchairs to PPGs with standard delegation; PPGs with Extended Delegation, 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 1.213.438.5777. All requests for custom wheelchairs must obtain an in-home assessment or have received an evaluation for in-home and out of home evaluation through a recognized wheelchair seating clinic. L.A. Care will approve, modify or deny the request for a standard wheelchair in accordance with L.A. Care Policies. 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 1.877.431.2273.

HOW TO REQUEST AUTHORIZATION OF A WHEELCHAIR REPAIR

PPGs Dual or Full Risk

PPG is responsible for the decision making, care coordination and financial reimbursement for the wheelchair. PPG will approve, modify or deny the request for the wheelchair repair in accordance with L.A. Care Policies.

PPGs – Shared Risk with Standard Delegation:

PPG should submit the Authorization Request Form to the L.A. Care's Utilization Management (UM) Department. L.A. Care will approve, modify or deny the request for a standard wheelchair in accordance with L.A. Care Policies.

PPGs – Shared Risk with Extended Delegation:

PPG processes the request using an L.A. Care contracted ancillary provider.

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 1.213.438.5777. 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.

TUBERCULOSIS TREATMENT SERVICES PROVIDED BY PRIMARY CARE PROVIDER

PPG 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. PPG 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

PPG shall ensure that primary care providers coordinate with Local Health Department in the referral of members requiring Tuberculosis Direct Observed Therapy, a linked and carved out service available through the Local Health Department (See L.A. Care 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 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. The referral is made by 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 if the member is unable to be reached by phone or by member preference.

A Health Risk Assessment is conducted for:

- 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, Reassessments of member risk level is performed by L.A. Care through a monthly predictive modeling report, designed to identify members with complex needs.

HRAs reports are accessible through the L.A. Care Portal for Provider Groups and by request. The report is used to identify members who have completed the HRA. The HRA responses are contained in L.A. Care's vendor system (C3). Access to C3 is granted to all PPGs and Providers after submitting the request through the Provider Network Liaison contact. Responses to the HRAs result in a generic care plan. 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 (ICP).

L.A. Care's Care Management staff is responsible to review High Risk HRA results, complete the ICP and convene an Interdisciplinary Care Team (ICT meeting) per regulatory guidance. The PPG Care Management staff is responsible to review the Moderate and Low Risk HRA results and develop an ICP according to the member's needs. The HRA results and developed ICPs are shared with the PCP.

DEVELOPING INDIVIDUALIZED 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**easurable, **A**ctionable, **R**ealistic, **T**ime-bound.

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

ICPs 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
- Pharmacy data

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

Timing of the ICP

The ICP will be reviewed and revised by the designated Care Manager (at a minimum):

- At least annually
- Upon notification of change in member status scheduled follow-up

For High Risk members, the ICP is reviewed during ICT meetings and in accordance with scheduled follow-up on member goals. The ICP should be developed within 30 days of HRA completion.

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).

The outcome of the ICT meeting is shared with the members (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 member representative was invited
- topics discussed
- any revision to the ICP

CARE MANAGEMENT: (CARE AND CASE MANAGEMENT MAY BE USED INTERCHANGEABLY)

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

Care Management (CM) 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 five levels:

- Basic Care Management
- Care Coordination
- High Risk Care Management
- Complex Care Management
- Targeted Care Management

All Care Management programs are free and providers are encouraged to refer their members according to the identified need.

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 (IHA) 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) as warranted.

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 (SPD), completing and updating an Individualized Care Plan(ICP) as well as organizing an Interdisciplinary Care Team(ICT) meeting as warranted.

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
- Assistance with navigating the managed care system
- Health promotion (e.g. screening tests)

High Risk Care Management (High Risk Level):

High Risk Care Management is provided for members who have extensive utilization of medical services, have chronic or immediate medical needs requiring more management. These members do not meet criteria for Complex Case Management (CCM) or have declined to consent to participate in Complex Case Management (CCM). The High Risk population is managed by L.A. Care's CM staff. Members are managed intensively at the High Risk level for 30-45 days and then re-evaluated for possible lower level of CM.

Complex Care Management

L.A. Care 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 (ICT) approach comprised of patient care management and education through experienced licensed professionals in collaboration with the Primary Care Physician and other disciplines according to the members' individualized needs. The ICT may be comprised of the member, PCP, Specialists, 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 L.A. Care for 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. Identification may occur during multidisciplinary conferences or during the concurrent review process.
- Member or caregiver referral
- Members or caregivers are provided with materials (Member Handbook) containing instructions on how to self-refer and/or access Complex Case 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 1.213.438.5077. A copy of the referral form may be found at L.A. Care's website through <http://www.lacare.org/providers/provider-resources/provider-forms>.
- Other referrals including, but not limited to:
- L.A. Care 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 not 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 (NAL) 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 (LTC) referrals and monitoring logs
- Non-adherence with treatment plan

How to Refer for Complex or High Risk Care Management:

For more information about L.A. complex case management or high risk care management programs or to make a referral, call the L.A. Care CM Department directly at 1.844.200.0104 and ask to speak with a Case Manager or complete a CM Referral Form located on L.A. Care's website provider internet page : http://www.lacare.org/sites/default/files/la1348_061215.pdf or by faxing a request to 1.213.438.5077.

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 CM Department at 1.844.200.0104 and ask to speak with a Case Manager or complete a

MAJOR ORGAN TRANSPLANTS

Medi-Cal – Major Organ Transplants are a carved out health benefit (See Medi-Cal Linked and Carved out Services Section)

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 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 L.A. Care or its Delegates of general inpatient care placement that occurs after normal business hours on the next business day. L.A. Care or its Delegates 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 members may be eligible for additional inpatient hospice 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

Medi-Cal members are eligible for additional hospice services in a sub-acute setting. Hospice services are covered services and are not LTC 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 L.A. 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 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 DMHC, or to request an Independent Medical Review (IMR).
- 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 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.

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.

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

Medi-Cal Members and/or their representative may contact the California Department of Social Services to request a State Hearing or an Expedited State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary the Adverse Benefit Decision has been upheld. Medi-Cal Members must exhaust all levels of the Plan's internal appeal process prior to initiating a State Hearing. Medi-Cal Members also may contact the Medi-Cal Managed Care Office of the Ombudsman to request assistance with their appeal.

INDEPENDENT MEDICAL REVIEW (IMR)

A member may request an Independent Medical Review (IMR) through 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 FOR 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 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 new Primary Care Provider (PCP) does not need to complete the IHA, but must document that the previous IHA was reviewed and updated accordingly.

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 an 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 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 within 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 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
- 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. 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:
 - Healthcare Effectiveness Data and Information Set (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 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-member 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 caregivers/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 caregivers 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

(Described in further detail in Attachment B following this Section 5.0)

Mental Health Services

L.A. Care is responsible for outpatient mental health services to members with mild to moderate impairment(s) resulting from a Mental Disorder. A “Mental Disorder” is a mental health condition that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning, according the latest addition of the Diagnostic and Statistical Manual.. 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.

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 clinical indicated to evaluate a mental health condition
- Psychiatric consultation
- Outpatient Services for the purpose of monitoring medication treatment
- Outpatient laboratory, supplies and supplements

L.A. Care has contracted with Beacon Health Strategies, to administer the delivery of behavioral health services for L.A. Care members. While Beacon is the contracted administrative service provider with the Health Plan, College Health IPA will render all utilization management determinations.

Beacon Health Strategies performs medical review on all referrals for outpatient mental health services and will coordinate the requested services as necessary.

For referring your patients to receive outpatient mental health services, you may directly call **1.877.344.2858, Option 6** to speak with a Beacon representative, 24/7.

For Crisis Intervention, please call **1.877.344.2858, Option 1**, to speak with a Beacon representative, 24/7.

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

Specialty Mental Health Services, including inpatient psychiatric hospitalization, is the responsibility of the Los Angeles County Department of Mental Health (LAC DMH). For members who meet the criteria for Specialty Mental Health Services, L.A. Care behavioral health vendor will coordinate and ensure COC.

Behavioral Health Treatment for Autism Spectrum Disorder

Behavioral Health Treatment for members with Autism Spectrum Disorder (inclusive of Aspergers Disorder, Autism Disorder and Pervasive Developmental Disorders) is covered when prescribed by a Physician or licensed psychologist. Behavioral Health Treatment must be prior authorized and obtained from Participating Providers. This provider network is contracted directly with L.A. Care and can be reached at 1.888.347.2264.

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 autism spectrum disorder.

Exclusions and Limitations

- Alternative Therapies,
- Biofeedback, unless the treatment is Medically Necessary and prescribed by a licensed physician, surgeon or licensed psychologist.
- 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.

SUBSTANCE USE DISORDERS SERVICES

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.
- Where it is medically necessary to monitor the Member for life-threatening complications. In such instances, 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, and/or threatened delirium tremens.
- When the Member is medically stabilized, the PCP/ L.A. Care shall provide a referral/linkage to a Substance Abuse Treatment Program since Medi-Cal Substance Use Disorder treatment is a carved out benefit.

Outpatient Substance Use Disorders Services

For Medi-Cal members 18 and older identified with risky or hazardous alcohol use or a potential alcohol misuse problem, a PCP can provide up to three 15 minutes Brief Interventions every year. L.A. Care will maintain processes to ensure that substance use disorders treatment services are available to Medi-Cal members by providing timely linkage to these carved out benefits through the Office of Substance Abuse, Prevention and Control (SAPC), a program of L.A. County Department of Public Health (LAC DPH).

The following services are provided by SAPC:

- 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 PCP screening of L.A. Care Members for substance use disorders during the IHA and in all subsequent visits as appropriate. When a substance use disorder is recognized as a potential condition, the PCP will refer the Member to a treatment facility serving the same geographic area. Referral is done by calling the Community Assessment Services Center toll free number 1.800.564.6600.

Members can access substance use disorder treatment services by self-referral, by a family referral, or referral from the PCP or other appropriate provider. During treatment for substance use disorder, 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 SAPC and its providers with appropriate consent and release of medical record information following federal and state guidelines.

VISION SERVICES

Medi-Cal 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.

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 MEDI-CAL 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 Medi-Cal Members – Children up to Age 21:

Medi-Cal 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 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 fibroplasia 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)

Medi-Cal Linked and Carve Out Services

Linked and Carve Out Program	Medi-Cal
California Children Services (Ccs)	X
School Linked Child Health Disability Prevention (Chdp) Services	X
Tb/Dot	X
WIC, Nutritional Program	X
Developmental Disabilities Services (Dds)	X
Early Intervention/Early Start	X
Specialty Mental Health	X
Substance Use Disorder Treatment	X
Local Education Agency	X
HIV/ Aids Home And Community Based Waiver Programs	X
Dental Services	X
Vision	X
Targeted Case Management	X
Early Periodic Screening, Diagnosis And Treatment	X
Early Periodic Screening, Diagnosis And Treatment – Supplemental Srvc	X

CARE COORDINATION WITH 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.

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. An MOU is 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 Supplemental Nutrition Program (WIC)
- Regional Centers for Services for Persons with Developmental Disabilities
- Specialty Mental Health Services
- Public Health Department

A Subcontract is 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)

CCS services are carved out of and excluded from L.A. Care's responsibilities under the Medi-Cal contract with DHS, and will be provided by the L.A. County CCS in accordance with the current MOU between L.A. Care and CCS. 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 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 – COMPREHENSIVE PRENATAL SERVICES PROGRAM (CPSP)

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 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** - CPSP 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:

- Supplemental Nutrition Program for Women, Infants, and Children (WIC)

L.A. Care and its PPGs shall ensure that all pregnant, breastfeeding and postpartum women, and infants and children who are eligible for WIC 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 ONLY

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 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, 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 NUTRITIONAL SUPPLEMENT PROGRAM (WIC) – 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 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 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 COC. 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. Care 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:

- Assisted Living Waiver (ALW)
- Nursing Facility/Acute Hospital (NF/AH Waiver)
- Home and Community-Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD)
- HIV/AIDS Medi-Cal Waiver Program (MCWP)

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.

(HIV/AIDS) Home And Community Based Services Waiver Program Services

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

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 (Initial Health Assessment) 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. Additionally, the systems must 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 Start/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 COC.
- 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 within 120 days of enrollment and that the IHA will be consistent with the AAP 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 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

All inpatient mental health and outpatient specialty mental health services are carved out of and excluded from L.A. Care'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 MOU between L.A. Care and LAC/DMH. L.A. Care 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'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 MOU, L.A. Care policies and the established state laws and regulations.

ALCOHOL AND DRUG TREATMENT PROGRAMS

Substance use disorder treatment services are defined in the Scope of Benefits section - Members and Providers may directly refer to L.A. Care's behavioral health Provider, Beacon Health Strategies, by calling: 1.877.344.2858 (TTY/TDD 1.800.735.2929). Referrals are not required from the PPG/PCP or L.A. Care for Members seeking substance abuse treatment. Members have additional benefits available to all Medi-Cal members through the Los Angeles County Department of Mental Health (DMH) subject to DMH eligibility criteria.

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.
- Where it is medically necessary to monitor the Member for life-threatening complications. In such instances, 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, and/or 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
- For members 18 and older identified with risky or hazardous alcohol use or a potential alcohol misuse problem, a PCP can provide up to four 15-minute Brief Interventions every year.

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 Rehabilitative 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 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 1.800.564.6600.

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 recommended 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 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 Denti-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 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/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:
 - How to obtain fluoride varnish supplies
 - Providing fluoride varnish applications, periodic dental assessments and parental anticipatory guidance on scheduling visits.
 - Referring children to a dentist for dental examinations and care at 1 year of age per CHDP guidelines.
 - Coordinating member care with dental professionals and
 - 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 applicable 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 DOFR.

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

nonmedical 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 – MEDICAL

For members under the age of twenty-one (21) who are 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 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 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 supplemental 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 EPSDT 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 L.A. 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 SUPPLEMENTAL 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.

Medical necessity for Private Duty Nurse (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 :
 - intermittent suctioning at least every 8 hours and room air mist and oxygen as needed
 - 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
 - peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours
 - tube feeding by means of a nasogastric or gastrostomy tube
 - other medical technologies required continuously, which require the services of a professional nurse
 - 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 CCS program may authorize EPSDT supplemental service requests for skilled nursing services, 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 CCS Program (for children) for approval. L.A. Care'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 DHCS 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 COC 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 (LTC)

Effective April 1, 2014 California's Coordinated Care Initiative (CCI) began transitioning LTC services to managed care for a sub-set of beneficiaries. This includes skilled level of care and sub-acute level of care for adults. 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.

For members not eligible for CCI, L.A. Care's Two Plan Model Contract language defining long term care as the month of admission plus the following month continues. For members admitted to Nursing Facilities where there is no plan to return to the community setting, member should be submitted to DHCS/HCO for disenrollment to Medi-Cal Fee for Service.

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 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.

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: Verbal notification 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 and Member For denials/modifications: written notification to requesting practitioner and member deposited with the United States Postal Service in time for pick-up same day

Notification Timeframe

Type of Request	Decision	Initial Notification	Written Notification
<p>Pre-Service Urgent Expedited Request. An Expedited 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:</p> <p>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 member's medical condition, would subject the member to server pain that cannot be adequately managed without the care or treatment that is the subject of the request.</p>	<p>Decision Timeframe: The decision must be made within a timely fashion appropriate to the member's condition not to exceed 72 hours after receipt of the initial request.in cases where the enrollee faces imminent and serious threat to 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 as set forth in sentence one of this paragraph, would be detrimental to the enrollee's life or health, or could jeopardize the enrollee's ability to regain maximum function.</p>	<p>Practitioner and Member: Initial Notification of Decision: Verbal notification to requesting practitioner and member as soon as the decision is made not to exceed 72 hours after receipt of the original request.</p>	<p>Practitioner and Member: Written Notification For Approvals: Approval Template for denials/modifications, provide an expedited written notification to requesting practitioner and member as the member's health condition requires and no later than 72 hours (3 calendar days) after receipt of the request deposited with the United States Postal Service in time for pick-up by 72 hours (or 3 calendar days) from the receipt of the original request.</p>
<p>Downgrade an Expedited Request to Routine – this is a modify decision that must be made by a physician reviewer</p>	<p>Decision Timeframe: In a timely fashion appropriate to the member's condition not to exceed 72 hours after receipt of the initial request</p>	<p>Practitioner: Initial Notification of Decision: Verbal notification to requesting practitioner as soon as the decision is made not to exceed 72 hours after receipt of the original request</p>	<p>Practitioner and Member: Written Notification to the requesting practitioner and member same day as the downgrade decision using the</p> <div style="text-align: center; margin-top: 20px;">  <p>MISSING COPY?</p> </div>

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
<p>Delay of Pre-Service Urgent Delay of Expedited Request</p> <p>A delay to ask for additional information is not a requirement:</p>	<p>Decision Timeframe:</p> <p>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.</p> <p>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.</p>	<p>Practitioner:</p> <p>Verbal or fax notification to requesting practitioner same day as delay decision</p>	<p>Practitioner and Member: Written Notification to the requesting practitioner and member same day as delay decision</p> <p>NOA TEMPLATE: Delay</p>

Notification Timeframe

Type of Request	Decision	Initial Notification	Written Notification
<p>Pre-Service Routine Non-urgent Request</p>	<p>Decision Timeframe for Medi-Cal & MCLA Decisions to approve, modify, deny, or terminate requests by providers prior to the provision of health care services to enrollees that do not meet the requirements for the 72-hour review shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five (5) working days from the receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request.</p> <p>Decision Timeframe for L.A. Care Covered, and PASC-SEIU Decisions to approve, modify, deny, or terminate requests by providers prior to the provision of health care services to enrollees that do not meet the requirements for the 72-hour review shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five (5) working days from date of receipt of request</p>	<p>Practitioner: Initial Notification: All decisions: Within 24 hours of the decision with confirmation (Notification May Be Oral and/or Electronic)</p>	<p>Practitioner and Member: Denial/Modification Within 2 working days of denial/modification decision</p> <p>Deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made not to exceed 14 calendar days from receipt of the original request.</p> <p>NOA TEMPLATE: Denial or Modify</p> <p>Approvals: Written notification mailed to member</p>

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
<p>Delay of Pre-Service Routine</p> <p>Non-urgent Request - Extension Needed</p> <p>A delay to ask for additional information is not a requirement:</p> <p>The delay extension is 14 days for Medi-Cal and L.A. Care Covered & 30 days for PASC-SEIU</p> <p>Medi-Cal and L.A. Care Covered Members 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 L.A. Care can provide justification upon request by the State for the need for additional information and how it is in the Member's interest.</p>	<p>Decision Timeframe</p> <p>Medi-Cal, L.A. Care Covered, & PASC-SEIU</p> <p>Within 5 working days of receipt of request</p> <p>Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.</p>	<p>Practitioner:</p> <p>All decisions:</p> <p>Within 24 hours of the decision with confirmation</p> <p>(Notification May Be Oral and/or Electronic)</p>	<p>Practitioner and Member:</p> <p>NOA TEMPLATE: Delay</p> <p>Important NCQA Note:</p> <p>Since the delay extension is only 14 days for making the decision for Medi-Cal and L.A. Care Covered & 30 days for PASC-SEIU, NCQA would expect the member be given the full 14 days- or 30 days respectively to respond.</p> <p>Although allowing the full time of 14 or 30 days for the member/ provider to respond provides very little time for the UM decision following the delay period, according to NCQA, it is more important to provide as much time as possible to the member/ provider within mandated timeframes to provide the requested information.</p>

