Universal Provider Manual
Serving Los Angeles County
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<th>Acronym or Word</th>
<th>Definition</th>
<th>Additional Information</th>
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</thead>
<tbody>
<tr>
<td>ABA</td>
<td>Applied Behavioral Analysis</td>
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<tr>
<td>ACH</td>
<td>Automated Clearinghouse</td>
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<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
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<tr>
<td>AMSC</td>
<td>Alcohol Misuse Screening and Counseling</td>
<td>--</td>
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<tr>
<td>APL</td>
<td>All Plan Letter</td>
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<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
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</tr>
<tr>
<td>ASH</td>
<td>American Specialty Health</td>
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<tr>
<td>ASL</td>
<td>Advanced Life Support</td>
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</tr>
<tr>
<td>ASL</td>
<td>American Sign Language</td>
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<tr>
<td>BAA</td>
<td>Business Associate Agreement</td>
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<tr>
<td>--</td>
<td>Balance Billing</td>
<td>When a Provider bills for the difference between the Provider’s charge and the allowed amount.</td>
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<tr>
<td>BHT</td>
<td>Behavioral Health Treatment</td>
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<tr>
<td>BIPOC</td>
<td>Black, Indigenous, and all other People of Color</td>
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<tr>
<td>BLS</td>
<td>Basic Life Support</td>
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<tr>
<td>C&amp;L</td>
<td>Cultural and Linguistics</td>
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<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
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<tr>
<td>CAIR</td>
<td>California Immunization Registry</td>
<td>--</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
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</tr>
<tr>
<td>CBAS</td>
<td>Community Based Adult Services</td>
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<tr>
<td>CCA</td>
<td>Center for Caregiver Advancement</td>
<td>--</td>
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<tr>
<td>CCS</td>
<td>California Children Services</td>
<td>CCS program provides physical habilitation and rehabilitation for children with specified handicap conditions through CCS certified Providers.</td>
</tr>
<tr>
<td>CCT</td>
<td>Critical Care Transport</td>
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<tr>
<td>CE</td>
<td>Continuing Education</td>
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</tr>
<tr>
<td>CHCAC</td>
<td>Children’s Health Consultant Advisory Committee</td>
<td>--</td>
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<tr>
<td>CHDP</td>
<td>Child Health and Disability Prevention</td>
<td>CHPD is a preventive program that delivers periodic health assessments and services to low income children and youth in California.</td>
</tr>
<tr>
<td>CHF</td>
<td>Chronic Heart Failure</td>
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<tr>
<td>CHIA</td>
<td>California Healthcare Interpreting Association</td>
<td>--</td>
</tr>
<tr>
<td>CIN</td>
<td>Client Identification Number</td>
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<tr>
<td>Acronym or Word</td>
<td>Definition</td>
<td>Additional Information</td>
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<tr>
<td>CLTCEC</td>
<td>California Long-Term Care Education Center</td>
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<tr>
<td>CMC</td>
<td>Cal MediConnect</td>
<td>CMC provides coordinated care for Los Angeles County seniors and people with disabilities who are eligible for Medicare and Medi-Cal.</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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</tr>
<tr>
<td>COC</td>
<td>Continuity of Care</td>
<td>--</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>--</td>
</tr>
<tr>
<td>--</td>
<td>Covered Entities</td>
<td>Covered Entities are defined in the HIPAA rules as 1. Health plans, 2. Health care clearinghouses and 3. Health care providers who electronically transmit any health information in connection with transactions for which the U.S. Department of Health &amp; Human Services (HHS) has adopted standards.</td>
</tr>
<tr>
<td>CPA</td>
<td>Certified Public Accounting</td>
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<tr>
<td>CPO</td>
<td>Care Plan Options</td>
<td>--</td>
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<tr>
<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
<td>--</td>
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<tr>
<td>CPSP</td>
<td>Comprehensive Perinatal Services Program</td>
<td>Pregnancy and Postpartum Services for pregnant Members provide comprehensive, multidisciplinary pregnancy and postpartum services with case coordination.</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
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</tr>
<tr>
<td>CRC</td>
<td>Community Resource Centers</td>
<td>The CRCs offer a broad array of no-cost programming, classes and resources to help health plan Members and others in the community stay active, healthy and informed.</td>
</tr>
<tr>
<td>CRS</td>
<td>California Relay Service</td>
<td>--</td>
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<tr>
<td>CTC</td>
<td>Call the Car</td>
<td>--</td>
</tr>
<tr>
<td>CURES</td>
<td>Controlled Substance Utilization Review and Evaluation System</td>
<td>--</td>
</tr>
<tr>
<td>D&amp;O</td>
<td>Directors and Officers Insurance</td>
<td>Policy coverage for claims made against directors and officers of a company.</td>
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<tr>
<td>DEA</td>
<td>Drug Enforcement Administration</td>
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<tr>
<td>DHCS</td>
<td>Department of Health Care Services</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
<td>--</td>
</tr>
<tr>
<td>DMH</td>
<td>Los Angeles County Department of Mental Health</td>
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<tr>
<td>DMHC</td>
<td>Department of Managed Health Care</td>
<td>--</td>
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<tr>
<td>DMP</td>
<td>Drug Management Program</td>
<td>--</td>
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<tr>
<td>Acronym or Word</td>
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<td>Additional Information</td>
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<tr>
<td>DOFR</td>
<td>Division of Financial Responsibility</td>
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<tr>
<td>DOT</td>
<td>Directly Observed Therapy</td>
<td>--</td>
</tr>
<tr>
<td>DPH</td>
<td>Los Angeles County Department of Public Health</td>
<td>--</td>
</tr>
<tr>
<td>DPP</td>
<td>Diabetes Prevention Program</td>
<td>--</td>
</tr>
<tr>
<td>DPSS</td>
<td>Los Angeles County Department of Public Social Services</td>
<td>--</td>
</tr>
<tr>
<td>DROH</td>
<td>Days Receipt on Hand</td>
<td>--</td>
</tr>
<tr>
<td>DUR</td>
<td>Drug Utilization Review</td>
<td>--</td>
</tr>
<tr>
<td>E&amp;O</td>
<td>Errors and Omissions Insurance</td>
<td>Errors and Omissions (E&amp;O) Insurance covers managed care activities.</td>
</tr>
<tr>
<td>ECAC</td>
<td>Executive Community Advisory Committee</td>
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<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
<td>EDI is the electronic interchange of business information using a standardized format.</td>
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<tr>
<td>EFT</td>
<td>Electronic Funds Transfer</td>
<td>EFT is the electronic transfer of money from a bank account to another, either within a single financial institution or across multiple institutions.</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Records</td>
<td>--</td>
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<tr>
<td>E-List</td>
<td>Monthly Eligibility List</td>
<td>Member-level roster of all eligible Members assigned to the Provider, which included all Primary Care Physician (PCP) and Member demographics.</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
<td>--</td>
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<tr>
<td>EOC</td>
<td>Evidence of Coverage</td>
<td>--</td>
</tr>
<tr>
<td>ePHI</td>
<td>Electronic Protected Health Information</td>
<td>ePHI is protected health information (PHI) that is produced, saved, transferred or received in an electronic form.</td>
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<tr>
<td>EPLS</td>
<td>Excluded Parties List System</td>
<td>--</td>
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<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnostic and Treatment</td>
<td>--</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
<td>--</td>
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<tr>
<td>ERA</td>
<td>Electronic Remittance Advice</td>
<td>--</td>
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<tr>
<td>FDA</td>
<td>United States Food and Drug Administration</td>
<td>--</td>
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<tr>
<td>FDR</td>
<td>First Tier, Downstream, and Related Entities</td>
<td>--</td>
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<tr>
<td>FFS</td>
<td>Fee-for-Service</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Centers</td>
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<tr>
<td>FSR</td>
<td>Facility Site Review</td>
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<tr>
<td>FTCA</td>
<td>Federal Tort Claims Act</td>
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<tr>
<td>FTP</td>
<td>File Transfer Protocol</td>
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<tr>
<td>Acronym or Word</td>
<td>Definition</td>
<td>Additional Information</td>
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<tr>
<td>FWA</td>
<td>Fraud, Waste, and Abuse</td>
<td>--</td>
</tr>
<tr>
<td>GAAP</td>
<td>Generally Accepted Accounting Principles</td>
<td>--</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>HEAR</td>
<td>Health Education Audio Reference</td>
<td>The HEAR library has pre-recorded messages on various health topics for Members.</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
<td>--</td>
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<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
<td>--</td>
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<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health</td>
<td>--</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
<td>--</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
<td>--</td>
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<tr>
<td>HOS</td>
<td>Health Outcomes Survey</td>
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<tr>
<td>IBNR</td>
<td>Incurred but not Reported</td>
<td>--</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Disease</td>
<td>Diagnosis code sets.</td>
</tr>
<tr>
<td>ICT</td>
<td>Interdisciplinary Care Team</td>
<td>--</td>
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<tr>
<td>IHA</td>
<td>Initial Health Assessment</td>
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<tr>
<td>IHEBA</td>
<td>Individualized Health Education Behavioral Assessment</td>
<td>IHEBA is a comprehensive assessment that is completed during a Member’s initial encounter with a selected or assigned PCP, appropriate medical specialist, or non-physician medical Provider.</td>
</tr>
<tr>
<td>IHSS</td>
<td>In-Home Supportive Services</td>
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<tr>
<td>IMR</td>
<td>Independent Medical Review</td>
<td>--</td>
</tr>
<tr>
<td>IPA</td>
<td>Independent Practice Associations</td>
<td>--</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra-uterine Device</td>
<td>--</td>
</tr>
<tr>
<td>IVR</td>
<td>Interactive Voice Response</td>
<td>--</td>
</tr>
<tr>
<td>Joint PICC</td>
<td>Joint Performance Improvement Collaborative Committee</td>
<td>--</td>
</tr>
<tr>
<td>--</td>
<td>L.A. Care Network</td>
<td>L.A. Care Network is a list of the doctors, other health care providers, and hospitals that is contracted with to provide medical care to its Members.</td>
</tr>
<tr>
<td>LACC</td>
<td>L.A. Care Covered</td>
<td>As a state selected qualified health plan, L.A. Care provides the opportunity for all members of a family to receive health coverage under one (1) health plan in the Covered California state exchange.</td>
</tr>
<tr>
<td>LACCD</td>
<td>L.A. Care Covered Direct</td>
<td>L.A. Care Covered Direct (LACCD) is also offered to those who prefer not to purchase coverage through Covered California.</td>
</tr>
<tr>
<td>LEP</td>
<td>Limited English Proficiency</td>
<td>--</td>
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<tr>
<td>Acronym or Word</td>
<td>Definition</td>
<td>Additional Information</td>
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<tr>
<td>LMA</td>
<td>Learning Management System</td>
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<tr>
<td>LOB</td>
<td>Line of Business</td>
<td></td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
<td></td>
</tr>
<tr>
<td>MA</td>
<td>Medicare Advantage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Necessity or Medically Necessary</td>
<td>Medical Necessity means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. Activities that may be justified as reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care.</td>
</tr>
<tr>
<td>MCLA</td>
<td>L.A. Care Medi-Cal</td>
<td>Medi-Cal is a public program that provides health care coverage to young adults, families, older adults, and people with disabilities who meet the income requirements.</td>
</tr>
<tr>
<td></td>
<td>Member</td>
<td>A person enrolled into L.A. Care Health Plan.</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>MLTSS</td>
<td>Managed Long Term Services and Supports</td>
<td></td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
<td></td>
</tr>
<tr>
<td>MRR</td>
<td>Medical Record Review</td>
<td></td>
</tr>
<tr>
<td>MSO</td>
<td>Management Services Organization</td>
<td></td>
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<tr>
<td>MSSP</td>
<td>Multipurpose Senior Services Program</td>
<td></td>
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<tr>
<td>MTM</td>
<td>Medication Therapy Management</td>
<td></td>
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<tr>
<td>MTM</td>
<td>Medically Tailored Meal</td>
<td></td>
</tr>
<tr>
<td>MyHIM</td>
<td>My Health in Motion™</td>
<td>MyHIM houses multiple resources including health education materials and videos, access to health coaches via messaging, and self-paced workshops.</td>
</tr>
<tr>
<td>NAL</td>
<td>Nurse Advice Line</td>
<td>A service provided by L.A. Care free of charge, intended to give Members general health information, education, advice, and to assist Members in taking a more informed role in decisions regarding their health care options.</td>
</tr>
<tr>
<td>NCIHC</td>
<td>National Council on Interpreting in Health Care</td>
<td></td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>NDN</td>
<td>Non-Discrimination Notice</td>
<td></td>
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<tr>
<td>NEMT</td>
<td>Non-Emergency Medical Transportation</td>
<td></td>
</tr>
<tr>
<td>NF-A</td>
<td>Nursing Facility Level A</td>
<td></td>
</tr>
<tr>
<td>NF-B</td>
<td>Nursing Facility Level B</td>
<td></td>
</tr>
<tr>
<td>NMT</td>
<td>Non-Medical Transportation</td>
<td></td>
</tr>
<tr>
<td>NOA</td>
<td>Notice of Action</td>
<td></td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
<td></td>
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<tr>
<td>Acronym or Word</td>
<td>Definition</td>
<td>Additional Information</td>
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<tr>
<td><strong>NUBC</strong></td>
<td>National Uniform Billing Committee</td>
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<tr>
<td><strong>NUCC</strong></td>
<td>National Uniform Claim Committee</td>
<td>--</td>
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<tr>
<td><strong>O&amp;M</strong></td>
<td>Oversight and Monitoring</td>
<td>--</td>
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<tr>
<td><strong>OB/GYN</strong></td>
<td>Obstetrics and Gynecology</td>
<td>--</td>
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<tr>
<td><strong>OIG</strong></td>
<td>Office of Inspector General</td>
<td>--</td>
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<tr>
<td><strong>ORP</strong></td>
<td>Ordering, Referring and Prescribing</td>
<td>--</td>
</tr>
<tr>
<td><strong>P&amp;L</strong></td>
<td>Profit and Loss</td>
<td>--</td>
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<tr>
<td><strong>P4P</strong></td>
<td>Pay-for-Performance</td>
<td>A Provider incentive program.</td>
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<tr>
<td><strong>PA</strong></td>
<td>Prior Authorizations</td>
<td>--</td>
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<tr>
<td><strong>PAD</strong></td>
<td>Physician Administered Drugs</td>
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<tr>
<td><strong>PASC-SEIU</strong></td>
<td>Homecare Workers Health Care Plan</td>
<td><strong>PASC-SEIU Homecare Workers Health Care Plan</strong> - L.A. Care provides health coverage to Los Angeles County’s In-Home Supportive Services (IHSS) workers, who enable seniors and people with disabilities to remain safely in their homes by providing services such as meal preparation and personal care services.</td>
</tr>
<tr>
<td><strong>PBM</strong></td>
<td>Pharmacy Benefit Manager</td>
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<tr>
<td><strong>PCE</strong></td>
<td>Provider Continuing Education</td>
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<tr>
<td><strong>PCP</strong></td>
<td>Primary Care Physician</td>
<td>A PCP is a physician, including practitioners of general medicine, family practice, internal medicine, obstetrics and gynecology (OB/GYN), and pediatrics, who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.</td>
</tr>
<tr>
<td><strong>PCS</strong></td>
<td>Physician Certificate Statement</td>
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<tr>
<td><strong>PDF</strong></td>
<td>Portable Document Format</td>
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<tr>
<td><strong>PDR</strong></td>
<td>Provider Dispute Resolution</td>
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<td><strong>PDU</strong></td>
<td>Provider Data Unit</td>
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<tr>
<td><strong>PHI</strong></td>
<td>Protected Health Information</td>
<td>Protected Health Information (PHI) is any information related to a Member’s health condition, care, or payment for care that identifies the person or provides a reasonable likelihood that the information may result in identification.</td>
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<tr>
<td><strong>PMPM</strong></td>
<td>Per Member, Per Month</td>
<td>A monthly Provider capitation payment.</td>
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<tr>
<td><strong>PNM</strong></td>
<td>Provider Network Management</td>
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<tr>
<td><strong>PPG</strong></td>
<td>Participating Physician Group</td>
<td>--</td>
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<tr>
<td><strong>PQC</strong></td>
<td>Physician Quality Committee</td>
<td>--</td>
</tr>
<tr>
<td><strong>PQI</strong></td>
<td>Potential Quality of Care Issues</td>
<td>--</td>
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<tr>
<td><strong>PQR</strong></td>
<td>Provider Quality Review</td>
<td>--</td>
</tr>
<tr>
<td><strong>--</strong></td>
<td>Provider</td>
<td>A doctor, hospital and other licensed health care professionals or licensed health facility that works with, and is contracted with, L.A. Care Health Plan.</td>
</tr>
<tr>
<td><strong>QHP-EES</strong></td>
<td>Qualified Health Plan Enrollee</td>
<td>--</td>
</tr>
<tr>
<td><strong>QI</strong></td>
<td>Quality Improvement</td>
<td>--</td>
</tr>
<tr>
<td>Acronym or Word</td>
<td>Definition</td>
<td>Additional Information</td>
</tr>
<tr>
<td>----------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>QOC</td>
<td>Quality Oversight Committee</td>
<td>The Quality Oversight Committee (QOC), which reports to the Board of Governors through the Compliance and Quality Committee, is a cross-functional L.A. Care staff committee that is the cornerstone for quality improvement steering and decision making within the organization.</td>
</tr>
<tr>
<td>QOS</td>
<td>Quality of Service</td>
<td>--</td>
</tr>
<tr>
<td>RCAC</td>
<td>Regional Community Advisory Committee</td>
<td>--</td>
</tr>
<tr>
<td>Sensitive Services</td>
<td>Sensitive Services are services that require some form of confidentiality in the way services are provided and the way medical records are disclosed for the Medi-Cal Member.</td>
<td></td>
</tr>
<tr>
<td>S&amp;I</td>
<td>Suspended and Ineligible</td>
<td>--</td>
</tr>
<tr>
<td>SAPC</td>
<td>Substance Abuse Prevention and Control</td>
<td>--</td>
</tr>
<tr>
<td>SCT</td>
<td>Specialty Care Transport</td>
<td>--</td>
</tr>
<tr>
<td>SHA</td>
<td>Staying Healthy Assessments</td>
<td>--</td>
</tr>
<tr>
<td>SIU</td>
<td>Special Investigation Unit</td>
<td>--</td>
</tr>
<tr>
<td>SMHS</td>
<td>Specialty Mental Health Services</td>
<td>--</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
<td>--</td>
</tr>
<tr>
<td>SOC</td>
<td>Share of Cost</td>
<td>A Share of Cost (SOC) is the amount of money an individual is responsible to pay towards their medical-related services, supplies, or equipment before Medi-Cal will begin to pay.</td>
</tr>
<tr>
<td>SPC</td>
<td>Specialists</td>
<td>--</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
<td>--</td>
</tr>
<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
<td>--</td>
</tr>
<tr>
<td>TAC</td>
<td>Technical Advisory Committee</td>
<td>--</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculous</td>
<td>--</td>
</tr>
<tr>
<td>TJC</td>
<td>The Joint Commission</td>
<td>--</td>
</tr>
<tr>
<td>TNE</td>
<td>Tangible Net Equity</td>
<td>--</td>
</tr>
<tr>
<td>TPL</td>
<td>Third Party Tort Liability</td>
<td>TPL means the responsibility of persons other than contractor or the Member, for payment of claims for injuries or trauma sustained by Members.</td>
</tr>
<tr>
<td>TPO</td>
<td>Treatment, Payment, and Other Standard Operations</td>
<td>--</td>
</tr>
<tr>
<td>TTY</td>
<td>Text Telephone Relay</td>
<td>--</td>
</tr>
<tr>
<td>Transgender Services</td>
<td>Transgender Services, also known as gender-affirming care, includes the prevention, diagnosis and treatment of physical and mental health conditions, as well as sex reassignment therapies, for transgender individuals.</td>
<td></td>
</tr>
<tr>
<td>UCR</td>
<td>Usual, Customary, and Reasonable</td>
<td>--</td>
</tr>
<tr>
<td>UM</td>
<td>Utilization Management</td>
<td>--</td>
</tr>
<tr>
<td>UMC</td>
<td>Utilization Management Committee</td>
<td>--</td>
</tr>
<tr>
<td>Acronym or Word</td>
<td>Definition</td>
<td>Additional Information</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>UPM</td>
<td>Universal Provider Manual</td>
<td>The purpose of this Universal Provider Manual (UPM) is to furnish pertinent Providers with information on the important processes related to L.A. Care’s different product lines. The UPM is a communication tool for Providers and their staff related to accessing and providing comprehensive, effective, and quality medical services to L.A. Care Members.</td>
</tr>
<tr>
<td>VA</td>
<td>Veteran Affairs</td>
<td>--</td>
</tr>
<tr>
<td>--</td>
<td>Vital Documents</td>
<td>Vital Documents are generally documents that affect access to, retention in, or termination or exclusion from a recipient’s program services or benefits.</td>
</tr>
<tr>
<td>VSP</td>
<td>Vision Service Plan</td>
<td>--</td>
</tr>
<tr>
<td>WIC</td>
<td>Women, Infants, and Children Program</td>
<td>The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five (5) who are found to be at nutritional risk.</td>
</tr>
<tr>
<td>WPATH</td>
<td>World Professional Association for Transgender Health</td>
<td>--</td>
</tr>
</tbody>
</table>
Chapter 1 – Introduction