Notification Timeframe

Type of Request	Decision	Initial Notification	Written Notification
<p>Requests To Continue Routine Current Service/ Treatment Other Than Acute Hospital (Such as PT, Home Health, Long Term Care, etc.)</p> <p>For Medi-Cal 10 day advance notice required for termination of services (i.e. stopping services)</p>	<p>Decision Timeframe: If a request 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 may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e. preservice (within 5 working days of receipt of request or post-service within 30 calendar days of receipt of request).</p> <p>However, it is important to assess whether it is reasonable to handle the request as urgent if application of a non-urgent time frame could involve an unnecessary interruption in the member’s treatment that may jeopardize the member’s health or ability to recover.</p> <p>Timeframes specifically for Home Health Requests</p> <ol style="list-style-type: none"> 1. Home Health Discharge Orders = URGENT (Same Day), otherwise, patient may end up staying in-house for another day 2. Home Health Extension = Pre-service Urgent (24-72 hours), 	<p>Practitioner: All decisions: Within 24 hours of the decision with confirmation (Notification May Be Oral and/or Electronic)</p> <p>Member: Approvals: Within 24 hours (Written Notification)</p>	<p>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”</p> <p>NOA Template: Terminate</p> <p>Exceptions from the advance notice required in this section: The notice may be mailed no later than the date of action if:</p> <ol style="list-style-type: none"> 1. There is factual information confirming the death of a member; 2. There is receipt of a clear written statement signed by a member that: <ol style="list-style-type: none"> A. Member no longer wishes services; or B. 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; 3. The member has been admitted to an institution where the member is ineligible under the plan for further services; 4. The member’s whereabouts are unknown and the post office 5. returns agency mail directed to him indicating no forwarding address 6. The fact is established that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; 7. There is a change in the level of medical care is prescribed by the Member’s physician; 8. The notice involves an adverse determination made with regard to the preadmission screening requirements 9. 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
<p>Urgent Concurrent Review (acute hospital inpatient)</p> <p>Urgent Concurrent reviews are those reviews associated with inpatient care.</p> <p>A new request for inpatient care is considered urgent concurrent review and ongoing hospitalization requests are considered urgent concurrent review unless determined otherwise.</p> <p>Upon receipt of a new request for urgent concurrent review from a hospital, a review must be requested.</p> <p>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 L.A. Care did not approve the earlier care.</p> <p>For example, if L.A. 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, L.A. Care handles the request as an urgent concurrent request.</p>	<p>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 L.A. Care did not approve the earlier care.</p> <p>For example, if L.A. 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, L.A. Care handles the request as an urgent concurrent request.</p> <p>Upon receipt of a request for urgent concurrent review, L.A. Care UM immediately requests necessary information. For operational purposes 24 hours is considered equivalent to 1 calendar day.</p> <p>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).</p>	<p>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</p>	<p>Practitioner and Member: Written Notification: For denials/modifications: written notification to requesting hospital within 24 hours of the receipt of the request.</p> <p>NOA Template: Provider Terminate</p>

Notification Timeframe

Type of Request	Decision	Initial Notification	Written Notification
<p>If L.A. Care receives a request for coverage of an acute inpatient stay after the member's discharge, L.A. Care handles the request as a post-service issue.</p>	<p>When the hospital inpatient care has already been received, L.A. 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).</p> <p>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).</p> <p>Course of Treatments Requests</p> <p>If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved by L.A. 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).</p>		
<p>Request to Continue Concurrent Review (Acute Hospital Inpatient)</p> <p>A concurrent review decision is any review for an extension of a previously approved ongoing course already in place</p>	<p>Decision Timeframe:</p> <p>If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved does not meet the definition of Urgent Care, the request is handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., Pre-Service or Post-Service).</p>	<p>Practitioner:</p> <p>All Decisions:</p> <p>Within 24 hours of receipt of the request</p>	<p>Practitioner and Member:</p> <p>Written Notification:</p> <p>Within 24 hours of receipt of the request</p> <p>If oral notification is given within 24 hours of request, then written/ electronic notification must be given no later than 3 calendar days after the oral notification.</p> <p>NOA Template: to Hospital Terminate</p>
<p>Post-Service / Retrospective Review</p>	<p>Decision Timeframe:</p> <p>Within 30 calendar days from receipt or request</p>	<p>N/A</p>	<p>Practitioner and Member:</p> <p>Within 30 calendar days of receipt of the request.</p> <p>NOA Template: Denial or Modify</p>

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
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
Pharmaceuticals Including Injectables, Routine	Within one business day of receipt of the request.	For denials, verbal notification to member and requesting practitioner within the same time frame as the decision.	For denials, written notification to the member and requesting practitioner by confirmed facsimile transmission or deposited with the United States Postal Service in time for pick-up within one business day after the decision.
Pharmaceuticals Including Injectables, Urgent Concurrent And Urgent Preservice	Within one calendar day of receipt of the request.	For denials, verbal notification to member and requesting practitioner within the same time frame as the decision.	For denials, written notification to the member and requesting practitioner by confirmed facsimile transmission or deposited with the United States Postal Service in time for pick-up within one business day after the decision.
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.

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
<p>Delay of Pre-Service Urgent Delay of Expedited Request</p>	<p>Decision Timeframe: 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.</p> <p>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.</p>	<p>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.</p>	<p>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.</p> <p>NOA Template: Delay</p>
<p>Pre-Service Routine Non-urgent Request</p>	<p>Decision Timeframe Within 5 working days of receipt of request</p>	<p>Practitioner: Initial Notification: All decisions: Within 24 hours of the decision with confirmation (Notification May Be Oral and/or Electronic)</p> <p>Member: Approvals:</p>	<p>Practitioner and Member: Within 2 working days of denial/modification decision</p> <p>NOA Template: Denial or Modify</p>

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
<p>Delay of Pre-Service Routine Non-urgent Request - Extension Needed</p>	<p>Decision Timeframe: Medi-Cal-Within 5 working days of receipt of information not to exceed 14 calendar days from date of receipt of request</p>	<p>Practitioner: All decisions: Within 24 hours of the decision with confirmation (Notification May Be Oral and/or Electronic)</p>	<p>NOA TEMPLATE: Delay Medi-Cal Practitioner and Member: Within 2 working days of decision to delay; however: 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 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</p> <p>Important NCQA Note: Since the State allows only 14 days for making the decision for Medi-Cal. 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.</p>

Notification Timeframe

Type of Request	Decision	Initial Notification	Written Notification
<p>Medi-Cal Only-Requests to Continue Routine Current Service/Treatment (such as PT, LTC, etc.) Exceptions from the advance notice required in this section: The notice may be mailed not later than the date of action if:</p> <ul style="list-style-type: none"> (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— <ul style="list-style-type: none"> (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 	<p>Decision Timeframe: within 5 working days of receipt of request</p>	<p>Practitioner: All decisions: Within 24 hours of the decision with confirmation (Notification May Be Oral and/or Electronic)</p> <p>Member: Approvals: Within 24 hours (Written Notification)</p>	<p>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”</p> <p>NOA Template: Terminate</p>

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
<p>(e) The fact is established that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;</p> <p>(f) There is a change in the level of medical care prescribed by the Member's physician;</p> <p>(g) The notice involves an adverse determination made with regard to the preadmission screening requirements</p> <p>(h) The date of action will occur in less than 10 days- LTC exceptions to the 30 days' notice</p>			
<p>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.</p>	<p>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 L.A. Care did not approve the earlier care. For example, if L.A. 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, L.A. Care handles the request as an urgent concurrent request.</p>	<p>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</p>	<p>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</p>

Notification Timeframe

Type of Request	Decision	Initial Notification	Written Notification
<p>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 L.A. Care did not approve the earlier care.</p> <p>For example, if L.A. 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, L.A. Care handles the request as an urgent concurrent request.</p> <p>If L.A. Care receives a request for coverage of an acute inpatient stay after the member's discharge, L.A. Care handles the request as a post-service issue.</p>	<p>For example, if L.A. 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, L.A. Care handles the request as an urgent concurrent request.</p> <p>Upon receipt of a request for urgent concurrent review, L.A. Care UM immediately requests necessary information. For operational purposes 24 hours is considered equivalent to 1 calendar day.</p> <p>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).</p> <p>When the hospital inpatient care has already been received, L.A. 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).</p> <p>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).</p>		

Notification Timeframe			
Type of Request	Decision	Initial Notification	Written Notification
	<p>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 L.A. 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).</p>		
<p>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</p>	<p>Decision Timeframe: If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved does not meet the definition of Urgent Care, the request is handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., Pre-Service or Post-Service).</p>	<p>Practitioner: All Decisions: Within 24 hours of receipt of the request Member: Approvals: Within 24 hours of receipt of the request</p>	
<p>Post-Service / Retrospective Review</p>	<p>Decision Timeframe: within 30 calendar days from receipt or request</p>	<p>Practitioner and Member: None specified</p>	
<p>Hospice - Inpatient Care</p>	<p>Decision Timeframe: Within 24 hours of receipt of request</p>	<p>Practitioner: Initial Notification: Within 24 hours of making the decision Member: None Specified</p>	

Attachment B

L.A. Care Health Plan

Vision, Dental, and Behavioral Health Benefit Grid

	Medi-Cal
Vision Benefits	<p>Medi-Cal Vision care services are covered and are the responsibility of and provided by L.A. Care.</p> <ul style="list-style-type: none">• L.A. Care has contracted with Vision Vendor - VSP - to coordinate L.A. Care's Medi-Cal members' vision care and lenses services.• All referrals for Vision care services should be referred to VSP.• To access Medi-Cal vision care and lenses benefits, Medi-Cal members should be directed to call VSP at the toll free number 1.800.877.7195.• To find out more about Medi-Cal eye exams or vision care coverage, Medi-Cal members can also call L.A. Care Member Services at the toll free number 1.888.839.9909 <p>For Medi-Cal Members up to Age 21, and certain adults as defined by DHCS, Medi-Cal Eye exams are covered by L.A. Care and carved out to the Prison Industry Labs. Lenses are limited to one pair of eyeglasses every two years unless:</p> <ul style="list-style-type: none">• 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. <p>L.A. Care Medi-Cal 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 Medi-Cal Adults retrospective to July 1, 2009</p> <p>To date, reinstatement of Optometry Services for Medi-Cal Adults does not include lenses for adults.</p>
Dental Benefits	<p>Medi-Cal dental benefits are not covered under L.A. Care, but are carved out to the Medi-Cal Denti-Cal Program.</p> <p>Effective July 1, 2009 the State of California excluded Adult dental services from the Medi-Cal Denti-Cal Program</p> <p>L.A. Care is responsible for ensuring that Medi-Cal members up to age 21 are referred to appropriate Medi-Cal dental providers through the Medi-Cal Denti-Cal Program.</p> <p>To find a Denti-Cal dentist, Medi-Cal members up through age 21 should call Denti-Cal at the toll free number 1.800.322.6384.</p> <p>Denti-Cal can also be contacted on the internet at http://www.denti-cal.ca.gov/</p>

Medi-Cal

Behavioral Health Benefits

L.A. Care covers Medi-Cal outpatient mental health services for members with mild to moderate mental health conditions.

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 Substance Abuse Treatment Program.

Medi-Cal Specialty Mental Health Services are carved out from L.A. Care:

Medi-Cal members may receive Specialty 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

Medi-Cal Alcohol/Drug Treatment Carved Out Services:

Medi-Cal members may receive substance use disorders services from the Los Angeles County Department of Public Health Substance Abuse Prevention and Control (DPH SAPC) with or without a referral from their PCP. The following services are the responsibility of and provided by DPH SAPC:

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

DPH SAPC can be reached by calling the Community Assessment Services Center toll free number 1.800.564.6600.

6.0 Quality Improvement Program

L.A. Care annually prepares a comprehensive Quality Improvement Program that defines L.A. Care's Quality Improvement (QI) structures and processes for all L.A. Care products. The QI Program is designed to improve the quality and safety of clinical care and services for L.A. Care's membership. A copy of L.A. Care's QI Program is available upon request by calling 1.213.694.1250, extension 5772.

The L.A. Care QI Program is responsible for the following activities:

- Define, oversee, continuously evaluate, and improve the quality and efficiency of health care delivered through organizational commitment to L.A. Care's goals and principles
- Ensure that medically necessary covered services are available and accessible to Members, taking into consideration the Member's cultural and linguistic needs
- Ensure L.A. Care's contracted network of Providers cooperates 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, the industry, and the community
- Promote health education and disease prevention designed to promote life-long wellness by encouraging and empowering each Member to adopt and maintain optimal health behaviors
- Maintain a well-credentialed network of Providers based on recognized and mandated credentialing standards
- Safeguard Members' protected health information (PHI)

6.1 Annual Quality Improvement Program Evaluation

Annually, L.A. Care reviews data reports and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes the following:

- 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

- Assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues
- Evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices as well as the goals and plans for the next year

6.2 Annual Quality Improvement Work Plan

The annual QI Work Plan is developed in collaboration with an interdepartmental team 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 (QOC) and the Compliance and Quality Committee of the Board.

6.3 Committee Structure

L.A. Care's quality committees oversee various functions of the QI program. The committees serve as the major mechanism for intradepartmental collaboration for the QI program.

The Quality Oversight Committee (QOC), a cross-functional staff committee of L.A. Care, is the cornerstone for communication within the organization. It is responsible for aligning organization-wide QI goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care's QI infrastructure. The QOC conducts the following activities:

- Reviews current strategic projects and performance improvement activities to ensure appropriate collaboration and to minimize duplication of efforts
- Reviews quantitative and qualitative analysis of performance data of subcommittees through formal reports as needed
- Identifies opportunities for improvement based on analysis of performance data and prioritizes these opportunities
- Tracks and trends quality measures through quarterly updates of the QI work plan
- Reviews and makes recommendations regarding quality delegated oversight activities such as reporting requirements on a quarterly basis
- Reviews, modifies, and approves policies and procedures

- Reviews and approves the QI and UM program descriptions, QI and UM work plans, quarterly QI work plan reports and evaluations of the QI and UM programs.

Network physicians participate in many of L.A. Care's QI Committees. For example, the Joint Performance Improvement Collaborative Committee and Physician Quality Committee (Joint PICC/PQC) reviews and approves the updated Clinical Practice Guidelines so that the QOC members know that the guidelines have been approved. Upon approval, the updated information is posted on the L.A. Care website at lacare.org. Providers are notified of the updates in the next newsletter, which includes a link to the updated guidelines.

The Joint PICC/PQC's primary objective is to ensure practitioner participation in the QI program through planning, design, and review of programs, quality improvement activities, and interventions designed to improve performance. The Joint PICC/PQC provides an opportunity for L.A. Care to collaborate with the Provider community and gather feedback on clinical and service initiatives. The Joint PICC/PQC reports to the QOC through the QI Medical Director (or designee). The Joint PICC/PQC serves as an advisory group to L.A. Care's QI infrastructure for the delivery of health services to the CFAD population. Participation in the Joint PICC/PQC, including committee membership, is open to network practitioners representing a broad spectrum of appropriate primary care specialties serving L.A. Care Members including, but not limited to, practitioners who provide health care services to dually-eligible Members or who have expertise in managing chronic conditions (e.g., asthma, diabetes, congestive heart failure).

6.4 Clinical Care Measures

L.A. Care measures clinical performance through Healthcare Effectiveness Data and Information Set (HEDIS). L.A. Care expects that the network assist the health plan in continuously improving its HEDIS rates. The network is also expected by contract to cooperate with the annual HEDIS data collection efforts and keep encounter data current and accurate.

6.5 Service Measures

L.A. Care monitors services and Member satisfaction by collecting, analyzing, and acting on numerous sources of data, focusing on areas such as Member satisfaction, complaints and appeals, access to and availability of practitioners and Provider satisfaction.

The following measures will be collected annually:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)

6.5.1 Continuity and Coordination of Medical Care

L.A. Care encourages PPGs and their affiliated Provider network to assess and improve how well they coordinate care through the following:

- If referring to a specialist, contact the specialist before the Member's appointment.
- Have staff set up a quick phone appointment and fax over the Member's medical history.
- Request that the specialist also contact the PCP once the evaluation and/or treatment is finished.
- Keep track of specialty referrals that require prior authorization.
- Talk to the PPG about getting timely hospital discharge reports that will help follow up and coordinate care after a hospitalization or emergency room visit.

6.5.2 Continuity and Coordination of Medical and Behavioral Health Care

L.A. Care provides mental health services and substance use disorder services through PCPs and Behavioral Health Specialists from Beacon Health Services. Beacon Behavioral Services may be reached at 1.877.344.2858.

Specialty Mental Health Services are provided through the Los Angeles County Department of Mental Health (LACDMH). There is no need for an L.A. Care referral to obtain services from LACDMH. LACDMH may be reached toll-free at 1.800.854.7771.

L.A. Care will coordinate non-specialty behavioral health services and cover laboratory, radiological, and radioisotope services needed for the diagnosis, treatment, and monitoring of a behavioral health condition. L.A. Care covers mental health drugs listed on the formulary and prescribed by the PCP 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.

For a directory of L.A. Care's behavioral health Providers, please refer to the electronic Provider and hospital directory on L.A. Care's website, at <http://www.lacare.org/members/member-tools/find-doctor-or-hospital>, which will link to the Find a Doctor or Hospital tool.

6.6 Preventive Health Care Guidelines

More information about Preventive Services is provided at the following L.A. Care website address: www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines

Clinical Practice Guidelines for Acute and Chronic Medical Care – See the L.A. Care website at www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines for current and updated guidelines for acute and chronic medical care, including guidelines for asthma and diabetes.

Clinical Practice Guidelines for Behavioral Health Care – See the L.A. Care website at www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines for current guidelines for behavioral health care, inclu

L.A. Care's Chronic Care Improvement Programs (CCIPs) use a system of coordinated healthcare interventions and communications in an effort to improve the health status of those eligible Members with chronic conditions and those for whom self-care efforts are significant. The CCIPs achieve this objective by educating Members and by enhancing their ability to self-manage their condition or illness. CCIPs are developed from evidenced-based clinical practice guidelines and support the practitioner/patient relationship and plan of care. The current CCIPs address asthma (*L.A. Cares About Asthma*), cardiovascular disease (*L.A. Care About Your Heart*), 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.

6.8 Patient Safety

L.A. Care is committed to improving patient safety and promoting a supportive environment for network Providers to improve patient safety in their practices.

Many of the ongoing QI Program measurement activities include safety components, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation.

6.9 Disease Reporting Statement

L.A. Care complies with disease reporting standards as cited by Section 2500 of Title 17 of the California Code of Regulations, which requires public health professionals, medical Providers, and others 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 the required diseases or conditions are available at <http://www.dhcs.ca.gov>.

6.10 PPG and Other Contracted Provider and Vendor Reporting Responsibilities

L.A. Care requires PPGs/their affiliated Provider networks and contracted vendors to have a mechanism in place to address the following issues regarding Critical Incidents:

- Collecting and tracking Critical Incidents by a Member
- Reporting all Critical Incidents to L.A. Care's QI Department every quarter
- Training their staff on protocol for Critical Incidents

A "Critical Incident" is an incident in which a Member is exposed to one or more of the following:

- Abuse; neglect or exploitation
- Serious, life-threatening, medical event that requires immediate emergency evaluation by medical professional(s)
- Disappearance
- Suicide attempt
- Death
- Restraint or seclusion

6.11 Categories of Critical Incidents

6.11.1 Abuse is characterized by any one of the following:

- Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any Member
- Knowing, reckless, or intentional acts or failures to act which cause injury or death or which place a Member at risk of injury or death
- Rape or sexual assault

- Corporal punishment or striking
- Unauthorized use or the use of excessive force in the placement of bodily restraints
- Use of bodily or chemical restraints, which is not in compliance with federal laws, state laws or administrative regulations

6.11.2 Exploitation is characterized by the following:

An act committed by a caretaker, a relative of a Member, or any person in a fiduciary relationship with a Member that entails any one of the following:

- The taking or misuse of property or resources by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means
- The use of health services without just compensation
- The use of a Member for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish

6.11.3 Neglect is characterized by any one of the following:

- Inability of a Member to secure food, shelter, clothing, health care, or services necessary to maintain his/her mental and physical health
- Failure by any caretaker to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care
- Negligent act or omission by any caretaker which causes injury or death or which places a Member at risk of injury or death
- Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan
- Failure by any caretaker to provide adequate nutrition, clothing, or healthcare
- Failure by any caretaker to provide a safe environment
- Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services

6.11.4 Disappearance/Missing Member is characterized by the following:

Whenever there is police contact regarding a missing Member, regardless of the amount of time the Member was missing.