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

1.0 Welcome to L.A. Care Health Plan
L.A. Care Health Plan (L.A. Care) serves more than 2.4 million Members in Los Angeles County, making it the largest publicly operated health plan in the country. L.A. Care offers four (4) health coverage plans dedicated to being accountable and responsive to Members. As a public entity, the L.A. Care mission is to provide access to quality health care for L.A. County’s vulnerable and low-income communities, and to support the safety net required to achieve that purpose.

1.1 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). In Los Angeles County, Medi-Cal is operated through the Two-Plan Model consisting of a local initiative health plan and a commercial health plan. L.A. Care is the local initiative managed health care plan in Los Angeles County. Currently, Health Net is the commercial health plan. Medi-Cal beneficiaries represent a vast majority of L.A. Care Members.

1.2 Plan Partner Collaboration
When Members join L.A. Care, they can choose to get their health care from L.A. Care or one (1) of the Plan Partners we work with to provide health coverage in L.A. County.

These include:
- Anthem Blue Cross
- Blue Shield of California Promise Health Plan (Blue Shield Promise)
- Kaiser Permanente

1.3 Product Lines
L.A. Care offers five (5) product lines, which are also called lines of business (LOBs).
Below are the LOBs offered by L.A. Care:

1. **Cal MediConnect (CMC)**
   CMC provides coordinated care for Los Angeles County seniors and people with disabilities who are eligible for Medicare and Medi-Cal. Please note: The CMC program is transitioning on December 31, 2022. Starting January 1, 2023, CMC Members will be transitioned to Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans) provided by the same company that provides CMC. Under exclusively aligned enrollment, beneficiaries can enroll in a D-SNP for Medicare benefits and in a Medi-Cal managed care plan for Medi-Cal benefits, which are both operated by the same parent organization for better care coordination and integration. For more information on this transition, please visit the Department of Health Care Services (DHCS): [https://www.dhcs.ca.gov/](https://www.dhcs.ca.gov/)

2. **L.A. Care Covered (LACC)**
   As a state selected qualified health plan, L.A. Care provides the opportunity for all members of a family to receive health coverage under one (1) health plan in the Covered California state exchange. For more information on the LACC LOB and for eligibility criteria, please visit: [https://www.lacare.org/health-plans/la-care-covered](https://www.lacare.org/health-plans/la-care-covered)

3. **L.A. Care Covered Direct (LACCD)**
   L.A. Care Covered Direct (LACCD) is also offered to those who do not qualify for financial assistance or prefer to purchase health coverage directly with L.A. Care. For more information on the LACCD LOB and for eligibility criteria, please visit: [https://www.lacare.org/health-plans/la-care-covered](https://www.lacare.org/health-plans/la-care-covered)

4. **L.A. Care Medi-Cal (MCLA)**
   Medi-Cal is a public program that provides health care coverage to young adults, families, older adults, people with disabilities, and undocumented immigrants who meet the income and age requirements. In addition to offering a direct Medi-Cal LOB, L.A. Care works with three (3) subcontracted health plans to provide coverage to Medi-Cal Members. These Plan Partners are Anthem Blue Cross, Blue Shield of California Promise Health Plan (Blue Shield Promise), and Kaiser Permanente. For more information on the MCLA LOB and for eligibility criteria, please visit: [https://www.lacare.org/health-plans/medi-cal/plan-overview](https://www.lacare.org/health-plans/medi-cal/plan-overview)

5. **Homecare Workers Health Care Plan (PASC-SEIU)**
   This is a homecare worker’s health care plan. L.A. Care provides health coverage to Los Angeles County’s In-Home Supportive Services (IHSS) workers. IHSS workers enable seniors and people with disabilities to remain safely in their homes by providing services such as meal preparation and personal care services. For more information on the PASC-SEIU LOB and for eligibility criteria, please visit: [https://www.lacare.org/health-plans/pasc-seiu/plan-overview](https://www.lacare.org/health-plans/pasc-seiu/plan-overview)

### 1.4 Community Resource Centers (CRC)

In 2019, L.A. Care and Blue Shield Promise committed a combined $146 million over five (5) years to develop and expand a Community Resource Center (CRC) network across Los Angeles County. By the end of 2022, the health plans will jointly operate 14 centers. The CRCs offer a broad array of no-cost programming, classes, and resources to help health plan Members and others in the community stay active, healthy, and informed. The centers also provide on-site support from community social service organizations focused on addressing social determinants of health such as food and income security.
CRCs are not only open to health plan Members, but to everyone in the community. Visitors have access to a variety of health care and community resources. The centers also offer a wide variety of exercise, nutrition, and health management classes in a safe, fun, and inclusive space for local Members and residents at no cost.

1.4.A Resources currently offered:

- Free WiFi for Telemedicine consultations using the individual’s own device
- Private telemedicine consultation spaces to connect with health plan telehealth resources
- Fitness and Exercise Classes
- Health Education Classes
- Linkage to Assistance Programs
- Medi-Cal Enrollment Support

Please refer to the CRC website for the most up-to-date information regarding hours of operation, appointments, and live, in-person and virtual classes here: [www.activehealthyinformed.org](http://www.activehealthyinformed.org)

For more information on the CRCs, please refer to Chapter 9 – Health Education, or call L.A. Care at (877) 287-6290.

1.5 Universal Provider Manual (UPM)

The purpose of this Universal Provider Manual (UPM) is to give Providers information on the important processes related to L.A. Care’s different product lines. The UPM is a communication tool for Providers and their staff related to accessing and providing comprehensive, effective, and quality medical services to L.A. Care Members. L.A. Care’s contracted Providers are required to be compliant with the UPM, in addition to federal and state regulations.

- Section Coverage
  Every chapter of this UPM includes the following:
  - Introduction to chapter or section
  - Objectives and Provider responsibilities
  - Department reference contacts
  - Helpful website links and policies and procedures, as applicable

1.6 Responsibility of Participating Providers

Providers in the L.A. Care Network are expected to deliver services that align with their agreement with L.A. Care. All Providers rendering care to Members must comply with the provisions within their agreement with L.A. Care.

1.6.A Notice to Providers:

- **Amendments to Contracts, UPM, and Procedures**
  Periodically L.A. Care amends its Provider contracts, the UPM, and L.A. Care’s 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 legal, contractual, and regulatory compliance. Providers will be notified about important changes made to the UPM and its updated procedures via the communication channels below.
• **Communication Channels**  
L.A. Care is committed to providing the latest information about policy, regulatory, and legal changes, education and training opportunities, as well as updates on the UPM and clinical best practices.  
L.A. Care will communicate with its Providers through the following:  
  o Email  
  o Fax  
  o Letters  
  o Newsletters: The Pulse, Progress Notes, and Health Advisories  
To register to receive the newsletters, please visit:  
  [https://www.lacare.org/providers/provider-central/news](https://www.lacare.org/providers/provider-central/news)  
  o Provider Portal:  
To register for the Provider Portal, please visit:  

Website announcements can be viewed on the L.A. Care website, please visit:  
  [https://www.lacare.org/](https://www.lacare.org/)  

1.6.B Provider Expectations:  

• **Code of Conduct**  
The Code of Conduct is a guide to ensure compliance with the rules and regulations that govern our business. While the Code of Conduct is not designed to cover every possible situation, it does provide examples of everyday scenarios to assist Providers with proactively addressing issues.  
For more information on the L.A. Care Code of Conduct, please visit:  

• **Reporting Submissions**  
As part of the monitoring process, Providers must submit reports to L.A. Care, as requested from various departments. Providers are required to submit the requested information in a timely, accurate, and complete file. Failure to do so could lead to additional audits and sanctions.  

• **Contact Support**  
For general questions or to update contact information, Providers can reach out to L.A. Care by phone, email, and US mail. Additionally, Providers can call their assigned Provider Network Account Manager for support.  

• **By Phone:**  
Provider Solution Center at (866) 522-2736  

• **By Email:**  
  [ProviderRelations@lacare.org](mailto:ProviderRelations@lacare.org)  

• **By Mail:**  
  L.A. Care Health Plan  
  Attn: Contracts and Relationship Management
1.6.C Resources to Meet Service Requirements

- **Provider Programs**
  L.A. Care offers Provider opportunities in the areas of education, training, and grant making. Programs include:
  - Trainings, Classes, and Seminars
  - Elevating the Safety Net
  - Managed Care Pharmacy Residency Program
  - Physician Leadership Program

  For more information on the L.A. Care Provider programs, please visit: [https://www.lacare.org/providers/provider-central/provider-programs](https://www.lacare.org/providers/provider-central/provider-programs)

- **Provider Tools and Toolkits**
  To help Providers meet regulatory agencies’ service requirements and to assist in providing high quality effective care, L.A. Care has prepared and made available several toolkits on topics such as serving diverse populations, Facility Site Review (FSR), appropriate use of antibiotics, and behavioral health.

  For more information, on the L.A. Care Provider Tools and Toolkits, please visit: [https://www.lacare.org/providers/provider-resources/tools-toolkits](https://www.lacare.org/providers/provider-resources/tools-toolkits)

- **Access to Care Quick Tips**
  - All Providers are responsible for fulfilling the access to care standards outlined in detail in Chapter 3 Access to Care. L.A. Care provides a handy printable Access to Care Quick Tips for your convenience.

  For more information on the L.A. Care Access to Care Quick Tips, please visit: [https://www.lacare.org/sites/default/files/la25730919_provider_quick_tips_20190905.pdf](https://www.lacare.org/sites/default/files/la25730919_provider_quick_tips_20190905.pdf)

1.7 L.A. Care is Committed to its Providers

L.A. Care advances individual and community health through a variety of targeted activities including a Community Health Investment Fund and sponsorship programs that have awarded more than $180 million throughout the years to support the health care safety net and expand health coverage. L.A. Care prioritizes quality, access and inclusion, elevating health care for all of L.A. County.

L.A. Care considers the following Provider types as examples, but are not all inclusive of Safety Net Providers:

- Child Health and Disability Prevention (CHDP) Providers
- Federally Qualified Health Centers (FQHCs)
- Licensed community clinics
1.8 Join Our Network
If you are a physician or group practice interested in joining the L.A. Care Direct Network, please visit the L.A. Care contracting site to submit a letter of interest: https://www.lacare.org/providers/provider-central/join-our-network

Your participation in our network represents a valuable contribution to our community and we look forward to partnering with you.

1.9 Statement of Principles on Social Justice and Systemic Racism
L.A. Care Health Plan (L.A. Care) and its Board of Governors stand proudly with Black, Indigenous, and all other People of Color (BIPOC) in America. We do not tolerate racism or discrimination in any form – we denounce anti-Blackness and the systemic oppression of all BIPOC in America and abroad.

L.A. Care acknowledges the pain, anger, fear, and frustration caused by the senseless deaths of countless BIPOC and acts of discrimination toward BIPOC communities. These terrible tragedies have repeatedly exposed persistent and divisive systemic racism and inequity impacting BIPOC communities. We also stand in solidarity with our health care and safety net partners who, every day, respond to Members affected by racial injustice and inequity. America’s growing social justice movement tells us in no uncertain terms that we are at a pivotal moment in our history. L.A. Care has not, and will not, ignore the long unresolved issues of racism and inequity that have burdened all BIPOC communities. Actions, not words, are what is needed now. L.A. Care is committed to supporting our employees, Members, Providers, and the communities in which they all live – to listen to them, learn from them, and take action.

In addition to continuing to listen and learn from our BIPOC employees, Members, and Providers, L.A. Care has implemented and is actively working on the following and more:

- An Equity Council which will focus on equity issues and topics related to our L.A. Care employees and Members and our contracted Provider network and vendors
- Advocacy work for social justice, and including these efforts in our policy agenda
- An Equity and Resilience Initiative that will support community-based organizations working to mitigate the impact of health care inequities among racially marginalized individuals and communities
- A partnership with the Los Angeles County Commission on Human Relations

While our organization cannot solve these challenges alone, we are starting with our family of employees, Members, Providers, and community stakeholders who have shared their perspectives now reflected in this statement. We will look internally to ensure that our own work environment is free of any racism or discrimination. Working together, we can aspire to achieve an America that is truly fair, equitable, inclusive, and just – for all.

Thank you,
L.A. Care Health Plan
Chapter 2 – Membership and Membership Services

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

2.0 Introduction

The L.A. Care Health Plan (L.A. Care) Membership and Membership Services Department provides assistance to Providers and Members in the areas of enrollment, eligibility, disenrollment information, Member rights and responsibilities and changes in covered services.

2.1 Membership Identification Card

L.A. Care provides each Member with a membership identification card indicating their participation with L.A. Care or with the Participating Physician Group (PPG). A Member’s possession of an L.A. Care membership identification card does not guarantee current membership with L.A. Care or with the identified PPG on the card.

2.1.A Membership card expected timeframes by line of business (LOB):

<table>
<thead>
<tr>
<th>Line of Business (LOB)</th>
<th>Confirmation of Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC</td>
<td>Within 10 calendar days from receipt of the Centers for Medicare and Medicaid Services (CMS) confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later.</td>
</tr>
<tr>
<td>LACC/D</td>
<td>Within 10 business days from receipt of eligibility file.</td>
</tr>
<tr>
<td>MCLA</td>
<td>Within seven (7) calendar days from receipt of eligibility file.</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>Within 10 business days from receipt of eligibility file.</td>
</tr>
</tbody>
</table>

For our Members, the Membership Identification Card has everything they need to see their Provider, call the Customer Solution Center, contact the Nurse Advice Line (NAL), and obtain prescription medication.

To view the L.A. Care Membership Identification Card by line of business, please visit: https://www.lacare.org/members/welcome-la-care/member-id-card

In the event that a Provider wishes to obtain a virtual copy of a Member’s identification card, they can visit the L.A. Care Provider Portal to do so.

To request access to the Provider Portal or to sign-in, please visit: https://www.lacare.org/providers/provider-central/la-care-provider-central
2.2 Eligibility Verification
Providers can check Member eligibility 24 hours a day/seven (7) days a week. Membership and eligibility should be verified on the date the Member is to be seen as services are subject to eligibility at the point of service. Verification is necessary to assure that payment is made, correctly, for health care services rendered by the Provider to the Member.

2.2.A L.A. Care Member eligibility verification can be conducted in two (2) ways:

- **L.A. Care Provider Portal**
  1. Register for access and/or sign-in to the Provider Portal here: [https://www.lacare.org/providers/provider-central/la-care-provider-central](https://www.lacare.org/providers/provider-central/la-care-provider-central)
  2. From menu, select option: Member Eligibility Verification
  3. Complete the Member information marked with an asterisk, as required
  4. Click: Submit to disclose Member eligibility information

- **L.A. Care Provider Solutions Center** at (866) 522-2736
  1. Select option: one (1) for Eligibility
  2. Follow Interactive Voice Response (IVR) instructions
  3. Enter requested Member information
  4. IVR will telephonically disclose Member eligibility information
  5. For further inquiries, related to the following, Providers can stay on the line to speak with a representative during business hours: Monday through Friday (8:00 AM to 6:00 PM PST)
     - Prior Authorization Status
     - Claim Status
     - Claim Appeal Status

2.3 Member Rights and Responsibilities
L.A. Care contracted Providers will treat Members with respect and dignity at all times. All L.A. Care Members receive a statement of Member Rights and Responsibilities in their Evidence of Coverage (EOC).

Member Rights and Responsibilities include:

- **Respectful and Courteous Treatment**
  Members have the right to be treated with respect, dignity, and courtesy from L.A. Care’s Providers and staff.

- **Privacy and Confidentiality**
  Members have the right to have a private relationship with their Provider and to have their medical record(s) kept confidential.

- **Choice and Involvement in Care**
  Members have the right to receive information about L.A. Care, its services, its doctors, and other Providers.

- **Voice Concerns**
  Members have the right to complain about L.A. Care, the health plans, and in-network Providers, or the care received without fear of losing their benefits.
- Service outside the Provider Network
  Members have the right to receive emergency or urgent services, as well as family planning and sexually transmitted disease services, outside of the L.A. Care network.

- Service and Information in Language of Origin
  Members have the right to request an interpreter at no charge and not use a family member or friend to translate.

- Know your Rights
  Members have the right to receive information about their rights and responsibilities.

For details on Member Rights and Responsibilities, please visit: [https://www.lacare.org/members/welcome-lacare/rights-responsibilities](https://www.lacare.org/members/welcome-lacare/rights-responsibilities)

### 2.4 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 and/or appeal on their behalf. A grievance may include concerns about the operations of L.A. Care and/or its Providers. Common complaints include: long wait times, the demeanor of health care personnel, the inadequacy of facilities, and the lack of courteous service.

For more information on grievances, please refer to Chapter 18 - Appeals and Grievances.

### 2.5 Public Advisory Committee Meetings
Members and Providers alike are encouraged to take part in the L.A. Care monthly public advisory committee meetings, established to help L.A. Care meet the needs of our community.