6.11.5 Death is characterized by the following:

Whenever the death of a Member is reported regardless of the cause or setting in which it occurred.

6.11.6 A Serious Life Threatening, Medical Event that Requires Immediate Emergency Evaluation by a Medical Professional is characterized by the following:

Admission of a Member to a hospital or psychiatric facility for emergency medical services (treatment by EMS) that results in medical care that is unanticipated and/or unscheduled for the Member and which would not routinely be provided by a physician.

6.11.7 Restraints or Seclusion falls under one of the following types:

- Personal – the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of a Member's body.
- Mechanical – the use of a device that restricts the free movement of part or all of a Member's body. Such devices include anklets, wristlets, camisoles, helmets with fasteners, muffs with fasteners, mitts with fasteners, Posey gait belts, waist straps, head straps, and restraining sheets. Such devices do not include those used to provide support for functional body position or proper balance, such as a wheelchair belt or one used for medical treatment, such as a helmet used to prevent injury during a seizure. It also means to render unusable a device for free movement, such as locking a wheelchair or not allowing an individual access to technology.
- Chemical – the use of a chemical (including a pharmaceutical) through topical application, oral administration, injection, or other means to control a Member's activity and which is not a standard treatment for a Member's medical or psychiatric condition.
- Seclusion – involuntary confinement in a room such that a Member is physically prevented from leaving.
- Isolation – forced separation or failure to include a Member in the social surroundings of the setting or community.

6.11.8 Suicide Attempt is characterized by the following:

The intentional attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a Member receiving services.

6.12 Referrals to Local Agencies

PPGs, PCPs, and their affiliated Provider networks and/or vendors must refer identified Critical Incidents to local Adult Protective Services (APS) agencies or law enforcement, when appropriate, as required by state and/or federal regulations.

6.12.1 Critical Incident Reporting Agency/Authority

PPGs and their affiliated provider networks must report any identified Critical Incident(s) to the appropriate authorities as required. Critical Incidents must also be reported to L.A. Care by secure e-mail to CI@lacare.org on a quarterly basis to L.A. Care's QI department via L.A. Care's Critical Incident Tracking Report Tool.

<p>Suspected Abuse, Exploitation and Neglect</p>	<p>Adult Protective Services (APS) County Contact Information. Los Angeles County http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm</p> <p>Community & Senior Services 3333 Wilshire Blvd. Suite 400 Los Angeles, CA 90010 1.888.202.4248</p> <p>24 Hour Abuse Hotline: 1.877.477.3646 http://www.dss.cahwnet.gov/cdssweb/entres/forms/English/SOC341.pdf</p>
<p>Seclusion and Restraint</p>	<p>Report as Abuse Incident (see above) Adult Protective Services (APS) County Contact Information. Los Angeles County http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm</p> <p>Community & Senior Services 3333 Wilshire Blvd. Suite 400 Los Angeles, CA 90010 1.888.202.4248</p> <p>24 Hour Abuse Hotline: 1.877.477.3646 http://www.dss.cahwnet.gov/cdssweb/entres/forms/English/SOC341.pdf</p>
<p>Suicide Attempt</p>	<p><i>For immediate threats:</i> Call 911 <i>For non-immediate threats:</i> The 24-Hour Suicide Prevention Crisis Line at 1.877.727.4747</p>
<p>Serious Life Threatening Medical Event that Requires Immediate Emergency Evaluation by a Medical Professional</p>	<p>Call 911 L.A. Care, PPGs, PCPs, and their affiliated networks must follow company procedure.</p>
<p>Missing Persons</p>	<p>Adult Missing Person Unit: 1.213.996.1800 <i>Note: Contrary to popular belief, law enforcement agencies in California do not require a person to wait a specific period of time before reporting a missing person.</i></p>
<p>Death</p>	<p>Report notification of death to immediate supervisor for further reporting direction. In addition, call L.A. Care Member Services: 1.888.839.9909</p>

7.0 Credentialing

7.1 Overview

7.1.1 Criteria and Standards

L.A. Care contracted providers are required to be credentialed in accordance with L.A. Care's credentialing criteria and the standards of the Department of Health Care Services (DHCS), National Committee on Quality Assurance (NCQA), and Centers for Medicare & Medicaid Services (CMS).

7.1.2 Licenses and Qualifications

L.A. Care requires that all providers 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 must be qualified to participate in the Medi-Cal and CMS programs in order to participate in all L.A. Care lines of business. Failure to meet Medi-Cal, NCQA and CMS requirements may be cause for removal from L.A. Care's network.

7.2 Delegation of Credentialing

Delegation is a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although the organization can delegate the authority to perform such a function, it cannot delegate the responsibility for assuring that those functions are performed appropriately.

7.2.1 Monitoring Credentialing Activities

L.A. Care is responsible for monitoring all contracted PPGs', credentialing, and recredentialing 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, when L.A. Care has determined, based on L.A. Care's reasonable assessment of its provider network, that L.A. Care already has adequate access to the types of services provided by the Licentiate, L.A. Care retains the right to approve new providers and sites, as well as to terminate or suspend individual providers, based on credentialing issues at all times.

7.2.2 PPG Accountability

The PPG that has been delegated the credentialing responsibility is accountable for credentialing and recredentialing its providers, even if it delegates all or part of these activities. If the PPG delegates any credentialing and recredentialing activities, there must be evidence of oversight of the delegated activity. There must be annual evidence of a mutually agreed upon delegation agreement between the PPG and the delegate, i.e., NCQA certified Credential Verification Organizations (CVOs), non-certified CVOs, etc. The delegation agreement must meet all elements of NCQA's standards. As a note, CMS does not recognize NCQA certified CVOs. As such, all files are subject to full file review.

7.2.3 When delegates have access to the PPG's Member's protected health information (PHI) or create PHI in the course of their work, the mutually agreed-upon document between the PPG and the delegate 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 PHI.

7.2.4 If the delegation arrangement does not include the use of PHI in any form, an affirmative statement to that fact in the delegation agreement is sufficient, but is not required; the PPG may document the lack of PHI in a delegation arrangement in other manners.

7.2.5 Prior to delegation, L.A. Care's Credentialing Department audits the PPG (the potential delegated entity) to determine whether 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 recredentialing in accordance with the standards required by L.A. Care, NCQA, DHCS and CMS. Using a modified version of the Standardized Audit Tool in accordance with L.A. Care, NCQA, DHCS and CMS standards, the Credentialing Department will evaluate delegated entity's performance.

7.2.6 Types of Delegation Status

7.2.6.1 Upon completion of the pre-delegation audit, the audit tool is scored and recommendations regarding delegation are presented to L.A. Care Credentialing Committee as follows:

7.2.6.1.1 Full Delegation – PPG scores 100%.
No CAP Required.

7.2.6.1.2 Full delegation – PPG scores 80% to 99.9% CAP Required.

7.2.6.1.3 Denial of Delegation – PPG Scores 70% to 79.9%. CAP Required. – Opportunity to cure deficiencies. A follow up audit will be conducted within six months. A corrective action must be successfully completed.

7.2.6.1.4 Denial of Delegation – PPG chooses not to pursue delegation of credentialing, or 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 providers is performed by L.A. Care’s Credentialing department. Denial of delegation letters will be sent to the PPG.

7.2.6.2 Following recommendations by the Credentialing Committee, delegation letters will be sent to the PPG’s scoring 80% or above, and Delegation Agreements for credentialing will be executed.

7.2.6.3 L.A. Care retains the right to determine in its sole discretion whether to delegate credentialing functions regardless of the results of an audit.

7.2.7 Delegation Status

7.2.7.1 All credentialing activities have been delegated to either the PPG or a combination of a hospital and PPG. The Delegation Agreement will identify in detail exactly what functions have been delegated to the PPG.

7.2.8 Delegation Oversight

7.2.8.1 The PPG agrees, upon delegation, to make available to L.A. Care the credentialing and recredentialing status on the PPG’s participating providers, including credentialing data elements as well as documents and quarterly reports, as appropriate, using the standardized Industry Collaboration Effort (ICE) form or another approved L.A. Care format.

7.2.8.2 On an annual basis, L.A. Care will audit the credentialing and recredentialing activities of the PPG. The PPG’s credentialing and recredentialing files will be reviewed according to the following file pull methodology: A roster of providers which includes Autism providers credentialed and recredentialed within the audit period and a list of the PPG’s Utilization Management providers who make medical decisions will be requested. In addition, a full roster of the PPG’s network will also be requested. L.A. Care will also review the PPG’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) recredentialing files. If any credentialing element are deficient during the review of the 8/30 Rule, then the deficient element(s) will be reviewed for the remaining files, up to a maximum of 30 initial credentialing and 30 recredentialing files.

7.2.8.3 L.A. Care’s oversight audit will include a review of the PPG’s credentialing policies and procedures, Committee meeting minutes, practitioner credentialing and recredentialing files which includes Autism providers, Utilization Management providers who make medical decisions, a list of contracted health delivery organizations (HDOs), ongoing monitoring reports, oversight audits and any sub-delegations agreements, if applicable.

7.2.8.4 Results of L.A. Care’s oversight audit will be reported to the PPG, including the corrective action plan if deficiencies are noted. L.A. Care’s Credentialing Department works collaboratively with the PPG when deficiencies have been identified through the oversight process. The delegate is given a Corrective Action Plan (CAP) and asked to respond within 30 calendar days. If no response is received within 30 Calendar days, or the CAP is not acceptable or complete as submitted, the Regulatory Affairs and Compliance (RA&C) Department sends a revised CAP letter requesting a response within 14 calendar days and advising that failure to respond may be cause for revocation of the delegation agreement. The PPG will implement such CAP within the time period stated and will permit a re-audit by L.A. Care or its agent, if requested.

7.2.8.5 If a delegate has not cured the identified deficiencies by the next annual audit and when L.A. Care determines the deficiencies are reoccurring the delegate will be subject to additional point deduction if their process does not match their policies and L.A. Care will conduct a focus review of the delegate’s credentialing activities within six months of the previous audit, if applicable.

If the delegate continues to demonstrate noncompliance with the standards, L.A. Care will recommend de-delegation of the delegate’s credentialing activities within six months of the previous audit, if applicable.

7.2.8.6 At L.A. Care’s discretion, or in the event that L.A. Care determines that significant deficiencies are occurring related to performance by the delegate and are without remedy and fails to complete the CAP process and has gone through the exigent process

which results in de-delegation, the PPG cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee, regardless of the score.

7.2.8.7 A PPG that receives a rating of “excellent”, “commendable”, “accredited”, or “certified”, from NCQA, will be deemed to meet L.A. Care’s requirements for credentialing. These PPGs may be exempt from the L.A. Care audit of credentialing in elements for which they are accredited or certified. As a note, CMS does not recognize NCQA certified CVOs. In such cases, all files may be subject to full file review. If a PPG sub-delegates to an NCQA CVO for primary source activities, the PPG must still perform annual oversight of these activities for the Medicare line of business, if applicable.

7.2.8.8 If the PPG is NCQA accredited, and L.A. Care chooses to use the NCQA accreditation in lieu of a pre-delegation or annual audit, the PPG will be required to demonstrate compliance with the credentialing and recredentialing of UM Medical Director(s) annually. This will be accomplished through a signed Attestation submitted by the Medical Director(s) attesting to compliance with this requirement. If the PPG is not compliant with this process, the PPG will be subject to sanctions according to the PPGSA, Sections 1.36 and 1.37.

7.2.8.9 L.A. Care retains overall responsibility for ensuring that credentialing requirements are met; as such, L.A. Care will require documentation from PPG to establish proof of NCQA accreditation status. Elements not listed in the NCQA accreditation documentation will require further validation through due diligence or annual audits. L.A. Care retains the right to perform oversight audits as necessary.

7.2.8.10 L.A. Care retains the right to approve new participating providers/providers and sites (delegated or sub-delegated), and to terminate, suspend, and/or limit participation of PPG’s providers who do not meet L.A. Care’s credentialing requirements.

7.2.9 PPG Responsibilities

7.2.9.1 PPG must have policies and procedures to address credentialing of providers, non-practitioner health care professionals, licensed independent providers, Autism providers, UM providers making medical decisions, attending physicians within a teaching facility, if applicable, and HDOs that fall

within in its scope of credentialing. PPG must state in policy that they do not make credentialing and recredentialing decisions based 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; taking proactive steps to protect against discrimination occurring in the credentialing/recredentialing process these practices may include but are not limited to periodic audits of credentialing files and practitioner complaints, and maintaining a heterogeneous credentialing committee decisions to sign a statement affirming that they do not discriminate.

7.2.9.2 PPG will establish standards, requirements and process for the practitioner/HDOs that are performing services for L.A. Care Members to ensure that these providers and HDOs 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 regardless whether or not credentialing and recredentialing activities are delegated. For CBAS facilities, L.A. Care annually verifies license and credentialing status.

7.2.9.3 PPG’s policies must explicitly define the process used to ensure that the information submitted to L.A. Care is consistent with the information obtained during the credentialing process which is included in member materials and practitioner directories. Specifically, any practitioner information regarding qualifications given to members must match the information regarding practitioner’s education, training, certification and designated specialty gathered during the credentialing process. “Specialty” refers to an area of practice, including primary care disciplines.

7.2.9.4 PPG will establish a peer review process by designating a Credentialing Committee that includes representation from a range of participating providers. 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 providers and specialties.

7.2.9.5 PPG must notify the practitioner, in writing, of any adverse actions to the practitioner and notify L.A. Care of PPG's action taken as soon as the PPG has knowledge of the adverse action. The PPG must require the provider to notify the PPG of any adverse action taken against the provider within 14 days of knowledge.

7.2.9.6 PPG must document the review of adverse events, actions taken, the monitoring and follow through of the process including timeframes and closure of each adverse events.

7.2.9.7 PPG must notify L.A. Care in writing, if any contracted practitioner has any adverse action or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of providers. Failure to do so may result in the removal of the practitioner from L.A. Care's network. This is referenced in the California Participating Physician Application Information Release Acknowledgements.

Providers must not have limitations or restrictions on hospital privileges. L.A. Care's Credentialing Committee will make decisions based on review of any limitations or restrictions that have been imposed. If a facility should require a proprietary release form to release information on a practitioner's hospital status, the prospective participating practitioner will be required to complete the required proprietary form. Failure to do so will be considered non-compliance with the credentialing/recredentialing process.

7.2.9.8 PPGs that are delegated for credentialing and recredentialing are required to review, investigate and take appropriate action for any adverse events or criminal actions taken against a contracted provider including, but not limited to fair hearing and reporting to appropriate authorities as delegated. L.A. Care retains the right to approve, close panel to new membership, and/or terminate contracted providers at all times.

7.2.9.9 Pursuant to PPGSA, L.A. Care reserves the right to coordinate, consolidate, and participate in any PPG participating practitioner disciplinary hearing, conducted in accordance with L.A. Care Policy and Procedures, and California Business and Professions Code Section 805.

7.2.9.10 PPG will advise L.A. Care of any changes to its credentialing and recredentialing 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/or CMS requirements, L.A. Care shall notify PPG immediately. PPG will have 30 days to attain compliance, and, if not in compliance, L.A. Care may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

7.2.9.11 PPG will provide quarterly reports to L.A. Care following the end of each report month (May 15th, August 15th, November 15th, February 15th) with accurate and complete PPG practitioner data. PPG must provide Board certification status and Board expiration date, if applicable, when adding a practitioner to L.A. Care's network and any updates.

7.2.9.11.1 Using the standardized ICE format and Excel grid will include the following:

- Number of adds/deletes of PCPS (i.e. MDs, DOs, etc.)
- Number of adds/deletes of SCPS (i.e. MDs, and DOs, etc.)
- Numbers of adds/deletes of independent providers (i.e. DCs, DPMs, etc.)
- Any new or revised policies and procedures, additions of a computer system, CVO
- Providers termed for quality issues

7.2.9.12 PPG will submit a profile of the PCP, SCP, Mid-Levels and Autism providers credentialing information to L.A. Care. Along with the profile, the following documents must be attached; first and last page of the contract, W-9, all addenda to the California Participating Physician Application (CPPA), and appropriate hospital coverage letter, if applicable, must be attached.

7.2.9.13 PPG profiles must meet L.A. Care's requirements as follows: Providers 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 members are discharged from the hospital, referral of members back to PCP with a hospital discharge summary, and coordinate a seven day week, 24-hour call coverage utilizing the providers that are contracted with the PPG.

7.2.9.14 The PPG is responsible to ensure that members have access to their assigned PCP twenty-four (24) hours per day, seven (7) days per week. PPG will notify L.A. Care thirty (30) days prior to any changes in the status of any of the PPG's participating providers, including, but not limited to, termination, resignation or any leave. PPGs must ensure that physicians on leave of any duration are covered by a practitioner with a like specialty (e.g. Pediatrician covered by a Pediatrician) or a provider who is otherwise experienced and qualified to provide appropriate coverage.

Failure to ensure that physicians on extended leave are covered by a credentialed practitioner with a like specialty or a provider who is otherwise experienced and qualified to provide appropriate coverage shall be considered a material breach and may result in sanctions as outlined in section 1.36 of the Participating Provider Group Service Agreement (PPGSA).

7.2.9.15 PPGs will ensure that providers and all of their contracted sites are reviewed in accordance with the requirements of L.A. Care, NCQA, DHCS and CMS requirements. All Providers must have a current and valid (i.e., within 3 years of the date of initial credentialing/recredentialing) full scope site review at the time of initial credentialing/recredentialing. Providers who are only contracted for the Medicare program are required to undergo a medical record review.

7.2.9.16 PPG's Board of Governors (Board), or the group or committee to whom the Board has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures on an annual basis.

7.3 Provisional Credentialing

7.3.1 Provisional Credentialing Criteria

The PPG may conduct provisional credentialing (in compliance with L.A. Care, NCQA, DHCS, and CMS requirements) of providers who completed residency or fellowship requirements for their particular specialty area within the 12 months before the credentialing decision.

7.4 Confidentiality and Practitioner Rights

7.4.1 Confidential Information

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 providers can access their own credentialing information, as outlined in *Right to review information*, below.

7.4.2 Confidential Files

During the credentialing process, all information that is obtained is considered confidential. All Committee meeting minutes and practitioner files are to be securely stored and can only be seen by an appropriate Medical Director or his/her equally qualified designee, and the Credentialing Committee members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1157 of the State of California Evidence Code and Section 1370 of the Health and Safety Code of the State of California.

7.4.3 Right to Review Information

PPG's policies and procedures must state that providers are notified of their right to review information obtained by the PPG to evaluate their credentialing application. The evaluation includes information obtained from any outside source (malpractice insurance carriers, state licensing boards, etc.).

7.4.4 Written Policies and Procedures

PPG must have written policies and procedures for notifying a practitioner in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. The policies and procedures must clearly identify timeframes, methods, documentation and responsibility for notification.

7.4.5 Sources of Information

PPG is not required to reveal the source of information if the information is not obtained to meet PPG credentialing verification requirements or if disclosure is prohibited by law.

7.4.6 Right to Correct Erroneous Information

Policies and procedures must also state the practitioner's right to correct erroneous information submitted by another source. The policy must clearly state:

7.4.6.1 Timeframe for changes

7.4.6.2 Format for submitting corrections

7.4.6.3 The person to whom corrections must be submitted

7.4.6.4 Receipt of documented corrections

7.4.6.5 How providers are notified of their right to correct erroneous information as outlined in this manual.

7.4.7 Right to Application Status Information

PPG's credentialing policies and procedures must state that providers have a right to be informed of the status of their applications upon request, and must also describe the process for responding to such requests, including what information that the PPG may share with providers. This element does not require the PPG to allow a practitioner to review references, recommendations or other peer-review protected information

7.5 Requirements

7.5.1 Qualifications

All providers/providers must be qualified to participate in the Medi-Cal and CMS programs in order to participate in all L.A. Care lines of business. Providers/providers must not be excluded, suspended or ineligible or opted out for participation in the Medi-Cal or Medicare programs. Failure to meet Medi-Cal and/or CMS requirements may be cause for removal from L.A. Care's network.