The L.A. Care public meetings include:

- Board of Governors
- Children’s Health Consultant Advisory Committee (CHCAC)
- Community Health Information Meeting
- Executive Community Advisory Committee (ECAC)
- Regional Community Advisory Committee (RCAC)
- Technical Advisory Committee (TAC)

For more information on the L.A. Care public advisory committee meetings, please call the L.A. Care Community Outreach and Engagement Department at (888) 522-2732 or visit: [https://www.lacare.org/about-us/public-meetings/committee-meetings](https://www.lacare.org/about-us/public-meetings/committee-meetings)

To view the L.A. Care upcoming schedule of events, please visit: [https://www.lacare.org/events](https://www.lacare.org/events)
2.6 Healthy Living and Prevention

L.A. Care provides Members with various programs, workshops, and resources to maintain and improve health. Members can sign up for various workshops, activities, and even speak with a certified health coach.

There are many things a Provider can do to inspire a healthier lifestyle. L.A. Care invites Providers to explore our many resources, programs, and the health library to encourage Members to maintain their health.

2.6.A Available resources include:

- Community Health Resources
- Community Resource Centers (CRC)
- Diabetes Prevention Program (DPP)
- Managing Your Health (e.g. weight management, asthma, depression, etc.)
- Maternity Care
- Wellness Programs
- Wellness Activities (e.g. Health In Motion Program)

For more information on healthy living and preventive programs and resources, please visit:

- [https://www.lacare.org/healthy-living/health-resources/healthy-living-prevention](https://www.lacare.org/healthy-living/health-resources/healthy-living-prevention)

2.7 Provider Termination

The L.A. Care Credentialing Committee may terminate, suspend, or modify participation of those Providers who fail to meet eligibility criteria. L.A. Care retains the right to terminate or suspend individual Providers at all times based on credentialing issues.

In the event that L.A. Care terminates a Provider, a 30 calendar day Member notification letter will be sent to the Member prior to the Provider termination date.

For more information on credentialing criteria, please refer to Chapter 7 – Credentialing.

2.8 For More Information

For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at ProviderRelations@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 3 - Access to Care

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

3.0 Introduction
Access to comprehensive, equitable and quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing unnecessary disability and premature death. This section summarizes the Access to Care requirements for L.A. Care Health Plan (L.A. Care) Providers.

All Providers are responsible for ensuring Members have access to services 24 hours a day, 365 days a year. This includes making arrangements for the covering physician, after-hours availability, and urgent care access other than an emergency room (ER) for non-emergent conditions. Providers are also responsible for ensuring L.A. Care has updated contact information such as telephone number(s), address with correct suite number, and names of contracted providers at the location.

3.1 Access to Care – Provider Requirements
L.A. Care regularly monitors and audits the appointment and access standards identified in this chapter. This helps to evaluate the Provider’s level of service to its Members. If requested by L.A. Care, the Providers must make any changes requested by L.A. Care to meet established provider service and access requirements in compliance with applicable rules, regulations, and guidance. Periodically, L.A. Care may also request an inventory of services.

Providers are responsible for responding to any appointment and access deficiencies identified. Providers shall submit confirmation of these changes to their Provider Network Account Manager or the Provider Network Management (PNM) Department.

For more information on Access to Care Quick Tips, please visit: https://www.lacare.org/sites/default/files/la25730919_provider_quick_tips_20190905.pdf

3.2 Provider Appointment Availability and After-Hours Survey
Providers are required to participate in the L.A. Care annual Provider Appointment Availability and After-Hours Survey to ensure regulatory access standards are being met. Providers are audited for the required after-hours call system during the annual survey.

3.2.A After-Hours Call System standards include the following:

- **Access:**
  - Recording or answering service must state emergency instructions to address medical emergencies
Recording or answering service must state a way of contacting the Provider

- **Timeliness:**
  - Recording or answering service must state that Provider will call back within 30 minutes

Results for each measurement year are presented at the Access and Availability Workgroup, as well as at various quality committees. Non-compliant Providers are monitored on a quarterly basis via the Quality Improvement Appointment Availability & After Hours Oversight and Monitoring (O&M) Workbooks.

### 3.3 Timely Access Standards

L.A. Care conducts an annual Access to Care webinar to inform Providers about Timely Access Standards as prescribed by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and other regulatory agencies.

Providers must follow the Timely Access Standards below:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Timeframe</th>
<th>CMC</th>
<th>LACC</th>
<th>MCLA</th>
<th>PASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider – Routine Care</td>
<td>Within 10 business days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Primary Care Provider – Urgent Care</td>
<td>Within 48 hours</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Specialist – Routine Care</td>
<td>Within 15 business days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Specialist – Urgent Care</td>
<td>Within 96 hours</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Preventive Health Exams – Adults</td>
<td>Within 30 calendar days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Preventive Health Exams – Pediatrics</td>
<td>Within 10 business days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Routine Ancillary</td>
<td>Within 15 business days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Initial Prenatal</td>
<td>Within 10 business days</td>
<td>●</td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Initial Prenatal</td>
<td>Within 14 calendar days</td>
<td>●</td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Normal Business Hours – Call Back</td>
<td>Within 30 minutes</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Missed Appts – Call Back (Rescheduling)</td>
<td>Within 48 hours</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Behavioral Health – Routine Care (MD)</td>
<td>Within 15 business days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Behavioral Health – Routine Care (Non-MD)</td>
<td>Within 10 business days</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Behavioral Health – Urgent Care</td>
<td>Within 48 hours</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Emergency Care and After-Hours Care</td>
<td>24 hours a day, seven (7) days a week</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

### 3.4 Minimum Site Hours

L.A. Care has established the criteria for the minimum site hours’ requirement for Primary Care Providers (PCPs). A violation of the requirements would demonstrate that the Provider has not given adequate access and would be deemed ineligible to participate in the L.A. Care network of contracted entities that provide Members with health services (Network of Providers).
3.4.A Minimum Site Hours Requirements

Providers must offer hours of operation that are no less than the hours of operation offered to other Members.

The Requirements are as follows:

1. Each physician must be physically present or accessible to see Members through virtual or telemedicine at each site where there is assigned membership for a minimum of eight (8) hours per week.
2. Physicians who have more than one (1) office location may receive the Member assignment only at approved site(s) where they are available to see Members at a minimum of eight (8) hours per week.
3. Physicians may be assigned Members at no more than four (4) sites; and each site must be open to see Members for a minimum of 16 hours per week.

L.A. Care may conduct unannounced site visits or phone calls at any time to verify compliance with the agreement and the Universal Provider Manual (UPM). Additionally, a Provider attestation asserting compliance with the policy and procedure could be requested.

3.5 Changes to Office (Site) Hours

If the Provider is contracted with one (1) of the L.A. Care Participating Physician Groups (PPGs), the Provider shall inform the PPG of any change to their office hours.

3.6 Facility Site Review (FSR)

State law requires L.A. Care to have adequate facilities, service at site locations, and Providers available to meet contractual requirements for the delivery of primary care within their service areas. All Primary Care Physician (PCP) sites must have the capacity to support the safe and effective provision of primary care services. To ensure compliance, L.A. Care is required to perform initial and subsequent site reviews, consisting of a Facility Site Review (FSR) and a Medical Record Review (MRR), using the DHCS tools and standards.

The FSR confirms the Provider site operates in compliance with all applicable local, state, and federal laws and regulations. MRRs are conducted to review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the Member received care. Incomplete records or lack of documentation imply the Provider did not deliver quality, timely, or appropriate medical care.

FSR will validate that the current office hours are posted within the office or readily available upon request. When a Provider is not on site during regular office hours, personnel should be able to contact the Provider (or covering physician) at all times by telephone, cell phone, pager, etc.

3.7 For More Information

For questions regarding the information provided in this chapter, please contact the Access to Care Team via email at ATC@lacare.org.

For information tailored to our Direct Network Providers, please reference the **Direct Network Contracted Provider Reference Guide**.
Chapter 4 – Scope of Benefits

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

4.0 Introduction
The L.A. Care Health Plan (L.A. Care) Scope of Benefits outlines benefits and services available to Members through an extensive network of primary, specialty, and ancillary Providers across Los Angeles County. The benefits and services listed in this chapter are available for prevention, diagnosis, and treatment of illness or injury (including ancillary services).

4.1 Covered Benefits/Services Chart
This section pertains to the covered benefits and services for L.A. Care Members by line of business (LOB). Providers are required to request pre-approval (prior authorization) from L.A. Care for some benefits and services that require prior authorization and have Medical Necessity. Additionally, Providers are required to request prior authorization if the care is out-of-network. Prior authorization exceptions include sensitive services, emergencies and/or urgent care services. Limitations and exclusions to benefits and services may apply and differ by product line. For additional information regarding prior authorizations, please visit Chapter 5 – Utilization Management.

Additional information about covered benefits and services may be found online in the Member’s Evidence of Coverage (EOC). To access the EOCs, please visit: https://www.lacare.org/members/welcome-la-care/member-documents.

For commercial lines of business including L.A. Care Covered/L.A. Care Covered Direct (LACC/D) and PASC-SEIU, covered benefits may require a copay, co-insurance or deductible up to a maximum out-of-pocket as specified in the plan’s EOC.