7.5.2 Notification of Sanctions or Reports

The PPG or vendor is required to notify the Plan immediately when providers are identified on any sanctions reports for removal from network.

7.5.3 These requirements include verification of the following circumstances:

7.5.3.1 Excluded Providers

7.5.3.1.1 Confirmation that providers/providers 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 providers have the 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 OIG reports 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: <https://exclusions.oig.hhs.gov/Default.aspx>

7.5.3.2 Medi-Cal Suspended and Ineligible Providers

7.5.3.2.1 Medi-Cal law (*Welfare and Institutions Code*, Section 14123) mandates that the Department of Health Care Services (DHCS) suspends a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (b) suspended from the federal Medicare program for any reason.

7.5.3.2.2 Suspension is automatic when either of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the *California Administrative Procedures Act*.

7.5.3.2.3 All contracted PPGs and vendors, i.e., carved out contacts, are required to review sanctions Med-Cal publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

List of suspended providers are available at: http://files.medi-cal.ca.gov/pubsdoco/manual/man_query.asp?wSearch=%28%23filename+%2A%5F%2Az03%2A%2E%2A%29&w-FLogo=Suspended+and+Ineligible+Provider+List&w-FLogoH=32&wFLogoW=418&wAlt=Suspend-ed+and+Ineligible+Provider+List&wPath=pubsdoco%2F-publications%2Fmasters%2DMTP%2FzOnlineOnly%2Fsusp100%2D49%5Fz03%2F&prevP=search

7.5.3.3 Opt-Out Providers

7.5.3.3.1 If a practitioner/provider opts out of Medicare, that practitioner/ providers may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services. Payment must be made for emergency or urgently needed services furnished by an "opt-out" practitioner to a member, but payment should not otherwise be made to opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. This list must be checked on a regular basis.

7.5.3.3.2 All contracted PPGs and vendors are required to review Opt-Out publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

List of Opt-Out providers are available at: <https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx>

7.5.3.4 National Provider Identifier (NPI) Number

7.5.3.4.1 All providers of Covered Services, including PCP and specialists, must have a valid National Provider Identifier (NPI) Number.

7.5.3.4.2 All contracted PPGs and vendors are required to verify that their contracted providers have a valid NPI number.

7.5.3.5 Clinical Laboratory Identifier Amendments (CLIA) Certification

7.5.3.5.1 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 to meet certain federal requirements if they perform even one test, including waived tests, on materials derived from human body for the purpose of providing information for the assessment of health, diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of health of, human beings to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of the tests performed.

7.5.3.5.2 All contracted PPGs and vendors shall ensure that all contracted laboratory testing sites have either a current and valid CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. If a vendor is used to perform laboratory testing, the vendor is required to have a CLIA certificate and there must be a contract between both parties.

7.5.3.6 Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) Certificate, as applicable

7.5.3.6.1 The PPG must have a documented process for allowing a provider with a valid DEA certificate and participates within L.A. Care's network, to write all prescriptions for a provider who has a pending DEA certificate, or require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the provider's members who need prescriptions for medications. The PPG will maintain a current DEA or CDS certificate on all contracted providers.

7.5.3.7 Medicare Number

7.5.3.7.1 All PPGs must ensure that their contracted facilities and contracted providers that serve Medicare members must have a Medicare number.

7.5.3.8 Ongoing Monitoring of Sanctions, Complaints, and Quality Issues

7.5.3.8.1 PPG must implement a process for monitoring practitioner sanctions, complaints and the occurrence of adverse events between recredentialing cycles. The PPG must conduct ongoing monitoring of all providers who fall within the scope of credentialing. The PPG must be fully compliant with L.A. Care, NCQA, DHCS, and CMS and use the approved current sources of sanction information.

7.5.3.8.2 PPG must develop and implement policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles, and must take appropriate action against providers when it identifies occurrences of poor quality. PPG identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

7.5.3.8.3 PPG must show how they monitor all adverse events and demonstrate this process has been reviewed by the Credentialing Committee at least every six months. The PPG's Credentials committee may vote to flag a practitioner for ongoing monitoring. The PPG must fully demonstrate in the PPG's Credentialing Committee which types of monitoring they impose, the timeframe used, the intervention, and the outcome.

7.5.3.8.4 PPG must provide proof of any practitioner identified on the OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc. The PPG must demonstrate that they have taken action to terminate the contracted practitioner. If a practitioner has been identified on any of the lists above, they are to be terminated for all lines of business for L.A. Care.

7.5.3.8.5 PPG must notify L.A. Care promptly and no later than fourteen (14) calendar days of any adverse event or criminal action, changes in privileges, accusation, probation, other disciplinary action against a practitioner, or non-compliance with L.A. Care's policies and procedures. Failure to do so may result in the removal of the practitioner from L.A. Care's network.

7.5.3.8.6 L.A. Care retains the right, based on quality, facility site review, adverse events, criminal actions, or changes in privileges, accusations, and/or probation to close providers to new member assignment until such time the L.A. Care's Credentialing Committee determines otherwise.

7.5.3.8.7 PPG who fails to comply with any requested information within the specific timeframe is subject to sanctions as described in L.A. Care's policies and procedures and PPGSA, section 1.36 and 1.37. In the event that the PPG fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and will be subject to L.A. Care's policies and procedures and Credentials committee's outcome of the adverse events.

7.6 Recredentialing

7.6.1 Participating providers must satisfy recredentialing standards required for continued participation in the network. Recredentialing is completed three years from the month of initial credentialing and every three (3) years thereafter.

7.6.2 A facility site review does not need to be repeated as part of the recredentialing 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 recredentialing date, and does not need to be repeated until the due date of the next scheduled facility site review survey or when determined necessary through monitoring activities by the Plan

7.6.3 If a practitioner/provider is contracted for the Medi-Cal and Medicare programs, they are subject to both a facility 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.

7.7 Credentialing Committee

7.7.1 The Credentialing Committee will consist of not less than three (3) participating providers in good standings with state and federal agencies in order to ensure accurate representation of medical specialties.

7.7.2 Administrative support staff may attend at the request of the Chair but are not entitled to vote.

7.7.3 A quorum should consist of three (3) practitioner committee members. Any action taken upon the vote of a majority of committee members present at a duly held meeting at which a quorum is present shall be an act of the committee.

7.8 Meetings and Reporting

7.8.1 The Credentialing Committee shall meet at least quarterly but as frequently necessary to demonstrate follow-up on all findings and required action. The Credentialing Committee shall maintain a permanent record of its proceedings and actions. The activities, findings, recommendations, and actions of the committee must be reported to the governing body or designee in writing on a scheduled basis.

7.8.2 Additional meetings of the Credentialing Committee may be called by the Committee Chairperson on an as-needed basis.

7.9 Committee Decisions

7.9.1 L.A. Care considers the decision made by the Credentialing Committee to be final.

7.9.2 The PPG's credentialing policies and procedures must include a time frame for notifying applicants of credentialing decisions, not to exceed sixty (60) calendar days from the Committee's decision.

7.10 Participation of Medical Director or other Designated Practitioner

7.10.1 PPG must have a practitioner (medical director or equally qualified designated practitioner) who has overall responsibility for the credentialing process. PPG's credentialing policies and procedures must clearly indicate the Medical Director is directly responsible for the credentialing program and must include a description of his/her participation.

7.11 Committee Functions

7.11.1 Review and evaluate the qualifications of each practitioner applying for initial credentialing, and recredentialing.

7.11.2 Investigate, review and report on matters referred by the Medical Director or his/her designee or the Board regarding the qualifications, conduct, professional character or competence of any applicant or practitioner.

7.11.3 Review of periodic reports of activities, i.e., ongoing monitoring reports, credentialing activity reports, etc.

7.11.4 Review annually policies and procedures relevant to the credentialing process, and make revisions as necessary to comply with L.A. Care, NCQA, DHCS, and CMS requirements, regulations and practices.

7.11.5 PPG's Credentialing Committee must review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care. At a minimum, the Credentialing Committee must receive and review the credentials of providers who do not meet the PPG's established criteria.

7.11.6 PPG's Credentialing Committee must clearly document detailed discussion that reflects thoughtful consideration of credentials reviewed during its meeting in the minutes. Discussion that demonstrates approval/denial does not meet the intent of detailed discussion.

7.11.7 When the credentialing function is not delegated to the PPG, L.A. Care's Credentialing Department will be responsible for credentialing and recredentialing activities in-house.

7.11.8 L.A. Care's Credentialing Committee may terminate, suspend or modify participation of those providers who fail to meet eligibility criteria. The decisions to terminate, suspend, or modify participation of a contracted practitioner as a result of a reportable quality of care issue shall be subject to an appeals process by the practitioner.

7.12 Credentials Committee File Review

7.12.1 PPG's policies and procedures must describe the process used to determine and approve clean files. They must identify the Medical Director as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean and approved. With regard to clean files, the practitioner may not provide care to members until the final decision of the Credentialing Committee or the Medical Director or his or her equally qualified designee.

7.12.2 PPG's credentialing and recredentialing policies must explicitly define the process used to reach a credentialing decision.

7.13 Appeal and Fair Hearing

7.13.1 Delegated PPG, or if not delegated, L.A. Care must have a mechanism for fair hearing and appeal process for addressing adverse decisions that could result in limitation of a practitioner's participation based on issues of quality of care and/or service, in accordance with all applicable statutes. The process should include notification to practitioner within an established time frame and established time frame for practitioner to request a hearing, scheduling of hearing requests, followed by the procedures hearings, the

composition of the hearing committee and the agenda for the hearing.

7.13.2 Licentiate is not entitled to a hearing under LS-005: When L.A. Care has determined, based on L.A. Care's reasonable assessment of its provider network that L.A. Care already has adequate access to the types of services provided by the Licentiate.

7.13.3 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 Provider Manual, any one or more of the following actions or recommended actions taken for a medical disciplinary cause or reason shall be deemed actual or potential adverse action and constitute grounds for a hearing:

7.13.3.1 Denial of initial panel appointment

7.13.3.2 Denial of reappointment to panel

7.13.3.3 Suspension of panel appointment (except as described below)

7.13.3.4 Revocation of panel appointment

7.13.3.5 Other adverse restrictions on panel appointment (except as described below)

7.13.4 The following actions entitle the practitioner the opportunity to appear before a Credentialing 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 Credentialing Committee is adverse to the practitioner, unless the right to a hearing has been forfeited.

7.13.5 Peer Review Committee has the right to recommend closing panels to new members/specific age range or gender of a practitioner's panel appointment while an investigation is being conducted to determine the need for committee action, without the practitioner having a right to the rebuttal and/or fair hearing process set forth below.

7.13.6 The Credentialing 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, an opportunity to present rebuttal information and a fair hearing, in accordance with the procedure described in L.A. Care's Policy LS-005, but those rights apply subsequent to the summary action, rather than prior to it.

7.14 Required Reporting

7.14.1 PPG must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank/Healthcare Integrity Protection Data Bank within thirty (30) calendar days after the effective date of the action, if any of the following events occur:

7.14.2 The practitioner's application for participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.

7.14.3 The practitioner's participation status is terminated or revoked for a medical disciplinary cause or reason.

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

7.14.5 The practitioner resigns or takes a leave of absence from participation status following notice of any impending investigation based on information indicating medical disciplinary cause or reason or for any of the following:

7.14.5.1 Resigns, retires, or takes a leave of absence.

7.14.5.2 Withdraws or abandons the application.

7.14.5.3 Withdraws or abandons his or her request for renewal.

7.15 Expired License

7.15.1 L.A. Care requires that all providers who are performing services for L.A. Care members have a current California license at all times to provide patient care to members and abide by State and Federal laws and regulations.

7.15.2 Failure to Renew

7.15.2.1 Providers contracted with L.A. Care shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. The license to practice medicine in California must be renewed upon expiration (every two (2) years).

7.15.2.2 If any practitioner fails to renew their license by the expiration date, the following steps will be initiated by L.A. Care.

7.15.2.3 If the identified practitioner(s) has member enrollment:

7.15.2.3.1 Close provider's panel to new members upon license expiration.

7.15.2.3.2 Notify PPG of expiration and possible reassignment of members

7.15.2.3.3 Remove assigned members from unlicensed practitioner/practitioner five (5) business days following license expiration, if not renewed

7.15.2.3.4 Reassign members to a qualified licensed credentialed practitioner and

7.15.2.3.5 Remove unlicensed practitioner from network

7.15.2.4 If the identified practitioner(s) has no member enrollment:

7.15.2.4.1 Close practitioner's panel to new members

7.15.2.4.2 If practitioner has not renewed by the fifth (5th) business day following the expiration date, the unlicensed practitioner will be removed from L.A. Care's network

Note: Credentialing and recredentialing standards are the same for all L.A. Care product lines. Some product lines may not be required to adhere to some standards and that is clearly identified in the policies and procedures.

In addition L.A. Care retains the right to close the practitioner's panel without notice.

8.0 Provider Network Management (PNM)

8.1 Provider Training and Education

Provider training and education (goals, objectives, curricula and implementation guidelines) are established by L.A. Care based on regulatory requirements. L.A. Care provides additional annual and ongoing training and education, as requested by its network and regulatory agencies.

The goal of provider training and education is to improve the delivery of services to L.A. Care members by providing appropriate forums for providers to:

- be better informed about products offered by L.A. Care, its systems, and processes;
- understand the needs of L.A. Care members;
- improve clinical/patient interaction; and
- comply with regulatory requirements.

Distribution of L.A. Care's Provider Manuals

Physician Participating Groups (PPG) must make a L.A. Care provider manual available to its contracted providers/network within 10 business-days of becoming active with L.A. Care's provider network. Educating a new provider on how to locate the L.A. Care provider manual on the L.A. Care website will meet the provider manual distribution regulatory requirement. The Provider Manual can be located at L.A. Care's website at [lacare.org](http://www.lacare.org) or <http://www.lacare.org/providers/provider-resources/provider-manuals>.

Communication with Contracted Providers

On-site visits are an integral component of provider education because all contracted providers must receive ongoing education. On-site visits consist of, but are not limited to Joint Operational Meetings (JOMs) and in-service educational opportunities. These visits will focus on policy and program updates as required by the Department of Health Care Services, (DHCS), Department of Managed Health Care (DMHC), and other regulatory agencies. These meetings are generally announced, but some visits may be unannounced if L.A. Care deems them necessary. L.A. Care understands that, in some instances, on-site educational opportunities may be limited due to time constraints resulting from provider offices working diligently to serve our members. Therefore, updated information may also be shared in written documents, online via the Provider Portal or Webinars for the convenience of L.A. Care's PPGs and their contracted providers.

PPG Responsibility for Contracted Provider Education

PPGs are responsible for ensuring that all contracted Primary Care Physicians (PCPs), specialists, and ancillary providers receive on-going comprehensive training and education as stipulated in the Participating Provider Service Agreement (PPGSA) and required by applicable regulatory bodies. L.A. Care also requires its contracted network to meet the training requirements of the National Committee for Quality Assurance (NCQA).

PPG Publication of Provider Bulletins, Newsletters and General Meetings

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 or its affiliated contracted providers will meet the requirement to publish semi-annual newsletters/bulletins.

MONITORING AND OVERSIGHT

In order to ensure that PPGs are conducting new provider orientations and on-going provider education and training that are compliant with contractual requirements and regulatory guidelines, L.A. Care will require PPGs to submit monthly reports. These reports must be submitted monthly. L.A. Care may also conduct quarterly and annual audits of PPG records including training reports, signed attendance sheets; and, may sample provider records. L.A. Care will perform additional oversight of education and training as appropriate.

Management of Provider Network Panels

L.A. Care Direct Lines of Business and Plan Partners: Panel Status and Closure Requests:

The requirements for updates to provider panels and requests for panel closure are as follows:

Physicians:

A physician may request age/gender modifications to panels provided that the change initiated is effective for all lines of business, affiliated PPGs, and contracted health plans.

A physician may request Medi-Cal panel closure provided that it is applicable to all health plans affiliated with the contracted PPG.

PPGs:

A PPG may request modifications to provider panels with the stipulation that a minimum of fifteen percent (15%) of their network will continue to be active and available for assignment of adult members, and twenty percent (20%) for children aged 0-21.

L.A. Care Direct Lines of Business and Plan Partners: Provider Panel Availability

L.A. Care and the Plan Partners must also maintain a minimum of fifteen percent (15%) panel availability for the assignment of adult membership and twenty percent (20%) for children aged 0-21. Additionally, Plan Partners' provider networks must provide healthcare services in all L.A. Care approved zip codes.

L.A. Care retains the authority to close panels as deemed appropriate or necessary.

Non-compliance with Panel Availability Requirements

If a request for panel modification causes non-compliance with availability requirements, the provider's affiliated PPGs will be informed of this. Corrective Action Plans to address non-compliance may be requested or required of the PPG and/or Plan Partner. Failure to comply will result in panel closure.

8.2 Provider Directories

L.A. Care's Medi-Cal Provider Directory (Directory) is updated regularly. Data for the Directory is compiled by L.A. Care from PPG provider information. PPGs must submit accurate and timely provider data through the appropriate established process in order to ensure complete and updated in-network provider information is available to members and prospective beneficiaries. The provider directory includes a listing of PPGs, PCPs, hospitals, pharmacies and other network providers. Updated provider directories are located on the L.A. Care website at lacare.org. Directories are also available to providers in hardcopy upon request.

8.3 Primary Care and Mid-Level Medical Practitioner Capacity

PCPs, including practitioners of general medicine, family practice, internal medicine, obstetrics and gynecology (OB/GYN) and pediatrics, are allowed a maximum membership capacity of 2,000 members when there is no non-physician practitioner (mid-level extender) support. A single non-physician practitioner can potentially increase the supervising PCP's total

membership capacity by 1,000 members. However, the PCP cannot be assigned more than 5,000 L.A. Care members, including membership assigned across any product line, Plan Partner, or PPG contract within L.A. Care's network. Please note that physician panels are closed at 95% of capacity.

Number of PCP	Number of Mid-Level Extenders	Maximum Membership Capacity
1 PCP	No Extenders	2,000
1 PCP	1 Extender	3,000
1 PCP	2 Extenders	4,000
1 PCP	3 Extenders	5,000
1 PCP	4 Extenders	5,000

A Scope of Practice Agreement that 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

8.4 PNM Provider Relations Contact Information

Please call L.A. Care's Provider Services line at 1.866.522.2736 or your assigned Provider Relations Account representative if you have any questions or concerns. PCPs, specialists and ancillary providers contracted with L.A. Care's PPGs should communicate their questions directly to their contracted PPG. Providers directly contracted with L.A. Care may communicate with L.A. Care by telephone, in writing, or by e-mail.

Telephone: 1.866.522.2736

In Writing: L.A. Care Health Plan
Attention: Provider Relations
1055 W. 7th Street, 10th Floor
Los Angeles, CA. 90017

E-mail: ProviderRelations@lacare.org or e-mail your Provider Relations representative

8.5 Provider Appeals and Grievances

Provider clinical grievances will be handled through L.A. Care's Utilization Management process. Provider administrative grievances will be handled as specified below.

Providers Contracted with PPGs:

- Providers must communicate their grievances directly to their contracted PPG. This communication must be in writing.
- The PPG will be responsible for resolving the grievance within 30 calendar days and communicating to the provider the resolution/disposition.
 - PPG representative will give the provider detailed instructions for filing a grievance.
 - PPG representative will record the grievance on the provider grievance log. Regardless of the method of filing of the provider's grievance, PPG will send an acknowledgment letter to the provider within 5 business days
- If a provider contacted the PPG regarding a grievance and challenge the resolution provided by the PPG, then the provider may contact L.A. Care directly and submit a grievance against the PPG, to the contacts listed above.
 - The provider must submit a detailed written grievance, including the desired resolution and all supporting documentation and correspondence to Provider Relations. L.A. Care will respond with an acknowledgment letter within five (5) business days.
 - Provider Relations will inform the PPG of the grievance to provide response to L.A. Care within 5 business days.
 - Provider Relations will be responsible for informing the provider of the resolution/disposition in this case.

L.A. Care Directly Contracted Providers:

- Providers directly contracted with L.A. Care must communicate their administrative grievance with L.A. Care by telephone or in writing, to the contacts listed above.
- Provider Network Management will be coordinate grievance resolution within 30 calendar days. The provider will receive the resolution/disposition in writing.
 - The provider grievance will be recorded on the provider grievance log; regardless of the method of filing of the provider's grievance
 - Acknowledgement of receipt of grievance will be issued within five (5) business days

9.0 Health Education

9.1 Health Education Services

L.A. Care's Health Education Unit supports network providers in point-of-service patient education by offering Health Education services, resources, and programs at no cost to L.A. Care network providers or Direct Line of Business members.

9.1.1 Health Education Services – The *Health In Motion*™ Program

L.A. Care's *Health In Motion*™ program offers an array of skills-based, interactive wellness workshops and group appointments in various locations throughout Los Angeles County. To access a calendar of upcoming events, visit: www.lacare.org/healthy-living/health-resources/workshops-and-classes.

L.A. Care's Registered Dietitians and Certified Health Coaches assist Members unable to attend in-person workshop in managing their conditions and health status via telephonic consultations. Topics of expertise include the following:

- Medical Nutrition Therapy
- Diabetes Self-Management Education
- Weight management
- Support for managing chronic conditions, including hypertension and asthma
- Smoking cessation
- Senior health topics such as fall prevention and osteoporosis, among others.

To refer a patient for Health Education services, complete and fax the referral form located on L.A. Care's website at: www.lacare.org/providers/provider-resources/health-education-tools.

L.A. Care members may also access wellness tools and resources 24/7 in the comfort of their own home by visiting L.A. Care's on-line wellness site: My *Health In Motion*™. To access the site, members may go to www.lacare.org, and register into the member portal. To initiate registration, click on "Member Sign-In." Once the member is registered and has logged into the member portal, the member may click on the "My *Health In Motion*" tab.

9.1.2 Health Education Resources – Free Materials for Your Patients

L.A. Care makes available free hard copy health education materials in multiple topics and languages for L.A. Care providers. Health education topics

include: 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 hard-copy L.A. Care health education materials at no cost to them through the online health education material order form located at: www.lacare.org/providers/provider-resources/health-education-tools. Written Health Education materials provided by L.A. Care comply with the guidelines set forth by DHCS.

9.1.3 Staying Healthy Assessments

PCPs are responsible for ensuring the use of the Individual Health Education Behavioral Assessment (also called "IHEBA" or "Staying Healthy.") The assessment tool sponsored and approved by DHCS is called the Staying Healthy Assessment (SHA).

PCPs must administer the SHA to all new L.A. Care members within 120 days of enrollment as part of the Initial Health Assessment. Current members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam). Pediatric Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group.

The SHA must be re-administered to adults and seniors every three to five years. Annual administration is encouraged for 12-17 years and seniors due to rapidly changing risk factors.

The SHA must be reviewed annually for all age groups in the interval years between administrations.

L.A. Care offers training on completing Staying Healthy Assessment via an on-line recorded presentation on the L.A. Care website at: www.lacare.org/providers/provider-resources/staying-healthy-forms

PCPs may download Staying Healthy forms in writable PDF at: www.lacare.org/providers/provider-resources/staying-healthy-forms or order hard copies by accessing the Health Education Materials order form at: www.lacare.org/providers/provider-resources/health-education-tools. Additional tools and resources such as health education materials in multiple languages are also available to order online. Please contact healtheducation@lacare.org with any questions related to completing the SHA.

9.2 L.A. Care Family Resource Centers

L.A. Care operates four Family Resource Centers (FRC's) located throughout Los Angeles County: Lynwood, Inglewood, Boyle Heights and Pacoima. The FRC's partner with community based organizations in offering free health education and fitness classes open to all community members. New Member Orientations, health screenings, and application and enrollment assistance are also available. For more information about the Family Resource Centers please visit our website at www.lacare.org/frc.

9.3 Nurse Advice Line

L.A. Care offers a nurse advice line 24/7, including holidays. Members can call 1.800.249.3619 (TTY 711) to get answers to their common health care related questions.

9.4 Health Education Programs

L.A. Care's Health Education Programs are a combination of coordinated and systematic health education services, resources, and Member outreach designed to target a specific health problem or population. Eligible Members are identified for participation in these programs based on specific inclusion criteria for each program. The programs are available at no cost to Members:

- **“Healthy Mom” Program** – L.A. Care identifies new mothers via hospital discharge and authorization data. We conduct phone outreach to educate them on the importance of the postpartum visit and assist with scheduling an appointment with their obstetrician. L.A. Care offers interpreting and transportation services and provides Members with a gift card upon confirmation of visit attendance.
- **“Smoke Free” Program** – Adult L.A. Care Health Plan Members who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, Bupropion, Varenicline) receive 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.
- **“Fight the Flu” Program** – L.A. Care uses a coordinated series of communication methods to encourage Members to obtain a flu shot. Outreach efforts include: self-mailing educational postcards with promotional items, automated phone calls with messages targeted to the audience, and thank-you cards with an incentive, which also helps Members remember they received a flu shot.

9.5 Provider Education

The content of Provider education includes, but is not limited to, the following:

- Communication to providers of both applicable regulatory agencies' and L.A. Care Health Plan's health education requirements;
- The availability of health education services and resources;
- The availability of health education materials and the process for obtaining materials;
- The inclusion of health education material requirements; including qualified health educator oversight, reading level, field testing (if applicable), medical accuracy, availability of materials in alternative formats, and cultural/linguistic appropriateness; and
- Establishing a Staying Healthy Assessment (SHA) requirement.

L.A. Care's PPGs are responsible for educating their network providers on health education requirements and available L.A. Care health education services as listed above. Methods may include, but are not limited to: provider mailings and newsletters; meetings, seminars or other trainings; onsite visits; blast-faxes; informing network providers of the content of this Provider Manual; informing network providers of the content of applicable policies and procedures; and website postings.

10.0 Cultural and Linguistic Services

The relationship among culture, language, and health is complex and inextricably linked to the health status of individuals and, subsequently, their communities. Cultural competence and linguistic competence are widely recognized as fundamental aspects of equity and quality in health care and mental health care—particularly for diverse patient populations—and as essential strategies for reducing disparities by improving access, utilization and quality of care.

The goals of the L.A. Care Cultural and Linguistic (C&L) program are the following:

- Ensure that limited English proficient (LEP) Members receive the same scope and quality of health care services that other members receive
- Ensure the availability and accessibility of cultural and linguistic services including quality interpreting services and written materials in the Members' preferred languages and in a manner and format that is easily understood
- Improve health outcomes and decrease disparities
- Continually evaluate and improve C&L programs and services

C&L services include the following:

- Language proficiency assessment of bilingual Providers and staff
- Language assistance services that include the following:
 - Interpreting services
 - Translation services
 - Alternative format conversion
- Cultural and linguistic trainings for Providers and staff

10.1 Assessing Bilingual Language Proficiency

10.1.1 All L.A. Care Providers (PPGs, Network Providers, Specialty Plans, Vendors, Hospitals, LTSS providers):

L.A. Care Providers and staff who communicate directly with L.A. Care Members in a language other than English at medical and non-medical points of contact must be assessed and qualified for their language capabilities (Refer to Sections *10.2 Interpreting Services* and *10.3 Translation Services and Alternative Formats* for definitions of qualified interpreters and translators).

L.A. Care bilingual Providers and staff, who are *not* formally assessed and qualified, should use qualified interpreting services to better serve Members as well as to minimize the risk of liability and malpractice lawsuits.

At a minimum, assessing the language proficiency of L.A. Care contracted bilingual Providers and staff must be completed by using the Industry Collaboration Effort (ICE) Employee Language Skills Assessment Tool. However, more robust assessment by a professional language assessment vendor is strongly encouraged.

The evidence of the language proficiency assessment of L.A. Care contracted bilingual Providers and staff must be kept on file, including the following information:

- Name
- Title/Position
- Department
- Spoken and written language
- Proficiency level for spoken and written language (ICE Employee Language Skills Assessment Tool results or any other language proficiency assessment results)

AND one or more of the following (if any):

- Number of years of employment the individual has as an interpreter (e.g., resume)
- Certification of medical interpreters (e.g., National Board of Certification for Medical Interpreters, Certification Commission for Healthcare Interpreters)
- Documentation of successful completion of education and training in interpreting ethics, conduct and confidentiality that are promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare
- Other reasonable alternative documentation of interpreter capability

This information must be updated annually for L.A. Care contracted Providers and staff.

10.2 Interpreting Services

L.A. Care Members must be provided with qualified interpreting services, including American Sign Language (ASL), at no cost to them. Interpreting services must be available 24/7 at medical and non-medical points of contact. Languages for interpreting services should not be limited to the threshold languages. Effective communication through qualified interpreters improves quality of care, increases Member satisfaction, and minimizes the risk of liability and malpractice lawsuits.

Qualified interpreters must have:

- Documentation of demonstrated spoken language proficiency in both English and the other language
- A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems
- Documentation of successful completion of education and training in interpreting ethics, conduct and confidentiality that align with the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare or its equivalent

AND one or more of the following:

- Documentation of the number of years of employment the individual has as an interpreter (e.g., resume)
- Certification of medical interpreters (e.g., National Board of Certification for Medical Interpreters, Certification Commission for Healthcare Interpreters)
- Other reasonable alternative documentation of interpreter capability

10.2.1 All L.A. Care Providers (PPGs, Network Providers, Specialty Plans, Vendors, Hospitals, LTSS providers):

All L.A. Care network Providers must:

- Offer no-cost qualified interpreting services to Members.
- Not require, suggest to, or imply to Members that they provide their own interpreter.
- Strongly discourage use of friends and family members, especially minors, as interpreters except in extraordinary circumstances such as medical emergencies. A Member may choose to use a family Member or friend as an interpreter only after they are informed of the right to no-cost qualified interpreting services.
- Document a Member's preferred language in the medical chart.
- Document a Member's request or refusal of no-cost qualified interpreting services and request to use a family member or friend as an interpreter in the medical chart.
- Post translated signage at key points of contact regarding the availability of no-cost language services and how to access the services.

10.2.2 Face-to-Face Interpreting Services for L.A. Care Members

Face-to-face interpreting services should be used for L.A. Care Members medical encounters or to discuss complex matters because it is the most effective and preferred mode of interpreting services.

10.2.2.1 L.A. Care PPGs and Network Providers:

L.A. Care offers no-cost face-to-face interpreting services to contracted PPGs and Network Providers.

To request a face-to-face medical interpreter (including ASL), call L.A. Care's Member Services Department at 1.888.839.9909 at least 10 business days prior to the L.A. Care member medical appointment.

Both L.A. Care Members *and* Network Providers can request face-to-face interpreting services for confirmed Members medical appointments.

The following information is needed:

- Member Information
 - Name
 - L.A. Care ID number
 - Date of birth
 - Language being requested
 - Requested preferred gender of interpreter
- Appointment Information
- Provider's name
- Provider's specialty
- Requestor's name and phone number
- Contact person's name at appointment site and phone number (if different from requestor)
- Date and time of appointment
- Duration of appointment
- Address of appointment (including facility name and suite number)
 - Purpose of appointment
 - Other special instructions, as applicable

If the appointment date, time or location is changed, call L.A. Care's Member Services Department at 1.888.839.9909 immediately.

10.2.2.2 L.A. Care Specialty Plans, Vendors, Hospitals, and LTSS providers:

L.A. Care delegates interpreting services to Specialty Plans, Vendors, Hospitals, and LTSS providers. Please contact the appropriate personnel at your organization or facility to learn more information on how to access face-to-face interpreting services through these delegated entities.

10.2.3 Telephonic Interpreting Services

Telephonic interpreting services should be used to set up appointments or communicate simple matters, or as a backup to face-to-face interpreting services.

10.2.3.1 L.A. Care PPGs and Network Providers:

L.A. Care offers no-cost telephonic interpreting services to contracted PPGs and Network Providers.

To access L.A. Care’s telephonic interpreting services, call one of the following numbers:

PPGs may contact L.A. Care’s vendor, Language Select at: 1.888.718.4366

Network Providers may contact L.A. Care’s vendor, Language Select at: 1.888.930.3031

The following information is needed:

- Name of PPG or Medical Board License Number (Network Providers only)
- Member’s L.A. Care ID number
- Language being requested

10.2.3.2 L.A. Care Specialty Plans, Vendors, Hospitals, and LTSS providers:

L.A. Care delegates interpreting services to Specialty Plans, Vendors, Hospitals, and LTSS providers. Please contact the appropriate personnel at your organization or facility to learn more information on how to access telephonic interpreting services through these delegated entities.

10.2.4 California Relay Service – 711

California Relay Service (CRS) can be used to communicate with deaf and hard of hearing Members. CRS is a no-cost, 24/7 relay service which helps a person using a TTY/TDD to communicate by phone with a person who does not use a TTY/TDD. CRS can also help a non-TTY/TDD user call a TTY/TDD user. Trained relay operators are online to relay the conversation as it takes place.

10.2.4.1 All L.A. Care Providers (PPGs, Network Providers, Specialty Plans, Vendors, Hospitals, LTSS providers):

To communicate with deaf or hard of hearing L.A. Care Members over the phone, call CRS at 711.

The following information is needed:

- Member’s name
- Member’s phone number

10.3 Translation Services and Alternative Formats

According to regulatory timelines, L.A. Care Members should receive written “Member Informing Materials” in a Member’s preferred threshold language on a routine basis and in a preferred alternative format (e.g., large print, audio) upon request.

Translation can be completed by a translation services vendor or qualified internal bilingual staff as long as the following requirements are met:

- Translations must meet the following specifications:
 - A complete accurate meaning-for-meaning rendition of the source text (English) in the target language(s)
 - At the 6th grade reading level (calculated by Readability software, including but not limited to SMOG, Fry Graph, FOG, Flesch Reading Ease, and Dale-Chall)
 - Culturally appropriate and relevant to L.A. Care’s Member population
- Translation process must include the following at a minimum:
 - Three-step process including translation, editing, and proofreading
 - Completion of this three-step process by at least two separate qualified translators
- Qualified translators must meet the following criteria:
 - Documentation of demonstrated written language proficiency in both English and the other language
 - Formal education in the target language
 - Ability to read, write and understand the target language
 - Ability to read and understand the source language
 - Knowledge and experience with culture(s) of the intended audience
 - A fundamental knowledge of health care terminology and concepts relevant to health care delivery systems in both the source and target languages
- Written Member Informing Materials must be available in all Los Angeles County Threshold Languages. Following are the 11 threshold languages for:
 - English
 - Spanish
 - Arabic
 - Armenian
 - Chinese
 - Farsi
 - Khmer
 - Korean
 - Russian
 - Tagalog
 - Vietnamese

The documents that must be kept on file for translated Member Informing Materials include the following:

- The source document (English).
- The translated document.
- A signed attestation for each translated document in each translated language from the translation services vendor or bilingual staff who performed translation. It should attest to the accuracy and completeness of the translation using the three-step process by at least two separate qualified translators.

Member Informing Materials that are sent in English or are not fully translated (e.g., if member-specific information in Notice of Action letters remains in English) must include a translated written notice informing members of the availability of no-cost translation and interpreting services and how to access these services. This notice should be available in all threshold languages.

10.3.1 L.A. Care PPGs:

L.A. Care PPGs are delegated to translate the Member Informing Materials (e.g., appointment reminders, flyers and consent forms) that they have developed. PPGs are responsible for translating these materials into threshold languages and distributing them to Members in the appropriate threshold languages on a routine basis and in alternative formats upon request.

L.A. Care provides PPGs with translated Notice of Action (NOA) letter templates in all threshold languages. PPGs are responsible for sending NOA letters to Members. However, PPGs are responsible for translating the member-specific information within these NOA letter templates.

10.3.2 L.A. Care Network Providers:

Please contact the appropriate personnel at your PPG to learn more information on how to access materials in threshold languages and alternative formats.

10.3.3 L.A. Care Specialty Plans, Vendors, Hospitals, and LTSS providers:

L.A. Care delegates translation services and alternative formats to Specialty Plans, Vendors, Hospitals, and LTSS. Please contact the appropriate personnel at your organization or facility to learn more information on how to materials in threshold languages and alternative formats.

10.4 Cultural and Linguistic Service Trainings

Training on C&L requirements, cultural competency, and disability sensitivity is required for all network Providers. Training must be delivered to staff and Providers serving Members at both medical and non-medical key points of contact. These trainings must be completed initially and on an annual basis.

10.4.1 L.A. Care PPGs and Network Providers:

L.A. Care offers the following trainings to PPGs and Network Providers. The trainings are available at no cost either as instructor-led classroom trainings or via an online learning system:

- Cultural Competency (including C&L requirements)
- Disability Awareness
- Communicating Through Healthcare Interpreters (*CME – available only for Network Physicians*)

To schedule classroom training sessions or access the online CME course, e-mail CLStrainings@lacare.org.

PPGs are delegated to inform its staff and Network Providers of the availability of the L.A. Care's C&L trainings, services, and resources, as well as how to access the trainings. PPGs can distribute this information via multiple methods, such as the following:

- For Staff: Staff orientations, in-service trainings, meetings, staff newsletters and e-mail
- For Network Providers: Provider orientations, in-service trainings, meetings, Provider newsletters, faxes and mailings

10.4.2 L.A. Care Specialty Plans, Vendors, Hospitals, and LTSS providers:

L.A. Care delegates the provision of C&L education and training to Specialty Plans, Vendors, Hospitals, and LTSS providers. Contracted Providers and staff must be trained on the following content:

- Legal obligations under state and federal laws regarding language access services
- Resources and services available to help comply with those obligations
- C&L Requirements, including the following:
 - Posting of the interpreter poster at Provider office sites
 - Availability of no-cost qualified interpreting services, including ASL, at all points of contact 24/7, including after-hours services and how to access the services

- Discouraging the use of family and friends, especially minors, as interpreters.
- Documenting a Member's preferred language
- Documenting a Member's request and refusal of interpreting services
- Identifying, assessing and tracking the linguistic capability of bilingual clinical and non-clinical staff
- Processes for filing a grievance if a Member's cultural or language needs are not met
- Working effectively with Members who use in-person and telephonic interpreters
- Availability of written Member Informing Materials in threshold languages and alternative formats and how to access the services
- Availability and use of TTY/TDD
- Cultural competency, including the following:
 - Unbiased attitude and respect for cultural diversity
 - Respect for the multifaceted nature and individuality of people
 - Awareness that culture and cultural beliefs may influence health and health care delivery
 - Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with Providers and health care system.
 - Skills to communicate effectively with diverse populations
 - Language and literacy needs
- Disability sensitivity

Documentation of all provided trainings must be kept on file including, but not limited to, sign-in sheets and training evaluation.

10.5 Cultural and Linguistic Tools and Resources

Tools and resources are available to assist all Providers in delivering culturally and linguistically appropriate care.

10.5.1 L.A. Care PPGs and Network Providers:

L.A. Care offers the following C&L tools and resources to assist PPGs and Network Providers in delivering culturally and linguistically appropriate care.

10.5.1.1 Provider Toolkit for Serving Diverse Populations

The Provider toolkit is a comprehensive guide to culturally and linguistically appropriate services. It is organized in five sections, which contain helpful C&L information and tools.

To order the toolkits, go to <https://external.lacare.org/HealtheForm/>.

To download the toolkits (PDF), go to www.lacare.org/Providers/Provider-resources/Provider-tool-kits.

10.5.1.2 Language Skills Assessment Tool

The ICE Employee Language Skills Assessment Tool can be used to document language proficiency of bilingual Providers and staff.