4.1.A Covered Benefits and Services by line of business (LOB):

This list is for illustrative purposes only to provide general information. Covered Benefits available to a Member can change from time to time. Please see the applicable EOC for the most current benefits available or call L.A. Care. Please refer to your Provider contract for those Covered Services that a Provider may be contracted to provide.
<table>
<thead>
<tr>
<th>COVERED BENEFITS/SERVICES</th>
<th>PRODUCT LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMC</td>
</tr>
<tr>
<td>Abortion</td>
<td>☒</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>☒</td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>☒</td>
</tr>
<tr>
<td>Alcohol Misuse Screening and Counseling</td>
<td>☒</td>
</tr>
<tr>
<td>Ambulance Services (emergent) – Ground and Air Transportation</td>
<td>☒</td>
</tr>
<tr>
<td>Audiology</td>
<td>☒</td>
</tr>
<tr>
<td>Behavioral Health Treatment</td>
<td>☒</td>
</tr>
<tr>
<td>Behavioral/Mental Health – Outpatient Mild to Moderate</td>
<td>☒</td>
</tr>
<tr>
<td>Behavioral Health – Inpatient Severe Mental Illness and Alcohol and Drug Abuse Treatment</td>
<td>☒</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>☒</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>☒</td>
</tr>
<tr>
<td>Chemical Dependency Services</td>
<td>☒</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>☒</td>
</tr>
<tr>
<td>Circumcision</td>
<td>☐</td>
</tr>
<tr>
<td>Community Based Adult Services (CBAS)</td>
<td>☒</td>
</tr>
<tr>
<td>Dental Services</td>
<td>☒</td>
</tr>
<tr>
<td>Detoxification (Acute Phase)</td>
<td>☒</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>☒</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>☒</td>
</tr>
<tr>
<td>Dialysis</td>
<td>☒</td>
</tr>
<tr>
<td>Directly Observed Therapy (DOT)</td>
<td>☒</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) ordered by a Physician</td>
<td>☒</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</td>
<td>☐</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>☒</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>☒</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>☒</td>
</tr>
<tr>
<td>Health Education</td>
<td>☒</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>☒</td>
</tr>
<tr>
<td>Home Health</td>
<td>☒</td>
</tr>
<tr>
<td>Hospice</td>
<td>☒</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>☒</td>
</tr>
<tr>
<td>Immunization</td>
<td>☒</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>☒</td>
</tr>
<tr>
<td>Injectable Medications - Outpatient</td>
<td>☒</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>☒</td>
</tr>
<tr>
<td>Lab &amp; Pathology Services</td>
<td>☒</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>☒</td>
</tr>
<tr>
<td>Major Solid Organ, Bone Marrow and Stem Cell Transplants</td>
<td>☒</td>
</tr>
<tr>
<td>Mammography</td>
<td>☒</td>
</tr>
<tr>
<td>Nutritionist/Dietician</td>
<td>☒</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>☒</td>
</tr>
</tbody>
</table>
### COVERED BENEFITS/SERVICES

<table>
<thead>
<tr>
<th>COVERED BENEFITS/SERVICES</th>
<th>PRODUCT LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMC</td>
</tr>
<tr>
<td>Office Visit</td>
<td>☒</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>☒</td>
</tr>
<tr>
<td>Physical, Occupational &amp; Speech Therapies</td>
<td>☒</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>☒</td>
</tr>
<tr>
<td>Physician Services</td>
<td>☒</td>
</tr>
<tr>
<td>Podiatry</td>
<td>☒</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity Care</td>
<td>☒</td>
</tr>
<tr>
<td>Prosthetics &amp; Orthotics</td>
<td>☒</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>☒</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>☒</td>
</tr>
<tr>
<td>Reconstructive Surgery - Non cosmetic</td>
<td>☒</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>☒</td>
</tr>
<tr>
<td>Retail Clinics</td>
<td>☒</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>☒</td>
</tr>
<tr>
<td>Specialists</td>
<td>☒</td>
</tr>
<tr>
<td>Telehealth</td>
<td>☒</td>
</tr>
<tr>
<td>Transfusions (Blood and Blood Products)</td>
<td>☒</td>
</tr>
<tr>
<td>Transgender Services</td>
<td>☒</td>
</tr>
<tr>
<td>Transportation nonmedical transportation (NMT)</td>
<td>☒</td>
</tr>
<tr>
<td>Transportation nonemergency medical transportation (NEMT)</td>
<td>☒</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>☒</td>
</tr>
<tr>
<td>Vision Care</td>
<td>☒</td>
</tr>
</tbody>
</table>

### 4.2 Exclusions

Some benefits and services are excluded by L.A. Care, which means that L.A. Care does not pay for these benefits. The list below includes, but is not limited to, benefits and services that will not be provided by L.A. Care and are excluded from coverage.

#### 4.2.A Services excluded:

This list is for illustrative purposes only to provide general information. Covered Benefits excluded under an EOC can change from time to time.

### EXCLUSIONS

<table>
<thead>
<tr>
<th>CMC</th>
<th>MCLA</th>
<th>LACC/D</th>
<th>PASC-SEIU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services considered not &quot;reasonable and medically necessary&quot;</td>
<td>Cosmetic surgery</td>
<td>Chiropractic care</td>
<td>Acupuncture</td>
</tr>
<tr>
<td></td>
<td>Experimental services</td>
<td>Cosmetic surgery</td>
<td>Chiropractic care</td>
</tr>
<tr>
<td></td>
<td>Fertility preservation</td>
<td>Dental care (Adult)</td>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td></td>
<td>In vitro fertilization</td>
<td>Hearing aids</td>
<td>Habilitation services</td>
</tr>
<tr>
<td></td>
<td>Home modifications</td>
<td>Infertility treatment</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 4.3 Responsibility of Providers

L.A. Care requires that its contracted Providers (including, but not limited to, medical groups, hospitals, sub-delegated, and other specialized health plans) meet specific requirements. This section is provided to assist...

<table>
<thead>
<tr>
<th>Provider Requirements</th>
<th>Vehicle modifications</th>
<th>Long-term care</th>
<th>Non-emergency care when traveling outside the U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Treatments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental medical and surgical treatments, items, and drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical treatment for morbid obesity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A private room in a hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private duty nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal items in patient's room at a hospital or a nursing facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time nursing care in home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fees charged by immediate relatives or members of patient's household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective or voluntary enhancement procedures or services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care (except manual manipulation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine foot care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic shoes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive devices for feet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radial keratotomy, LASIK surgery, and other low-vision aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reversal of sterilization procedures and non-prescription contraceptive supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naturopath services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided to veterans in Veteran's Affairs (VA) facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private duty nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine foot care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information, please review the EOC located here: [https://www.lacare.org/members/welcome-la-care/member-documents](https://www.lacare.org/members/welcome-la-care/member-documents)
you with an understanding of which functions are the responsibility of L.A. Care and which functions apply to the Provider.

4.4 Utilization Management (UM)

Prior authorization ensures the types and amounts of services rendered are based on medical necessity, are a covered benefit, and are provided by the appropriate Providers. It is the responsibility of the Provider to verify eligibility and ensure the pre-approval has been requested and received from the L.A. Care UM Department, or a respective Participating Physician Group (PPG), for elective nonemergency and scheduled services before providing those services.

For more information on the UM process, please refer to Chapter 5 – Utilization Management.

4.5 Behavioral/Mental Health Services

- **Behavioral/Mental Health Services** are provided through the following delivery systems depending on the type of behavioral/mental health service and line of business (LOB):

  1. L.A. Care’s contracted partner Beacon Health Options (Beacon)
  2. L.A. Care’s network of Behavioral Health Treatment (BHT) providers
  3. Los Angeles County Department of Mental Health (DMH)
  4. Los Angeles County Department of Public Health (DPH) and Substance Use Disorder Prevention and Control (SAPC).

- **CMC**
  Mild to moderate outpatient behavioral/mental health services and inpatient mental health services are covered and administered by Beacon. For more information, Members and Providers can call Beacon to coordinate access to care at (877) 344-2858 or TTY (800) 735-2929.

  Specialty mental health services, including high moderate to severe outpatient mental health services, intensive outpatient and inpatient services, day treatment, and more are covered and administered through the DMH. For more information, please call the DMH at (800) 854-7771.

  Alcohol and drug abuse treatment services are covered and administered through the DPH and SAPC. For more information, please call the DMH at (844) 804-7500.

- **MCLA**
  Medi-Cal covers a range of mental health services, including outpatient non-specialty (mild to moderate), BHT, outpatient specialty (high moderate to severe), intensive outpatient and inpatient, inpatient mental health, and alcohol and drug abuse treatment.

  Mild to moderate outpatient behavioral/mental health services are covered and administered by Beacon. For more information, Members and Providers can call Beacon to coordinate access to care at (877) 344-2858 or TTY (800) 735-2929.

  BHT services are covered for Members under the age of 21 and require recommendation from a licensed physician or licensed psychologist, and prior authorization from L.A. Care. BHT
services are provided through L.A. Care’s directly contracted BHT network. For more information, please call L.A. Care’s Behavioral Health Department at (888) 347-2264.

Specialty mental health services, including high moderate to severe outpatient mental health services, intensive outpatient and inpatient services, inpatient mental health services, day treatment, and more are covered and administered through the DMH. For more information, please call the DMH at (800) 854-7771.

Alcohol and drug abuse treatment services are covered and administered through the DPH and SAPC. For more information, please call the DMH at (844) 804-7500.

- **LACC/D**
  Behavioral/Mental Health services out-of-pocket responsibility varies between metal levels. All services are provided through Beacon. To access behavior health Providers (mental health or substance use disorder), Members do not need a referral from their Provider. No prior authorization is required for most outpatient behavioral/mental health services. For more information on Behavioral Health Treatment (BHT), please call Beacon at (877) 344-2858 or TTY (800) 735-2929 or visit: https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered

- **PASC-SEIU**
  All services are provided through Beacon. To access behavior health Providers (mental health or substance use disorder), Members do not need a referral from their Provider. No prior authorization is required for most outpatient behavioral/mental health services. For more information on BHT, please call Beacon at (877) 344-2858 or TTY (800) 735-2929 or visit: https://www.lacare.org/members/welcome-la-care/member-documents/pasc-seiu-plan

For additional information on behavioral/mental health services, please refer to Chapter 19 – Behavioral Health or please contact the following:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon</td>
<td>(877) 344-2858</td>
<td>(866) 422-3413</td>
</tr>
<tr>
<td>L.A. Care Behavioral Health Department</td>
<td>(888) 347-2264</td>
<td>(213) 438-5054</td>
</tr>
<tr>
<td>DMH</td>
<td>(800) 854-7771</td>
<td>(562) 863-3971</td>
</tr>
<tr>
<td>DPH and SAPC</td>
<td>(844) 804-7500</td>
<td>--</td>
</tr>
</tbody>
</table>

Providers can also call the L.A. Care Behavioral Health Information line for questions or concerns, at (844) 858-9940 or email behavioralhealth@lacare.org.

### 4.6 Supplemental Benefits

4.6.A Acupuncture Services are provided by American Specialty Health (ASH) for CMC and LACC/D. Providers can reach ASH at (800) 848-3555.
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- CMC
Authorization is not required for the first two (2) visits per month, or more often if they are medically necessary. L.A. Care will also pay for up to 12 acupuncture visits in 90 days, if the patient has chronic low back pain. Please reference the EOC for coverage details.

- MCLA
Acupuncture services are provided through L.A. Care directly contracted acupuncturists. Authorization is not required for the first two (2) visits per month; additional appointments will need a referral. L.A. Care may pre-approve additional services as medically necessary.

- LACC/D
Limitations may apply to acupuncture services. For coverage details, please visit: https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered

- PASC-SEIU
Excluded service.

4.6.B Dental Services

- CMC
Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program. It will provide up to $1,800 in covered services per year if medically necessary. For more information about dental services, please call Medi-Cal Dental Program at (800) 322-6384 or TTY (800) 735-2922 or visit: https://smilecalifornia.org/

- LACC/D
L.A. Care Covered and L.A. Care Covered Direct cover dental services for Members up to the age of 19. The annual deductible is waived. Dental benefits are provided by Liberty Dental through its extensive network of dental Providers. Members can contact Liberty Dental regarding provider information at (888) 700-5243 or TTY (877) 855-8039 or visit: https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered

- MCLA
Certain dental services for Medi-Cal Members are available through the Medi-Cal Dental Program as fee-for-service (FFS) or dental managed care. For more information about Medi-Cal Dental, please call at (800) 322-6384 or TTY (800) 735-2922 or visit: www.dental.dhcs.ca.gov or https://smilecalifornia.org/

- PASC-SEIU
Dental benefits and coverage are administered by PASC-SEIU. For information on Dental insurance please contact the SEIU Member Action Center at (855) 810-2015.

4.6.C Vision Services are provided by Vision Service Plan (VSP), unless otherwise noted. VSP provides routine vision services, such as annual exams and eyewear (glasses and contacts), if covered under the benefit. Providers can reach VSP at (800) 877-7195 or visit: https://www.vsp.com/.
• CMC
CMC covers one (1) routine eye exam every year, and up to $300 for eyeglasses (frames and lenses) or up to $300 for contact lenses every two (2) years. For more coverage details, please call VSP at (800) 877-7195.

• LACC/D
LACC and LACCD provide vision coverage for Members up to the age of 19 through VSP. For more coverage details, please call VSP at (800) 877-7195.

• MCLA
Medi-Cal covers routine eye exams once every 24 months for Members of all ages. Eyeglasses (frames and lenses) and replacement glasses are covered once every 24 months. Low vision devices for those with vision impairment and medically necessary contact lenses are also covered when required for medical conditions. For coverage details, please call VSP at (800) 877-7195.

• PASC-SEIU
Vision benefits and coverage are administered by PASC-SEIU. For information on Vision insurance, please contact the SEIU Member Action Center at (855) 810-2015.

4.6.D Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) are provided by the L.A. Care contracted vendor, Call the Car (CTC). Eligible L.A. Care Members may access NMT and NEMT for medical appointments.

For more information on Member Transportation, please visit: https://www.lacare.org/members/member-support/transportation

• 4.6.D.1 Non-Medical Transportation (NMT)
Members who qualify may use unlimited NMT when it is for travel to and from covered services and/or picking up prescriptions and/or medical supplies.

  o There are two (2) types of NMT levels of service:
    ▪ Ambulatory Curb-to-Curb: Member can walk and does not need assistance.
    ▪ Ambulatory Door-Thru-Door: Member can walk with use of a walker, cane, or crutches, and does require assistance.

  o Transportation Types:
    ▪ Ambulatory Curb-to-Curb
    ▪ Ambulatory Door-Thru-Door
    ▪ Rideshare
    ▪ Sedan
    ▪ Taxi

• 4.6.D.2 Non-Emergency Medical Transportation (NEMT)
Members who qualify are entitled to unlimited NEMT when they are physically or medically unable to access medically necessary covered services and/or pick up pharmacy prescriptions and/or medical supplies by ordinary means of public or private conveyance. Services for the Members’ medical or physical condition must be covered by L.A. Care or carved out to Department of Health Care Services (DHCS) and/or County Departments.
Transportation Types:
- Advanced Life Support (ASL)
- Air Ambulance
- Basic Life Support (BLS)
- Litter/Gurney Van, Bariatric Gurney
- Specialty Care Transport (SCT)
- Wheelchair Van, Bariatric Wheelchair

4.6.D.3 Benefit Limits by Line of Business (LOB) and Authorization Responsibility

<table>
<thead>
<tr>
<th>Product Line</th>
<th>Transportation Type</th>
<th>Benefit</th>
<th>Authorization Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal (MCLA)</td>
<td>Emergency Medical</td>
<td>Unlimited</td>
<td>Authorization not required</td>
</tr>
<tr>
<td></td>
<td>*NEMT:</td>
<td></td>
<td>*L.A. Care provides authorization</td>
</tr>
<tr>
<td></td>
<td>Advanced Life Support (ALS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Basic Life Support (BLS)/Critical Care Transport (CCT), Gurney/Litter Van and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wheelchair Van</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NMT</td>
<td>Unlimited</td>
<td>Authorization not required to eligible location</td>
</tr>
<tr>
<td>Cal MediConnect (CMC)</td>
<td>Emergency Medical</td>
<td>Unlimited</td>
<td>Authorization not required</td>
</tr>
<tr>
<td></td>
<td>*NEMT:</td>
<td></td>
<td>*L.A. Care provides authorization</td>
</tr>
<tr>
<td></td>
<td>ALS/BLS/CCT, Gurney/Litter Van and Wheelchair Van</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NMT</td>
<td>Unlimited</td>
<td>Authorization not required to eligible location</td>
</tr>
<tr>
<td>L.A. Care Covered/L.A. Care Covered Direct (LACC/D)</td>
<td>Emergency Medical</td>
<td>Unlimited</td>
<td>Authorization not required</td>
</tr>
<tr>
<td></td>
<td>*NEMT:</td>
<td></td>
<td>Authorization not required</td>
</tr>
<tr>
<td></td>
<td>ALS/BLS/CCT, Gurney/Litter Van and Wheelchair Van</td>
<td>Unlimited for transfers/discharges only from facility to facility or facility to home for non-ambulatory Members</td>
<td>Authorization not required</td>
</tr>
<tr>
<td></td>
<td>NMT</td>
<td>No benefit</td>
<td>No benefit</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>Emergency Medical</td>
<td>Unlimited</td>
<td>Authorization not required</td>
</tr>
<tr>
<td></td>
<td>*NEMT:</td>
<td></td>
<td>Authorization not required</td>
</tr>
<tr>
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<td>ALS/BLS/CCT, Gurney/Litter Van and Wheelchair Van</td>
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</tr>
<tr>
<td></td>
<td>NMT</td>
<td>No benefit</td>
<td>No benefit</td>
</tr>
</tbody>
</table>

*Prior authorization is not required when a Member is transferred from an acute care hospital, immediately following a stay as an inpatient Member at the acute level of care, to a skilled nursing facility (SNF) or an intermediate care facility.

4.6.D.4 Scheduling Transportation
Transportation services, NMT or NEMT, for Members can be scheduled by calling:
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1. All NEMT services will require a Physician Certificate Statement (PCS) form to be submitted before transportation is arranged. The PCS form can be found here: Referral Form for Transportation Services and Physician Certification Statement

2. Send the signed PCS form to the L.A. Care UM Department for approval via fax at (213) 438-2201.

   - UM Department reviews prior authorization requests and can approve requests for the duration of up to 12 months maximum.

3. Please be advised that all transportation must be arranged by Call the Car.

   - If the facility arranges transportation using its own preferred vendor, L.A. Care will not reimburse the cost, excluding the below exception:

4. If NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient psychiatric facility is not provided within a 3 hour timeframe, then the facility may arrange for NEMT services and L.A. Care will cover the out-of-network NEMT services. Once services have been approved, L.A. Care will notify the Member, Provider and transportation broker via verbal and written notification within five (5) calendar days of receiving a routine PCS form request, and within three (3) calendar days of receiving an urgent PCS form request.

5. After receiving notification of approval, the Member will be able to schedule their transportation.

6. Facilities can also call to arrange an appointment or obtain an update on discharge, transfer, or auto approval transportation by calling the L.A. Care Health Services Department at (877) 431-2273, select Transportation, and then follow the prompts.

7. For NMT requests and scheduling, advance notice of at least two (2) business days (Monday thru Friday) before the Member’s scheduled appointment is required.

   - Appointments will be verified by CTC.

### 4.7 Sensitive Services

The following section/sentence is only applicable to (as denoted between the asterisks): MCLA and Medi-Cal Fee-For-Service (FFS) only.