To download the assessment tool (PDF), go to <http://www.lacare.org/Providers/Provider-resources/Provider-forms>.

10.5.1.3 Interpreting Services Poster

The poster is translated into 14 languages. It informs the availability of no-cost interpreting services and how to access the services from L.A. Care. It should be posted at all key points of contact such as front office and exam rooms.

To order the posters, go to <https://external.lacare.org/HealtheForm/>.

10.5.1.4 Telephonic Interpreting Card

The card has the number for L.A. Care's no-cost telephonic interpreting services and information needed to place interpreted calls.

To order the telephonic cards, go to <https://external.lacare.org/HealtheForm/>.

10.5.1.5 Culturally and Linguistically Appropriate Referrals

PPGs and Network Providers can refer Members to culturally and linguistically appropriate community services by using the online community directory, Healthy City or L.A. Care's referral form.

To access the online resource directory, go to <http://www.healthycity.org/>.

To download the referral forms, go to www.lacare.org/Providers/Provider-resources/health-education-tools.

10.5.1.6 Patient Interpreter Services Labels

The labels can be used to document a Member's spoken and written languages as well as request and refusal of interpreting services.

To download the labels (Word), go to www.lacare.org/Providers/Provider-resources/Provider-forms.

10.5.2 L.A. Care Specialty Plans, Vendors, Hospitals, and LTSS providers:

Please contact the appropriate personnel at your organization or facility to learn more information about available C&L tools and resources and how to access them.

10.6 Reporting Requirements

As part of L.A. Care’s monitoring process, regular reports must be submitted via e-mail to **CLReports@lacare.org**. Reports must be provided using either L.A. Care’s reporting templates or L.A. Care’s format requirements. For the most up-to-date reporting templates or format information, please e-mail **CLStrainings@lacare.org**.

10.6.1 L.A. Care PPGs:

PPGs must submit the following reports according to the following schedule:

Annual Report		Quarterly Report	
Due Date	Dates of Service	Due Date	Dates of Service
January 31	Qtr. 1 January – March	May 15	
	Qtr. 2 April – June	August 15	
	Qtr. 3 July – September	November 15	
	Qtr. 4 October – December	February 15	

1. Annual Bilingual Staff List
2. Quarterly Translated Document Report for the reporting period
3. Quarterly Face-to-Face Interpreting Utilization Report* for the reporting period
4. Quarterly Telephonic Interpreting Utilization Report* for the reporting period.

**Face-to-Face and Telephonic Interpreting Utilization Reports are required only if a PPG uses its own interpreting services instead of the services offered by L.A. Care.*

10.6.2 L.A. Care Specialty Plans and Vendors:

Specialty Plans and Vendors must submit the following reports according to the schedule listed below:

Annual Report		Quarterly Report	
Due Date	Dates of Service	Due Date	Dates of Service
January 31	Qtr. 1 January – March	May 15	
	Qtr. 2 April – June	August 15	
	Qtr. 3 July – September	November 15	
	Qtr. 4 October – December	February 15	

1. Annual Bilingual Staff List
2. Quarterly Translated Document Report for the reporting period
3. Quarterly Face-to-face Interpreting Utilization Report for the reporting period
4. Quarterly Telephonic Interpreting Utilization Report for the reporting period
5. Quarterly C&L Referral Report for the reporting period (*Behavioral health plans only*)

11.0 Finance

11.1 Capitation Payments

L.A. Care, under contractual agreement, pays PPGs a pre-determined capitation each month for the provision of health services to L.A. Care Medi-Cal Members.

This section covers guidelines for financial reports and requirements, capitation, and other related issues.

11.1.1 100% of capitation payments will be remitted to a PPG no later than the 10th calendar day of a month (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 PPG Services Agreement (PPGSA).

11.1.2 For further information regarding PPG compensation, please refer to the Capitation Schedule of the L.A. Care Physician Capitated Services Agreement.

11.2 Capitation Statement Report

11.2.1 A Capitation Statement Report will be placed in a protected PPG website on or before the 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) – representing the number of retroactive disenrollment months processed
- Capitation amount
- Capitation total

11.2.2 The Capitation Statement Report is also used to create the Group Capitation Payment Summary Report.

11.3 Insurance

Each PPG is responsible for the total costs, except as described here, of care rendered to Members enrolled with that PPG under the terms of its L.A. Care PPGSA. Each PPG must maintain adequate insurance as follows:

11.3.1 Professional Liability Insurance

A PPG must have and maintain, at its expense throughout the term of its PPGSA, Professional Liability Insurance for each employed physician. Limits must not be less than \$1,000,000.00 per

occurrence and \$3,000,000.00 in the aggregate for the year of coverage, or another amount acceptable and permitted by L.A. Care in writing. PPGs must provide copies of insurance policies within 5 business days of a written request by L.A. Care.

11.3.2 Federal Tort Claims Act Alternative

In lieu of providing Professional Liability Insurance described above, a PPG may provide L.A. Care 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 must ensure that only those Providers covered under the Professional Liability Insurance described above or under FTCA Coverage may provide Provider services to L.A. Care Members.

11.3.3 Reinsurance/Stop-Loss Insurance

A PPG must maintain adequate stop-loss insurance to cover its catastrophic cases in an amount reasonably acceptable to L.A. Care, but in no event less than \$30,000.00 plus 50% of any medically necessary billed charges. The cost of a PPG’s reinsurance/stop-loss coverage is the PPG’s sole financial responsibility.

11.3.4 General Liability Insurance

A PPG must 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 must not be less than \$100,000.00 for each claim and \$300,000.00 in aggregate under each insurance policy period.

11.3.5 Errors and Omissions

A PPG must maintain Errors and Omissions (E&O) Insurance that covers the claims made against managed care activities. The insurance policy must be written on a claim made basis. The limits of liability must not be less than \$100,000 for each claim and \$100,000 in aggregate for each insurance policy period.

11.3.6 Directors and Officers

A PPG must maintain Directors and Officers (D&O) Insurance that covers claims made against directors and officers of the company. The insurance policy must be written on a claim made basis. The limits of liability must not be less than \$100,000 for each claim and \$100,000 in aggregate for each insurance policy period.

11.3.7 Independent Certified Public Accounting Firm Liability Insurance

A PPG must ensure that all independent certified public accounting firms conducting audits on the PPG's financial statements maintain at its expense throughout the term of its PPGSA, liability insurance with limits of not less than \$250,000.00 in aggregate for the year of coverage or another amount acceptable to and permitted by L.A. Care in writing.

A PPG must provide copies of these insurance policies within 5 business days of a written request by L.A. Care.

11.4 Minimum Financial Solvency Standards

11.4.1 Each PPG must maintain adequate financial resources to meet its obligations as they become due. PPGs contracted with L.A. Care must be solvent at all times, and must maintain the following minimum financial solvency standards:

11.4.1.1 Prepare quarterly financial statements in accordance with Generally Accepted Accounting Principles (GAAP). These financial statements must include, but are not limited to, a Balance Sheet, a Statement of Income, and a Statement of Cash Flow. These financial statements must be submitted to the Financial Compliance Department of L.A. Care no later than 45 calendar days after the close of each quarter of the fiscal year.

11.4.1.2 Reimburse, contest, or deny at least ninety 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.

11.4.1.3 Estimate and document, on a monthly basis, the PPG's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method as stipulated by Title 28, California Code of Regulations, Section 1300.77.2.

11.4.1.4 Maintain, at all times, a positive working capital (current assets net of related party receivables less current liabilities).

11.4.1.5 Maintain, at all times, a positive Tangible Net Equity (TNE) as defined in Title 28, California Code of Regulations, Section 1300.76(e).

11.4.1.6 Maintain, at all times, the current minimum "cash to claims ratio" of .75.

A cash to claims ratio is cash, readily available marketable securities and receivables (excluding all risk pool, risk-sharing, incentive payment program, and pay-for-performance receivables reasonably anticipated to be collected within 60 days) divided by the organization's unpaid claims (claims payable and IBNR claims) liability (as listed per SB 260 and Title 28, California Code of Regulations, Section 1300.75.4.2).

11.4.1.7 On an annual basis, submit financial statements, including but not limited to a Balance Sheet, a Statement of Income, and a Statement of Cash Flow audited by an independent Certified Public Accounting Firm within 150 calendar days after the close of the fiscal year to L.A. Care's Financial Compliance Department.

11.4.2 Each PPG must actively monitor its affiliated network of Providers to measure their financial stability. Copies of all reports, including findings, recommendations, corrective action plans, and other information regarding these reviews must be provided to L.A. Care upon request.

11.4.3 On a discretionary basis, L.A. Care's Financial Compliance Department has the right to periodically schedule audits to ensure compliance with any of the following: the above requirements, CMS requirements, and all regulations per SB 260 Title 28 and the California Code of Regulations. Since the financial solvency standards apply to the PPG entity as a whole, these audits will be conducted for all of the PPG's books of business, not just for those contracted with L.A. Care. PPG Representatives must facilitate access to the records necessary to complete the audit.

11.5 Reimbursement Services and Reports

11.5.1 In accordance with the provisions of PPG's subcontracts, the PPG will provide all normal reimbursement services, including those relating to the payment of capitation, processing and payment of any claims on a fee-for-service basis, administration of any stop-loss and risk-sharing programs, and any other payment mechanisms. Claims processing may be delegated to PPGs (and is stated as such in the PPGSA) in cases where UM is delegated.

11.5.1.1 PPGs that are delegated for the claims processing function must submit a monthly claims timeliness report (in an ICE approved Medicare template) and a respective supporting claims data file to L.A. Care by the 15th calendar day of each month following the month being reported.

11.5.2 Upon request, the PPG must provide to L.A. Care a copy of payment records, summaries, and reconciliations with respect to L.A. Care Members. The PPG must also provide any other payment compensation reports that it customarily provides to its Providers.

11.6 Records, Reports, and Inspection

11.6.1 Records

Each PPG will maintain all books, records, and other pertinent information that may be necessary to ensure the PPG's compliance with its L.A. Care Services Agreement, and the requirements of 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, DHCS and DMHC requirements.

These books and records will include, without limitation, all physical records originated or prepared under the performance of a PPG contract including, but not limited to:

- Working papers
- All reports submitted to DMHC
- Financial records
- All books of account
- Encounter data
- All medical records
- Hospital discharge summaries
- Medical charts and prescription files
- Any other documentation pertaining to medical and non-medical services rendered to Members
- Records of Emergency Services and other information as reasonably requested by L.A. Care and DMHC to disclose the quality, appropriateness, and/or timeliness of health care services provided to Members under the PPG's Physician Capitated Services Agreement
- PPG subcontracts
- Reports from other contracted and non-contracted Providers

11.6.2 Any reports deemed necessary by L.A. Care, DHCS, and DMHC to ensure compliance by L.A. Care with the regulatory requirements must also be maintained.

11.6.3 Each PPG must maintain all books and records necessary to disclose how the PPG is fulfilling and discharging its obligations under its PPGSA, and the PPG's responsibilities as defined by DHCS and DMHC. These books and records will be maintained to disclose all the following:

- Quantity of covered services provided
- Quality of those services
- Method and amount of payment made for those services
- Persons eligible to receive covered services
- Method in which the PPG administered its daily business
- Cost of administering its daily business

11.6.4 Inspection of Records

At any time during normal business hours, PPGs must allow L.A. Care, DMHC, DHCS, and any other authorized federal and state agencies (as well as their designees) to collect, inspect, evaluate, and audit any and all books, records, and facilities maintained by a PPG and its affiliated network of Providers pertaining to services rendered under the PPG's Physician Capitated Services Agreement. Access is subject to the confidentiality restrictions discussed in the PPG's Physician Capitated Services Agreement.

11.6.5 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.

11.6.6 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 CMS and DMHC, must be made available to DMHC, CMS, and any other regulatory agencies.

12.0 Claims and Payment

This section covers guidelines for reimbursement for services rendered or claims processing and other claims-related areas for L.A. Care's Medi-Cal Direct Line of Business (LOB), MCLA.

12.1 Responsibility of Participating Providers

L.A. Care has entered into agreements with Plan Partners, Contracted Providers, PPG/IPA's and Hospitals (Participating Providers) to divide the financial responsibility of adjudicating claims. Within the terms of the Participating Provider's agreement with L.A. Care, each Participating Provider must stay within 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.

12.2 Claims Submission

Timely Filing Deadline

Timely filing of a claim to L.A. Care is as soon as possible but not later than within 180 days of the date of service unless a L.A. Care contract specifies otherwise. Contracted Providers please refer to your contract with L.A. Care for timely filing criteria.

Billing and Electronic Data Interchange Submissions

Providers must use good faith effort to bill with the most current coding available.

LA Care encourages Electronic Data Interchange (EDI) claims submissions.

Providers may register with:

- Office Ally at <https://cms.officeally.com>; L.A. Care's payer Identification is "LACAR." Providers may reach Office Ally customer support at 1.866.575.4120
- Change Healthcare at www.changehealthcare.com. For assistance with submitting claims electronically, please contact your Practice Management System Vendor or Change Healthcare Customer Support 1.877.363.3666

Any paper claims that must be submitted should be on CMS 1500 forms for professional services and on UB-04 forms for facility services.

PROFESSIONAL AND SUPPLIER CLAIMS

Providers sending paper professional and supplier claims to L.A. Care must use a valid version of Form CMS 1500. This form is maintained by the National Uniform Claim Committee (NUCC), an industry organization in which CMS participates.

Cal MediConnect Claims

Once a Cal MediConnect claim is submitted for the Medicare portion, L.A. Care Health Plan will create a new claim for the Medi-Cal portion for secondary processing. Providers should follow the standard processes (e.g., corrected claims, re-submissions, etc.) for these claims.

Incomplete Claims

Claims submitted with incomplete or invalid information may be returned to the submitter as an unclean claim. Examples include the following:

Unclean Claims

Unclean claims include those with incomplete or missing, required information. Claims that contain complete and necessary but invalid information are also unclean. Valid information may be required for all claims or may be required on a conditional basis.

Incomplete Information

These claims include those with missing required or conditional information (e.g., no Unique Physician Identification Number (UPIN) / Provider Identification Number (PIN) or National Provider Identifier (NPI) when effective).

Invalid Information

These claims include those with required or conditional information on a claim that is illogical, or incorrect (e.g., incorrect UPIN/PIN or NPI when effective) or that is no longer in effect (e.g., an expired number).

Paper Claims Submission

Initial and Resubmitted Paper Claims may be submitted hard copy to:

L.A. Care Health Plan
Attention: Claims Department
P.O. Box 811580
Los Angeles, CA 90081

L.A. Care encourages electronic submission of claims, as stated above.

12.3 Claims Adjudication

Every claim is subject to a comprehensive series of quality "edits" and "audits." These quality checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for Manual

review. Edit and audit checks include but are not limited to the verification of the following:

- Data validity
- Procedure and diagnosis compatibility
- Provider eligibility on date of service
- Recipient eligibility on date of service
- Medicare or other insurance coverage
- Claim duplication
- Authorization requirements

12.4 Provider Portal Claims Verification

The L.A. Care Provider Portal is the preferred method for contracted Providers to check claims status. Go to the following link to register at <http://www.lacare.org/providers/provider-sign-in/provider-registration>. Providers may obtain claim status by calling 1.866.522.2736 or e-mailing LACarePSU@lacare.org.

Non-contracted providers may register with Change Healthcare (formerly Emdeon) to submit claims electronically, check member eligibility, and obtain claims status for a fee. For assistance, contact Change Healthcare Customer Support 1.877.363.3666.

12.5 Coordination of Benefits

In accordance with requirements of the Balanced Budget Act of 1997, L.A. Care, as a secondary payer, will pay deductibles, co-insurance and co-payments for Medi-Cal covered services *up to the lower of our fee schedule or the Medicare/other insurance-allowed amount*.

California law limits Medi-Cal's reimbursements for a crossover claim to an amount that, when combined with the Medicare payment, does *not exceed Medi-Cal's maximum allowed for similar services (Welfare and Institutions Code, Section 14109.5)*. When a Member has other health insurance (including Medicare, a Medicare Health Maintenance Organization (HMO) or a commercial carrier), L.A. Care will coordinate payment of benefits. These other insurers are considered the primary payer, and L.A. Care is the secondary payer.

12.6 Balance Billing

Federal law prohibits balance billing of beneficiaries eligible for Medi-Cal and Medicare, including L.A. Care CMC members.

Balance billing is the practice of billing a Member for the difference between what is reimbursed for a covered service and what a Provider feels should have been paid. It includes asking a beneficiary to enter into a private payment agreement or waive their

balance billing protection and charging deductibles, coinsurance, co-pays or other administrative fees.

For information on a L.A. Care members' Medi-Cal eligibility, please call L.A. Care at 1.888.839.9909.

12.7 Provider Disputes

L.A. Care makes available to all Providers a fast, fair and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations or other contract, non-contracted issues to the Providers. The dispute resolution mechanism is handled in accordance with applicable law and the Provider's Agreement.

Disputes

A Provider has a right to file a dispute in writing to L.A. Care within 365 days from the date of service or the most recent action date, if there are multiple actions.

A Provider dispute is a written notice to L.A. Care challenging or appealing or requesting consideration of a claim such as the following:

- Payment of a claim
- Denial of a claim
- Adjusted
- Contested
- Seeking resolution of a billing determination
- Seeking resolution of other contract dispute
- Disputing a request for reimbursement of an overpayment to a claim

Second Level Disputes

A Provider who is unable to resolve a billing and payment issues can follow a second level dispute process within 365 days of the initial action in question.

Submitting Payment Disputes

A Provider must submit a written notice to L.A. Care by U.S. Mail or other physical delivery for a dispute relating to the adjudication of a claim or a billing determination. Disputes must be sent to the following address:

L.A. Care Health Plan
Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

Required Information for Provider

Payment Dispute Notices

A Provider Dispute Notice must contain at least the information listed below, as applicable. If the Provider Dispute Notice does not contain all of the applicable information listed below, L.A. Care may return the Provider Dispute Notice, with written identification of the missing information necessary to consider the dispute.

A Provider may submit an amended Provider Payment Dispute Notice (including the missing information) within 30 business days after the date the Provider Payment Dispute Notice was received back from L.A. Care. Amended Provider Payment Dispute Notices can be sent to:

L.A. Care Health Plan
Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

The following information is required for a Provider Payment Dispute Notice:

- Provider name, the tax identification number under which services were billed and contact information.
- If the payment dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, using L.A. Care's original claim number, the date of service, and a clear explanation of the basis upon which the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is disputed.
- If the payment dispute is not about a claim, a clear explanation of the issue and the Provider's position on the issue.
- If the payment dispute involves a Member or a group of Members, the name(s) and Member ID number(s), of CINs of the Member(s).
- Second Level Disputes must state "Second Level Dispute" and include a copy of the first level dispute filing and determination.

Acknowledgment of Receipt of Dispute

L.A. Care will acknowledge receipt of a dispute by mail within 15 calendar days of the date of receipt by L.A. Care.

Dispute Determinations

L.A. Care will issue a written determination stating the outcome decision for its determination within 45 calendar days after the receipt of a clean dispute.

12.8 Payment

L.A. Care encourages providers to register for Electronic Funds Transfer (EFT) to receive electronic payment. L.A. Care contracts with PaySpan® to process EFT.

Benefits of Electronic Claims Payment:

- Expedited Payment via EFT
- Expedited remittance advices via the 835 Electronic

Remittance Advice (ERA) that can be used to auto-post into your accounts receivable without manual intervention (Your software management system must contain this feature)

- No lost/missing checks or paper remittance advices
- Reduced administrative expenses (labor for posting payments, courier fees)
- Streamlined payment reconciliation process
- Receive all payments electronically (including capitation and incentive payments, where applicable)

How to Register with PaySpan® Health:

First Time Registration: You can begin the quick and easy enrollment process online at <https://www.payspanhealth.com/ProviderPortal/Registration>. Detailed registration instructions can be found at <http://www.lacare.org/sites/default/files/universal/how-to-register-for-payspan.pdf>.

***User must check box: "Assign new or additional Payers to this receiving account" in the Account Setup Section to complete the enrollment process.**

Existing Users: If you are already registered with PaySpan® Health, you may add L.A. Care as a new payer by following these simple steps:

***User must check box: "Assign new or additional Payers to this receiving account" in the Account Setup Section**

1. Request a new registration code at <https://www.payspanhealth.com/RequestRegCode/>
2. PaySpan® Health will send an automated email indicating that a registration code will be sent to you
3. Upon receiving the registration code, go to www.payspanhealth.com
4. Log into your account
5. Click **Your Payments**
6. On the right, select **Add New Reg. Code**
 - Start Registration. You may refer to the registration instructions found on page 3 at <http://www.lacare.org/sites/default/files/universal/how-to-register-for-payspan.pdf>

Need Assistance?

PaySpan® Health Provider Service Specialists are available to provide assistance at **1.877.331.7154**.

12.9 Reporting: Quarterly Filing of AB1455

PPGs shall submit a self-reported Claims Timeliness Report to L.A. Care within 30 calendar days following the end of each quarter in accordance with AB1455 regulations (Title 28, Sections 1300.71 and 1300.71.38, Claims Settlement Practices and Dispute Resolution Mechanism). Delegated payer's Principal Officer(s) must sign or personally transmit those reports to L.A. Care. The reports include a statement attesting to the accuracy of the information.

If the aggregate results for the quarter do not meet or exceed the 90% on-time standard within 30-calendar days or 95% on-time standard within 45 working days, Days Receipts on Hand (DROH), must be reported and a Corrective Action Plan (CAP) must be attached.

PPGs shall submit these reports electronically to AB1455ClaimsReportetal@lacare.org.

13.0 Encounter Data

Contracted PPGs, Specialty Plans, Vendors, Hospitals and LTSS Providers are responsible for gathering, processing, and submitting Encounter Data for the services provided to all L.A. Care Members. Encounter Data is the primary source of information about the delivery of services provided by healthcare or atypical providers 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.

L.A. Care staff will track the utilized services and analyze the validity of capitation rates when contracted PPGs submit Encounter Data that is timely, accurate, and complete. Capitation is a payment arrangement for health care service providers for a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Encounter Data 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, Capitation Rate development, and for meeting various regulatory requirements.

L.A. Care has contracted with TransUnion Healthcare, a data clearinghouse company, to assist PPGs with the proper formatting timely and accurate submission of Encounter Data.

13.1 Requirements

PPGs, Specialty Plans, Vendors, Hospitals and LTSS providers are required to submit all requested Encounter Data, including data for services provided under the capitated arrangement for L.A. Care Members. Encounter Data is required to be submitted within sixty (60) calendar days after the end date of service in which the encounter occurred. Encounter Data must be submitted at minimum, on a monthly basis. Services must be coded accurately and comply with national standards.

Entities that are required to submit encounters to L.A. Care directly must submit electronically using the national standard transaction format and in accordance with specifications established in the Implementation Guides[®] (subscription required) and L.A. Care's supplied Companion Guides.

PPG and Hospital Encounter Data must be submitted in an electronic format in accordance with the Encounter Data specifications established by TransUnion Healthcare. PPGs must submit Encounter Data directly to TransUnion Healthcare. When a PPG uses TransUnion Healthcare to process its Encounter Data, TransUnion Healthcare will convert the PPG's Encounter Data into the appropriate format to meet L.A. Care's specifications.

PPGs and Hospitals must use TransUnion Healthcare's services under the below mentioned terms and conditions free of charge. L.A. Care will reimburse TransUnion Healthcare for services rendered to all contracted PPGs. Listed below is TransUnion Healthcare's contact information.

Doris Bermejo
Major Account Executive
TransUnion Healthcare
200 Corporate Point, Suite 350
Culver City, CA 90230
1.310.337.8530 voice
Email: dbermej@transunion.com
Website: www.transunion.com/payers

To use TransUnion Healthcare services, PPGs and Hospitals are required to:

- Submit Encounter Data to TransUnion Healthcare within the parameters required by TransUnion Healthcare.
- Submit Encounter Data to TransUnion Healthcare sixty (60) calendar days after the end date of service in which the encounter occurred to ensure routine and timely submission of Encounter Data to L.A. Care.

14.0 Marketing

14.1 Regulatory Approval

L.A. Care's RA&C Department ensures all marketing materials are submitted to the appropriate regulatory agencies for approval. Once approved, L.A. Care uses these marketing materials to inform Members of their benefits, rights, and processes to navigate through the healthcare delivery system.

The purpose of the regulatory submission process section is to ensure that all marketing and or other Member materials used by L.A. Care and L.A. Care's Providers have been approved by DHCS, DMHC and other regulatory agencies.

14.2 Marketing Activities and Standards

L.A. Care's marketing standards for Providers' MCLA marketing and promotional activities are in accordance with DHCS and other relevant regulatory marketing guidance.

L.A. Care may impose sanctions on a Provider, according to this Manual or the Provider's contractual agreement, for any violation of these standards, in accordance with DHCS marketing guidelines.

Nothing here affects a Provider's obligation to communicate with L.A. Care or a Member pursuant to contractual, statutory, regulatory, or L.A. Care policy requirements.

Permitted Activities

- Providers may enter into discussions with their Members when the Member is asking for information or advice from the Provider regarding their options, as long as the Provider gives the Member objective information, in accordance with marketing guidelines from DHCS and other relevant regulatory marketing guidance.
- Providers may distribute L.A. Care materials or make them available in their office, provided that materials are distributed or made available for all plans with which the Provider contracts.
- Providers may display posters or other materials announcing their L.A. Care contractual arrangements, provided they do so for all plans with which the Provider contracts.
- Providers may provide objective information on *all* L.A. Care sponsors' specific plan formularies, based on a particular Member's medications and health care needs.

- Providers may provide objective information regarding *all* plan sponsors' specific plans being offered, such as covered benefits, cost sharing and UM tools.
- Providers may refer their Members to other sources of information, such as the following:
 - State Medi-Cal office
 - L.A. Care's Health Plan Field Representatives
- Providers may print out and share information with Members from the CMS and/or DHCS website.
- Providers may distribute printed information provided by a plan that compares the benefits of all the different plans with which they contract. Plan benefit comparison materials must adhere to all of the following:
 - Do not highlight or rank order any specific plan.
 - Include only objective information.
 - Have the concurrence of all plans listed in the materials.
 - Be approved by DHCS. (These materials are not subject to File and Use provisions that states materials will only need to be submitted and do not have to wait for approval prior to use.)
- Providers may provide a link on their website to the DHCS Online Enrollment Center.

L.A. Care considers health education material and wellness promotion materials as Marketing Materials if such material is any of the following:

- Used in any way to promote L.A. Care or a Provider
- Used to explain benefits
- Contains any commercial message or Member notification information

L.A. Care shall consider any communication via the Internet as both Marketing Materials and as Promotional Activities.

- Communication via the Internet consists of, but may not be limited to, electronic transfer, transmittal, dissemination, and distribution through the Provider's or partner organization's website.
- Providers must follow the approval procedures provided in this section for all Marketing Materials and Promotional Activities conducted through the Internet.

Marketing Standards

All Marketing Materials and Marketing Activities must follow all DHCs marketing guidelines, which pertain to, but are not limited to, all of the following:

- Advertising and pre-enrollment materials
- Post-enrollment materials
- Outreach to Members
- Promotional activities/events
- Other marketing activities

Marketing Materials must not contain false, misleading, or ambiguous information. L.A. Care and its contracted Providers must ensure all Marketing Materials are at a reading level no greater than 6th grade and they must be both culturally and linguistically appropriate (See Section 10 of this Manual, Cultural and Linguistic Services).

All Marketing materials must clearly be labeled with the following:

- The year they were last updated
- The source of any representations, endorsements, or awards referred to in the Marketing Materials
- The entity responsible for producing the Marketing Materials

L.A. Care Logo

L.A. Care reserves the right to review and ensure correct usage of the L.A. Care logo, including the contents of the material that contains the L.A. Care logo.

L.A. Care must review and approve the use of the L.A. Care logo prior to publishing.

14.3 Approval Process

14.3.1 A Provider must submit all Marketing Materials and Promotional Activities to L.A. Care through the Provider Network Management Department for review and approval at least 45 calendar days prior to using the Marketing Materials or engaging in the Promotional Activities.

Mail or fax to:

L.A. Care Health Plan

Attn: Provider Network Management Department

1055 West 7th Street, 10th Floor

Los Angeles, CA 90017

Fax: 1.213.438.5732

Providers must submit documentation of proposed Marketing Materials and Promotional Activities to L.A. Care. This documentation must include all of the following:

- An English draft in final layout of the proposed Marketing Materials or description of the proposed Activities
- A brief description of the use of the material
- A draft of translated versions of the proposed Marketing Materials with a letter attesting that the translated material conveys the same information and level of detail as the English material (translation to only occur after the English version has been approved)

- The total cost of the proposed Marketing Materials or Promotional Activities

If, upon review, L.A. Care does not object to a Provider's Marketing Materials and Promotional Activities and associated documentation, L.A. Care will send a written notice to the Provider within ten 10 business days stating L.A. Care's review and intent to submit the proposed Marketing Materials and Promotional Activities to DHCS and relevant regulatory agency.

If, upon review, L.A. Care objects to a Provider's Marketing Materials or Promotional Activities, L.A. Care will send a written notice to the Provider within 10 business days after receipt of all documentation that describes its objections in detail. In this situation, the following process applies:

- The Provider may resubmit revisions of the Marketing Materials or Promotional Activities and all applicable documentation to L.A. Care within 5 business days after receipt of L.A. Care's notice of objection.
- L.A. Care will review the resubmitted, revised documentation and will notify the Provider within 5 business days after receipt if the Marketing Material is approved.
- If approved, L.A. Care will submit the proposed Marketing Materials or Promotional Activities to DHCS and relevant regulatory agency.
- If a Provider fails to resubmit revisions of Marketing Materials or Promotional Activities within 5 working days after receipt of L.A. Care's review, then the Provider must submit such materials as new Marketing Materials or Promotional Activities.

14.3.2 A Provider must **NOT** use Marketing Materials or engage in Promotional Activities prior to receipt of L.A. Care's written notice of approval.

14.3.3 L.A. Care must notify the Physician Group or Provider that proposed Marketing Materials or Promotional Activities have been approved within 5 working days after receipt of regulatory approval.

14.3.4 L.A. Care will consider Marketing Materials and Promotional Activities approved if DHCS or relevant regulatory agency fail to respond to L.A. Care's request to approve Marketing Materials or Promotional Activities within 45 working days.

14.4 Prohibited Activities

Prohibited activities include the following:

- Engaging in prohibited activities in accordance with DHCS marketing guidelines
- Use of Marketing Materials or engaging in Promotional Activities without prior written approval from L.A. Care
- Use of logos or other identifying information used by a government or public agency, including L.A. Care, without prior authorization

The rules regarding prohibited activities include, but are not limited, to the following:

- Directing, urging, or attempting to persuade potential enrollees to enroll in a specific plan based on financial or other interests
- Mailing marketing materials on behalf of L.A. Care, without prior approval
- Offering anything of value to induce L.A. Care Members to select them as their Provider
- Offering inducements to persuade potential enrollees to enroll in L.A. Care
- Accepting any compensation directly or indirectly from a L.A. Care Field Representative or contracted Agents for enrollment activities
- Giving any Member names, addresses, or phone numbers for the solicitation of enrollment to the L.A. Care Health Plan Field Representatives or contracted Agents

Failure to Comply

L.A. Care may impose sanctions on a Provider for any violation of the terms and conditions of this section, in accordance with marketing guidelines from DHCS, and other relevant regulatory guidance, which include but are not limited to the following:

- Financial penalties
- Immediate suspension of use of all Marketing Materials and Promotional Activities for a period not to exceed 6 months
- Imposition of an enrollment cap or Membership cap and Provider Contract termination

15.0 Compliance

15.1 Goals And Objectives

The goal of L.A. Care's Compliance Program is to ensure that all L.A. Care members receive appropriate and quality health care services through the provider network in compliance with all applicable California and federal rules and regulations including CMS requirements as well as L.A. Care contractual requirements.

L.A. Care's Compliance Program:

Provides oversight and ongoing monitoring of delegated responsibilities of L.A. Care's provider network.

Requires the implementation of corrective actions by the Provider to address deficiencies concerning provision of health care services or L.A. Care performance standards.

Establishes policies and procedures to identify, investigate, and resolve potential or actual fraud, waste, and abuse (FWA) activities.

Establishes education/training opportunities and other available resources to assist Provider in becoming compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements and member rights concerning privacy and confidentiality.

Establishes education/training opportunities and other available resources to assist Providers in achieving and maintaining compliance with CMS MA-PD requirements.

Establishes education/training opportunities to assist Providers with compliance concerns and issues regarding fraud, waste, and abuse.

Provides L.A. Care's latest code of conduct online training program at: lachp.org/compliance/coc_2010_ppg.nsf/coc_login

Note: This link will be changing and you will be notified of this change.

(When taking the online training, please log-in with your name, as well as the name of the organization before beginning).

15.2 Authority and Responsibility

L.A. Care's Compliance Program strives to ensure compliance with federal and California State rules and regulations affecting the administration of the Medi-Cal program. This includes, but is not limited to, the following requirements as applicable to each Provider's contract with L.A. Care:

Requirements set forth by DHCS and DMHC as described in state and federal regulations and other guidance or communications.

Rules and regulations promulgated by and for the DMHC and the DHCS.

All applicable federal rules and regulations that apply to the provision of health care services.

Federal and California State governing law and legal rulings.

Terms and conditions as set forth in L.A. Care's contracts with CMS and DHCS.

Requirements established by L.A. Care and implemented with the provider as stated in the Provider's contract with L.A. Care.

15.3 Delegation of Compliance and Audit Program

L.A. Care does not delegate its Compliance Program responsibilities to a Provider. However, the provider is required to comply with all state and federal Compliance Program requirements. L.A. Care staff works with provider staff to administer compliance activities and implement corrective actions to rectify deficiencies. Provider staff are encouraged to work with L.A. Care compliance staff to ensure compliance with all L.A. Care performance standards.

15.4 Audit and Oversight Activities

To ensure that all L.A. Care members receive appropriate health care services, L.A. Care staff performs an annual audit of contract responsibilities and services delegated by L.A. Care to provider. L.A. Care's audit program for delegated Providers includes, but is not limited to, the following activities:

Annual on-site visit and/or desk-top audit to delegated Providers to ensure that all delegated responsibilities and services are in compliance with Medi-Cal program requirements. The annual evaluation will be a comprehensive assessment of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote L.A. Care's overall goals and objectives for the delegated function. If any problems or deficiencies are identified, the evaluation will specify any necessary corrective action and include procedures for assuring that the corrective action is implemented.

Ad-hoc on-site visits to review provider activities to ensure compliance with program requirements.

Ongoing monitoring through review of periodic reports and data required as outlined in the delegation agreement.

Review of all provider books and records and information as may be necessary to demonstrate provider compliance with federal, California State, and L.A. Care contractual requirements. Records include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and non-medical services rendered to members, and such other information as reasonably requested by L.A. Care.

15.5 Provider Compliance Responsibilities

15.5.1 General

Provider agrees to comply with Medi-Cal laws, state and federal regulations, and DHCS and DMHC instructions; provider also agrees to audits and inspection by DHCS and DMHC and/or their designees and to cooperate, assist, and provide information as requested, and maintain records (including records of education, training, and supporting documentation) for a minimum of 10 years.

Provider shall ensure all their related entities, contractors, or subcontractors, and downstream entities involved in transactions related to L.A. Care's Medi-Cal line of business maintain and provide access to all pertinent contracts, books, documents, papers, and records (including records of education, training, and supporting documentation) necessary for compliance with state and federal requirements.

Provider shall require all related entities, contractors, subcontractors, and downstream entities to agree to comply with Medi-Cal laws, state and federal regulations, and DHCS and DMHC instructions and agree to audits and inspection by DHCS and DMHC and/or their designees and to cooperate, assist, and provide information as requested, and maintain records (including records of education, training and supporting documentation) for a minimum of 10 years.

Provider shall conduct annual general and specialized compliance training for their employees. Provider must submit documentation of that general and specialized compliance training to L.A. Care's Compliance Officer annually.

15.5.2 Policies and Procedures and Standards of Conduct

Provider shall have written policies, procedures, and standards of conduct (code of conduct) that are detailed

and specific, describing the operation of the Provider's compliance program. The policies, procedures, and standards of conduct shall ensure the following:

1. Articulate the Provider's commitment to comply with all applicable federal and state standards
2. Describe compliance expectations as embodied in the standards of conduct
3. Implement the operation of the compliance program
4. Provide guidance to employees and others on dealing with suspected, detected, or reported compliance issues
5. Identify how to communicate compliance issues to appropriate compliance personnel
6. Describe how suspected, detected, or reported compliance issues are investigated and resolved by the provider
7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
8. Describe the Provider's expectations that all employees, downstream, and related entities conduct themselves in an ethical manner; that issues of noncompliance and potential FWA are reported through appropriate mechanisms; and that reported issues will be addressed and corrected.

Provider's compliance policies, procedures, and standards of conduct shall be distributed to Provider's employees who support the Provider's Medi-Cal business at the following times: within 90 days of hire, when there are updates to the policies, and annually thereafter.

Provider shall ensure that policies, procedures, and standards of conduct are distributed to downstream and related entities' employees who support the Provider's Medicare, Medi-Cal business at the following times: within 90 days of hire, when there are updates to the policies, and annually thereafter.

15.5.3 Compliance Officer or Designee

Provider shall designate a compliance officer, or designee, and a compliance committee who report directly and are accountable to the Provider's chief executive or other senior management.

15.5.4 Training and Education

Provider shall establish, implement, and provide effective compliance training and education for its employees (including the CEO, senior administrators or managers, and governing body members) and for

downstream and related entities. Provider's training and education shall include the following:

1. Annual training and education for Provider's employees (including the CEO, senior administrators or managers, and governing body members) and for downstream and related entities;
2. Provider's employees (including temporary workers, volunteers, the CEO, senior administrators or managers, and governing body members) and downstream and related entities receive general compliance and FWA training within 90 days of hire/contracting and annually thereafter;

15.5.5 Effective Lines of Communication

Provider ensures that general compliance information is communicated to downstream and related entities' employees; and

Provider reviews and updates, if necessary, the general compliance training whenever there are material changes in regulations, policy, or guidance, and at least once annually.

Provider shall establish and implement effective lines of communication, ensuring confidentiality between the Provider's compliance officer, members of the Provider's compliance committee, the Provider's employees, managers, and governing body, and the Provider's downstream and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

Provider's lines of communication shall include the following in order to be considered effective:

Provider has an effective way to communicate information from the Provider's compliance officer to others;

Provider's written standards of conduct and/or policies and procedures must require all employees, members of the governing body, and downstream and related entities to report compliance concerns and suspected or actual violations related to the Medi-Cal program to L.A. Care and the provider;

Provider must have a system in place to receive, record, respond to, and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees, and downstream and related entities and their employees;

Provider adopts, widely publicizes, and enforces a no-tolerance policy for retaliation or retribution against any employee or downstream and related entities who in good faith reports suspected FWA;

The methods available for reporting compliance or FWA concerns and the non-retaliation policy are publicized throughout the PPG's facilities; and

Provider makes the reporting mechanisms user friendly, easy to access and navigate, and available twenty-four hours a day, seven days a week for employees, members of the governing body, and downstream and related entities.

15.5.6 Well-Publicized Disciplinary Standards

Provider shall have well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals.

15.5.7 Routine Auditing and Monitoring

Provider shall establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the Provider's compliance with Medi-Cal requirements and the overall effectiveness of the compliance program; the Provider's compliance includes compliance by the Provider's downstream and related entities. Provider's system for routine monitoring and identification of compliance risks shall include the following in order to be considered effective:

Provider shall develop a monitoring and auditing work plan that addresses the risks associated with the Medi-Cal benefits. The compliance officer and compliance committee are key participants in this process;

Provider shall establish and implement policies and procedures to conduct a formal baseline assessment of the Provider's major compliance and FWA risk areas, such as through a risk assessment;

Provider shall have a monitoring and auditing work plan that is based upon the results of the risk assessment;

Provider shall have a work plan that includes a schedule that lists all of the monitoring and auditing activities for the calendar year;

Provider's compliance officer and compliance committee shall ensure the implementation of an audit function to conduct oversight of the Provider's operation and compliance program appropriate to the Provider's size, scope, and structure;

Provider shall develop a strategy to monitor and audit its downstream and related entities to ensure that they are in compliance with all applicable laws and regulations; and

Provider shall track and document compliance efforts.

15.5.8 OIG/GSA and Other Exclusions

Provider shall review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or downstream and related entities, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in state and federal programs.

15.5.9 System for Promptly Responding to Compliance Issues

Provider shall establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with state and federal requirements.

Provider's system for promptly responding to compliance issues shall include the following:

1. Provider conducts a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medi-Cal, state and/or federal program noncompliance or potential FWA;
2. Provider undertakes appropriate corrective actions in response to potential noncompliance or potential FWA;

The provider ensures that provider and downstream and related entities have corrected their deficiencies;

The elements of the corrective action that address noncompliance or FWA committed by the Provider's employee(s) or downstream and related entities are documented, and include ramifications should the PPG's employee(s) or its downstream and related entities fail to satisfactorily implement the corrective action. The provider enforces effective correction through disciplinary measures, including employment or contract termination, if warranted; and

Provider self-reports potential FWA discovered at the provider level, and potential fraud and abuse by

downstream and related entities, as well as significant waste and significant incidents of Medi-Cal, state and/or federal program noncompliance to L.A. Care.

15.6 L.A. Care's Program Integrity Plan

L.A. Care ("L.A. Care") recognizes the importance of preventing, detecting and investigating Fraud, Waste and Abuse (FWA). 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, i.e., Compliance Program.

These responsibilities are delegated to the Program Integrity Unit – a subdivision of RA&C which includes the Special Investigation Unit (SIU), whose mission is to maintain adherence to the Program Integrity Plan to ensure the integrity of publicly funded programs.

The Role of the SIU in Program Integrity

The SIU is a team of L.A. Care personnel charged with investigating allegations of FWA, and facilitating all anti-fraud efforts at L.A. Care. The team consists of clinicians and subject matter experts who represent the following areas within the organization including, but not limited to, Legal Services, Regulatory Affairs and Compliance, Health Services, Finance, Claims, Member Services, Pharmacy and Formulary, and Credentialing.

The goal of the SIU is to protect and preserve the integrity and availability of health care resources for L.A. Care members, stakeholders, and business partners by maintaining a comprehensive program integrity plan. Anti-fraud activities will be coordinated between L.A. Care and its Providers and the FDRs of its Providers. The term "Provider" includes all health care practitioners and institutions or organizations that provide health care services or supplies.

Fraud, Waste and Abuse Defined

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste is defined as an overutilization of services or careless practices that result in unnecessary costs. Waste is generally not considered a criminally negligent action, but rather the misuse of resources.

Abuse is defined as actions that may directly or indirectly result in unnecessary costs to the Medicaid and Medicare programs or any other health care

programs funded in whole or in part by the state, federal, and/or local governments; improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary. Abuse involves payment for items or services where there is no legal entitlement to that payment and the one receiving the payment has not knowingly and/or intentionally misrepresented facts to obtain payment.

Reporting Potentially Fraudulent Activities to L.A. Care

Under the terms of the contract between L.A. Care and the Provider, the Provider or its FDRs is required to report suspected cases of FWA.

There are four (4) ways in which Providers and FDRs 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, seven 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 FWA
- Criminal activity (fraud, kickback, embezzlement, theft, etc.)
- Conflict of interest issues
- Code of conduct violations

2. Through the SIU (Compliance Officer)

The SIU is set up to receive and handle reports of all types of potentially fraudulent activities. You can access this by calling L.A. Care's Compliance Officer directly at 1.213.694.1250, 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 FWA 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 is used to report FWA to L.A. Care, the following should be included:

- Name of Person Reporting Fraud or Abuse (Optional, but highly recommended)
- Name, Address, License or Insurance ID of suspect (if known)
- Nature of Complaint
- Date of Incident(s)
- Supporting Documentation (Optional)

If FWA is found, the fraudulent incident or activity is reported to the appropriate outside law enforcement and/or regulatory agency.

To learn more about FWA or how to report it to the government, please go to: www.stopmedi-calfraud.DHCS.ca.gov or call the Medi-Cal Fraud Hotline at 1.800.822.6222. You can also visit www.stopmedicare.fraud.gov.

Non-Retaliation

Neither L.A. Care nor any of its contracted entities, including PPGs, shall retaliate against any employee, temporary employee, contractor, or agent who, in good faith, reports suspected FWA or code of conduct violations to L.A. Care, the contracted entity, or to a regulatory agency. Additionally, L.A. Care's contracted entities shall require that its subcontractors abide by this non-retaliation policy.

Communication of L.A. Care's FWA Detection Efforts

L.A. Care uses various means to educate its provider network and membership about its FWA detection efforts. Information about L.A. Care's FWA detection activities is communicated in some of the following ways: provider bulletins; provider mailings; provider trainings; member newsletters; new member handbook and other sources which may include L.A. Care's Regional Community Advisory Committee meetings.

Annual Fraud Waste and Abuse and General Compliance Training

All L.A. Care contracted Providers must ensure that all employees and contracted downstream and related entities participate and complete the Medicare Parts C and D Fraud, Waste, and Abuse and General Compliance Training within 90 days of hire/contracting and annually thereafter. Effective January 1, 2016 all Medicare Providers must use the training materials provided by CMS; the materials can

be accessible through the CMS Medicare Learning Network at:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

Providers that have met FWA certification standards through enrollment as a Medicare provider are deemed to have met FWA training and educational requirements, but still must fulfill the general compliance training requirements.

All Providers are required to submit an executed FWA and General Compliance Awareness Attestation confirming their organization's compliance with this requirement.

15.7 Enforcement of Disciplinary Standards

It is L.A. Care's expectation that Providers and their FDRs immediately report to L.A. Care any suspected compliance issues, such as noncompliant, unethical, or illegal behavior. Such behavior may include, but is not limited to, falsifying diagnoses, claims, or other documents; refusal to cooperate with state or federal audits or investigations; and other behavior. Such reports can be made directly to L.A. Care's Compliance Officer at 1.213.694.1250, x4292. Anonymous complaints of noncompliant, unethical, or illegal conduct may also be reported by calling L.A. Care's Compliance Helpline at 1.800.400.4889 or via the internet at www.lacare.ethicspoint.com. The Compliance Helpline is available twenty-four hours a day, seven days a week. The provider or FDR shall also assist in the resolution of reported compliance issues.

L.A. Care will timely, consistently, and effectively act when noncompliant or unethical behavior is found and reported to L.A. Care. Such action will be appropriate to the seriousness of the violation and may include de-delegation of a function, restriction of enrollment or assignment of members, withholding capitation, instituting monetary sanctions, or terminating a contract. Refer to the PPGSA or other Provider Agreement for further details on these measures. PPG shall ensure that it has established, implemented, and enforced disciplinary standards that are publicized to those entities with which it contracts. It is L.A. Care's expectation that the provider will cooperate with L.A. Care's efforts to monitor compliance.

15.8 The Federal and California False Claims Acts

The federal and California False Claims Acts are the government's primary weapon in the fight against health care fraud. The majority of funds recovered come from False Claims Acts suits or settlements. The False Claims Acts permit a person who learns of Fraud against the government to file a lawsuit on behalf of the government against the person or business that committed the Fraud. If the action is successful, the person filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery. These persons are often referred to as whistleblowers.

For full details on the False Claims Acts and the protections available to whistleblowers, please see L.A. Care Policy RAC-013, "Federal and California False Claims Acts."

15.9 Health Insurance Portability and Accountability Act (HIPAA)

If a provider receives a misdirected communication from L.A. Care, the provider must immediately notify L.A. Care's Privacy Office by calling 1.213.694.1250, x4186 or e-mailing PrivacyOfficer@lacare.org. Providers should securely destroy, return to L.A. Care, or safely safeguard the misdirected communication.

As covered entities, L.A. Care expects all Providers to comply with applicable privacy and security requirements outlined by federal and state regulation and guidelines, including those set forth under the HIPAA Rules. A brief overview of some of these requirements is provided below, however Providers should review the actual HIPAA Rules or consult with their legal counsel to understand all applicable regulations and requirements.

Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information ("ePHI") it creates, receives, maintains, or transmits. It also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are

in place to protect networks, computers, and other electronic devices.

The Security Rule is intended to be scalable; in other words, it does not require specific technologies to be used. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

Privacy Rule

The Privacy Rule is intended to protect the privacy of all individually identifiable health information in the hands of covered entities, regardless of whether the information is transmitted or maintained on paper, electronically, or verbally. The Privacy Rule also gives members a number of rights under HIPAA, including:

- The right to access their PHI;
- The right to request a restriction on certain uses and disclosures of their PHI;
- The right to request changes to their PHI; and
- The right to receive a list (or accounting) of when the covered entity disclosed PHI, with some exceptions (such as for treatment, payment, and health care operations).

In addition to these rights, the Privacy Rule includes requirements to formally notify members of the covered entity's privacy practices, obtain a patient's permission before using or disclosing their PHI with limited exceptions, as well as other requirements that address their proper use and disclosure of patient information.

15.9.3 Breach Notification Rule

If an impermissible acquisition, access, use, or disclosure that compromises the security or privacy of PHI occurs, HIPAA's Breach Notification Rule outlines the requirements for assessment and notification. While there are specific federal requirements that outline how to assess, who to notify, and the notification timelines, there may be other state and contractual standards that also apply. Providers are strongly encouraged to familiarize themselves with all applicable requirements and guidance.

15.9.4 Transaction and Code Sets Standards

According to CMS, electronic transactions are activities involving the transfer of healthcare information for specific purposes. The HIPAA regulations have identified certain standard transactions for Electronic Data Interchange ("EDI") for the transmission of health care data. These transactions are:

- Claims and encounter information
- Payment and remittance advice
- Claims status
- Eligibility
- Enrollment and disenrollment
- Referrals and authorizations
- Coordination of benefits
- Premium payment

If a provider engages in one of the identified transactions electronically, they must comply with the standard for that transaction. See <https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html>.

15.10 Privacy and Information Security Related Resources and Websites

U.S. Department of Health & Human Services-Office of Civil Rights

<http://www.hhs.gov/ocr/hipaa/>

Centers for Medicare & Medicaid Services (CMS)

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Privacy_Office.html

California Department of Justice, Office of the Attorney General

www.privacy.ca.gov

California Department of Health Care Services

<http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx>

National Committee on Vital and Health Statistics

<http://www.ncvhs.hhs.gov/>

National Institutes of Health

<http://privacyruleandresearch.nih.gov/>

National Institute of Standards and Technology

<http://www.nist.gov>

Centers for Medicare and Medicaid Services Regulations & Guidance

<http://www.cms.gov/home/regsguidance.asp>

16.0 Pharmacy

16.1 Overview

Starting 4/1/2021 - the Pharmacy benefit will be carved out to DHCS through Medi-Cal Rx and will be managed by DHCS' PBM, Magellan. Providers can visit this website for additional resources: <https://medi-calrx.dhcs.ca.gov/home/>

17.0 Managed Long Term Services and Supports

Managed Long Term Services and Supports (MLTSS) provides services that support members living independently in the community. This includes In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), Care Plan Options (CPO), and Long Term Care (LTC) provided in nursing facilities.

L.A. Care is responsible for coordinating, paying for, and overseeing MLTSS services for members. L.A. Care MLTSS uses a member-centered care model designed to help members to find the right combination of services to reside safely in the community or in a long term care nursing facility. MLTSS also assists with referrals to community-based services. For example, programs such as Independent Living Centers, Regional Centers, and Los Angeles Area Agencies on Aging.

L.A. Care MLTSS contact information is:

E-mail MLTSS@lacare.org

Call 1.855.427.1223, or

Fax 1.213.438.4866

17.1 Managed Long Term Services and Supports: A Resource for Providers

L.A. Care MLTSS can be an important resource for members and providers. Providers should contact L.A. Care MLTSS when they identify a member who:

- Qualifies for nursing home placement, but wants to stay home.
- Has a condition that indicates a possible need for MLTSS in the future.
- Needs social services or caregiver support.
- Needs assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, and eating.
- Requires help with Instrumental Activities of Daily Living (IADLs) such as cooking, driving, using the phone or computer, shopping, keeping track of finances, and managing medication.
- Receives MLTSS services, but has unmet needs. (Unmet needs may refer to gaps in services or the need for coordination of MLTSS services i.e. member receiving IHSS, but may also benefit from attending a CBAS center for physical therapy or

occupational therapy and socialization; member attending CBAS center; but needs transportation for medical appointments).

- Experiences difficulty with a particular MLTSS program.
- Is preparing to transition into a long term care nursing facility or is returning to community living from a long term care nursing facility.

L.A. Care's MLTSS staff provides support and expertise to providers by:

- Assisting members to find the right combination of services through assessment and service coordination.
- Enhancing access to services, including L.A. Care benefits, MLTSS programs, and community resources.
- Providing oversight of MLTSS providers and working to implement system improvements.
- Serving as MLTSS subject matter experts on interdisciplinary care teams.
- Facilitating MLTSS provider and physician participation on interdisciplinary care teams.

17.2 In-Home Supportive Services

In-Home Supportive Services (IHSS) pays for homecare services that enable seniors and individuals with disabilities (including children) to remain safely in their own homes. Members who qualify, hire their own IHSS - provider to assist with: personal care services such as bathing, grooming, dressing, and feeding; domestic services such as cooking, house cleaning, and laundry; protective supervision for individuals with mental impairment; paramedical services such as assistance with medications, bowel and bladder care; and other services such as accompaniment to medical appointments.

To qualify for IHSS, a member must be: a legal resident of California; living in his/her own home; receiving (or eligible to receive) Supplemental Security Income/State Supplemental Payment (SSI/SSP) or Medi-Cal benefits; and be 65 years of age or older, legally blind, or disabled by Social Security standards. A Health Care Certification Form signed by a licensed health care professional indicating that the individual needs assistance to stay living at home is required. This form will be provided to the member when they begin the application process.

Accessing IHSS

IHSS program eligibility and service authorizations are determined by the Los Angeles County Department of Public Social Services (DPSS). Once approved for

services, members are responsible for hiring, training, and supervising their own IHSS provider. L.A. Care can assist members by coordinating and navigating the IHSS assessment and re-assessment process, connecting the member to resources that can assist with locating a - IHSS provider, resolving IHSS-related issues, navigating the DPSS grievance and appeals processes, and coordinating IHSS benefits with other health plan benefits.

Providers may refer L.A. Care members to the MLTSS IHSS team at 1.855.427.1223 for application assistance. The provider may also assist with completion of required IHSS forms, and provide members with other documentation to support their need for IHSS services. Members who have questions about their IHSS may be referred to L.A. Care MLTSS for assistance.

17.3 Community Based Adult Services

Community Based Adult Services (CBAS) is a facility-based program that members can attend during the day for assistance with daily needs. CBAS centers provide nursing services, medication management, social services, physical and occupational therapy, speech therapy, personal care, and family/caregiver training and support. CBAS centers also provide mental health services, nutritional counseling, meals, and transportation to and from a member's residence. To qualify for CBAS, members must be over 18 years of age and meet nursing home level of care criteria or have other disabilities or health conditions, such as traumatic brain injury, mild cognitive impairment, dementia, or a developmental disability.

Accessing CBAS Services

Accessing CBAS involves a multi-step enrollment process. A completed L.A. Care Managed Long Term Services and Supports Authorization Request Form must be submitted with a physician's order. CBAS must be ordered by the member's physician. The request form is accessible via the Provider Portal at www.lacare.org. Completed authorization request forms may be submitted to L.A. Care's Utilization Management Department via fax at 1.213.438.5739 for review.

A Face-to-Face evaluation is conducted by a registered nurse to determine if the member meets the program eligibility criteria. If the member is determined to meet eligibility criteria, a CBAS center is authorized to conduct a three-day assessment to develop an Individual Plan of Care (IPC). The completed IPC is

submitted to L.A. Care for review and authorization of services. The MLTSS Nurse Specialist will support the assigned physician with facilitation and coordination of care needs. The MLTSS Nurse Specialist will also conduct regular telephonic clinical review of members receiving CBAS services.

17.4 Multipurpose Senior Services Program

Multipurpose Senior Services Program (MSSP) provides intensive care coordination services for senior members who are certified for nursing home placement, but wish to remain at home. MSSP providers conduct an assessment to determine the services and supports needed for the member to maintain their independence, and connect the member to those services. MSSP providers may also purchase additional services for members such as supplemental chore and personal care services, nutrition, handyman services, respite care, transportation, and appliance assistance.

In order to be eligible for MSSP services, a member must be 65 years of age or older, live within an MSSP service area, be eligible for Medi-Cal, and be certified for nursing home placement. If the member does not meet the eligibility requirements for MSSP, MLTSS staff will work with the member and their care team to identify alternative services.

Accessing MSSP Services

L.A. Care contracts with six MSSP providers located in designated County geographic areas that are responsible for determining Member eligibility for MSSP. If the member is eligible, but placed on a waiting list, MLTSS staff will work with the member, the MSSP provider, and other community-based providers to ensure the member receives needed assistance during the waiting period.

Providers may refer members who can benefit from MSSP to L.A. Care MLTSS at 1.855.427.1223.

17.5 Care Plan Options

Care Plan Options (CPO) provides additional services that L.A. Care MLTSS may arrange to help Cal MediConnect members stay living safely in the community. This includes services that are outside of the normal scope of benefits and the MLTSS program, such as respite care, supplemental personal care services, home modifications or maintenance, and nutritional services.

Accessing CPO Services

Providers may refer members who can benefit from CPO services to L.A. Care MLTSS at 1.855.427.1223. Members who wish to access CPO services may also contact L.A. Care MLTSS directly.

17.6 Long Term Care

Long Term Care (LTC) is the provision of medical, social, and personal care services in an institution. Most LTC services are provided in skilled nursing facilities (SNFs). The primary purpose of LTC is to assist the member in activities of daily living, such as assistance with mobility, bathing, dressing, feeding, using the toilet, preparing special diets, and supervision of medication.

To qualify for LTC, members must be receiving Medical, require 24-hour long or short-term medical care, and be eligible to receive services in a SNF. Additional criteria for LTC may be found in State regulations under Title 22, CCR, Section 51335.

Accessing LTC Nursing Facility Services

LTC nursing facility placement must be ordered by a physician. If the physician believes a member needs LTC, they should complete a L.A. Care Managed Long Term Services and Supports Authorization Request Form and submit to L.A. Care's Utilization Management Department via fax at 1.213.438.4877 for review. The form is accessible via the Provider Portal at **www.lacare.org**. L.A. Care will notify the referring individual of the LTC referral outcome within five (5) business days for routine situations and 72 hours for urgent situations.

L.A. Care MLTSS assists members residing in a LTC nursing facility LTC by monitoring member progress, assisting with transitions of care, and coordinating LTC nursing facility services with other health plan benefits. The MLTSS Nurse Specialist will support the assigned physician with facilitation and coordination of care needs. The MLTSS Nurse Specialist will conduct regular telephonic clinical review of members in LTC nursing facilities.

For additional information please refer to L.A. Care's Skilled Nursing Facility Resource Center located at: **<https://www.lacare.org/providers/provider-resources/skilled-nursing-facility-resource-center>**.

The information in this Provider Manual is accurate as of **December 30, 2021**. For the most up to date provider information, please visit our website **lacare.org**.



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