* “Sensitive Services” are defined as services related to the following:
- Family planning
- Pregnancy
- Sexual assault
- Sexually transmitted diseases (STDs) for Members 12 years of age and older, if sexually active
- Substance or alcohol abuse

Benefit coverage for Members 12 years of age and older may receive any Sensitive Services (without parental consent). Parental or guardian consent is required for Members under 12 years of age who seek substance or alcohol abuse treatment services or for the treatment of STDs. Providers should encourage Members to use in-network Providers to enhance coordination of care; however, Members may access Sensitive Services through out-of-network Providers without prior authorization.

Services to treat STDs or referrals to substance and alcohol treatment are confidential.

Examples of covered Sensitive Services:

- Birth control pills and other forms of contraception as approved by Medi-Cal
- Elective therapeutic abortions
- Elective tubal ligation
- Elective vasectomy
- Human Immunodeficiency Virus (HIV) screening, testing, diagnosis, education, and referrals for treatment
- Intra-uterine device (IUD) including device, insertion, and removal
- "Morning after pill" to avoid pregnancy is approved by the U.S. Food and Drug Administration (FDA) for emergency
- Office visits for birth control education and instruction regarding the methods and devices listed above
- Office visits for education and instruction for birth control methods
- Routine pregnancy testing
- STD screening, testing, diagnosis, education, and referrals for treatment

4.8 Sexually Transmitted Disease (STD) Services

L.A. Care will provide Members with confidential sexually transmitted disease (STD) screening and testing, diagnosis, treatment, follow-up, counseling, education, and preventive care. The state law mandates that specified STDs be reported to the local health jurisdiction of the Member’s residence; nationally notifiable STDs include, but are not limited to confirmed and probable cases of the following:

- Chlamydia
- Chancroid
- Gonorrhea
- Hepatitis B
- Hepatitis C
- HIV
- Syphilis
For more information on how to report nationally notifiable STDs and other communicable diseases and conditions to the local health jurisdiction of the Member’s residence in Los Angeles County, please visit the health department’s website at:

- Los Angeles County Department of Public Health: [http://publichealth.lacounty.gov/dhsp/reportcase.htm#STD_Reporting_Information](http://publichealth.lacounty.gov/dhsp/reportcase.htm#STD_Reporting_Information)
- Pasadena Public Health Department: [https://www.cityofpasadena.net/public-health/healthcare-providers/](https://www.cityofpasadena.net/public-health/healthcare-providers/)

For more information on Sensitive Services, please visit the Member EOC here: [https://www.lacare.org/members/welcome-la-care/member-documents](https://www.lacare.org/members/welcome-la-care/member-documents)

### 4.9 Carve-Out Services

The following section is only applicable to *(as denoted between the asterisks): MCLA and Medi-Cal FFS only.*

*Beneficiaries enrolled in a managed care plan obtain most of their benefits from their health plan and the services not covered by the health plan are referred to as “carved-out.” Coordination of carve-out services is part of the role of the Primary Care Provider (PCP). When requests for carved out services are submitted to L.A. Care or UM delegate in error, they may be redirected to the applicable entity below that is responsible for covering them.

Below is a list which includes, but is not limited to, some Medi-Cal carve-out services that can be obtained through Medi-Cal FFS while a beneficiary remains enrolled in a Medi-Cal managed care plan:

- **Alcohol and Drug Treatment**
  - Alcohol misuse screening and counseling

- **Acute inpatient California Children Services (CCS)**
The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified Providers. Identified children with CCS eligible conditions are referred to CCS immediately upon identification.
For more information on CCS program, please visit: [https://www.dhcs.ca.gov/services/ccs](https://www.dhcs.ca.gov/services/ccs)

- **California Children Services (CCS)**
The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified Providers. Upon identification children with CCS eligible conditions are referred to CCS immediately.
For more information on the CCS program, please visit: [https://www.dhcs.ca.gov/services/ccs](https://www.dhcs.ca.gov/services/ccs)

- **Child Health and Disability Prevention Program (CHDP)** is a preventive program that delivers periodic health assessments and services to low income children and youth in California.
For more information on CHDP, please visit: [https://www.dhcs.ca.gov/services/chdp](https://www.dhcs.ca.gov/services/chdp)

- **Comprehensive Perinatal Services Program (CPSP)**
Pregnancy and Postpartum Services for pregnant Members provide comprehensive, multidisciplinary pregnancy and postpartum services
- Dental Services
- Directly Observed Therapy for Tuberculous (TB) – provided by local health jurisdiction
- Local Education Agency Services
- Pharmacy (Medi-Cal Rx)
- Women, Infants, and Children Program (WIC) The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk. For more information, please visit: https://www.fns.usda.gov/wic

4.9.A Carve-out services are to be rendered by a Medi-Cal enrolled Provider and must be billed through the Medi-Cal FFS system. In most cases, beneficiaries remain enrolled in their health plan while receiving these carve-out services. For more information about the coordination of the above services, please call the L.A. Care Health Services Department at (877) 431-2273. *

4.10 Balance Billing
Balance Billing is the practice of billing a Member the difference between the reimbursed amount for a covered service and a higher amount the Provider wants as payment. Balance Billing L.A. Care Members is prohibited by law in most circumstances. It includes asking a Member to enter into a private agreement, waiving their right to Balance Billing protection, or charging other administrative fees. No contracted Provider or affiliate will demand or collect money for covered services except for authorized co-payments.

Providers who engage in Balance Billing may be subject to sanctions by L.A. Care, Centers for Medicare and Medicaid Services (CMS), DHCS, and other industry regulators. For more information on Balance Billing, please visit: https://dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf

For more information on financial topics, please refer to Chapters 11 – Finance and Chapter 12 – Claims and Payment.

4.11 Cost Sharing, Share of Cost, Deductibles and Co-payments
- CMC
Members are full dual-eligible enrollees who receive benefits and services from both Medicare and Medicaid (Medi-Cal) programs. These individuals are not subject to out-of-pocket costs or cost sharing for covered services, with the exception of certain Part D prescription drugs which may incur a cost share based on low income subsidy level. Providers may not impose cost sharing on
Members for any plan covered benefits or services. Medi-Cal benefits must be provided with no co-payment.

For more information on CMC benefits, please visit: https://www.lacare.org/members/welcome-la-care/member-documents

- **LACC/D**
  Members may have a co-pay, coinsurance, and/or deductibles.
  For LACC/D Member’s out-of-pocket responsibility for certain services, please visit: https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered

- **MCLA**
  As of January 1, 2022, eligible beneficiaries with share of cost (SOC) will be mandatorily enrolled in FFS with the exception of Members with a SOC residing in a Long Term Care (LTC) facility. Applicable monthly deductibles will be assessed depending on the Member’s income. Providers will need to verify eligibility to determine if a Member residing in a LTC facility must pay a SOC.
  For more information on SOC, please visit: www.medi-cal.ca.gov

- **PASC-SEIU**
  Members may have a co-pay, coinsurance, and/or deductibles.
  For PASC-SEIU Member’s out-of-pocket responsibility for covered services, please visit: https://www.lacare.org/members/welcome-la-care/member-documents/pasc-seiu-plan

For additional information on payments, please refer to Chapter 12 – Claims and Payments.

### 4.12 Pharmacy Benefits and Services
A large number of pharmacies are available to L.A. Care Members across Los Angeles County. The pharmacy network includes most major chain pharmacies and community pharmacies. Members should fill prescriptions at network pharmacies.

To find a network pharmacy near a Member’s residence or Provider site, please utilize the Find a Pharmacy tool here: https://www.lacare.org/members/getting-care/pharmacy-services/find-pharmacy

For Medi-Cal, pharmacy benefits are carved-out to the Department of Health Care Services Medi-Cal Rx. For additional information about contracted pharmacies, please visit Medi-CalRx.dhcs.ca.gov.

For additional information on Pharmacy resources, please refer to Chapter 16 – Pharmacy and Formulary.

### 4.13 Nurse Advice Line (NAL)
The Nurse Advice Line (NAL), a service provided by L.A. Care free of charge, is intended to give Members general health information, education, advice, and to assist Members in taking a more informed role in decisions regarding their health care options. The NAL is available 24 hours a day, seven (7) days a week with registered nurses who follow medical doctor reviewed algorithms when triaging symptomatic calls. When Members call the NAL, they may also choose to get information about health issues through the Health Education Audio Reference (HEAR) Library.
4.13.A The HEAR library has pre-recorded messages on health topics that provide information Members need to help:

- Administer self-care
- Identify warning signs
- Prevent illness

For more information on the HEAR library and for simple directions on how to use it, please visit: [https://www.lacare.org/members/getting-care/nurse-advice-line/audio-reference-library](https://www.lacare.org/members/getting-care/nurse-advice-line/audio-reference-library)

Members may also chat with a live nurse by logging into their online account here: [L.A. Care Connect Member Login](https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered)

Providers are encouraged to share this information with Members.

- Nurse Advice Line (NAL): (800) 249-3619 or TTY 711

4.14 Plan Coverage Resources

For detailed information on plan coverage, Providers can visit:

- **CMC**  
  [https://www.lacare.org/health-plans/cal-mediconnect/plan-overview](https://www.lacare.org/health-plans/cal-mediconnect/plan-overview)

- **MCLA**  

- **LACC/D**  

- **PASC-SEIU**  

4.15 Medi-Cal Renewal

Providers can support Medi-Cal renewal efforts by reminding Medi-Cal beneficiaries of the below information during their point-of-care visits:

On an annual basis the Department of Public Social Services (DPSS) will check to see if a Medi-Cal beneficiary still qualifies for free or low-cost Medi-Cal. It is important that Medi-Cal beneficiaries report any changes to their demographic or contact information to DPSS to ensure they receive important information about their Medi-Cal coverage. DPSS will only ask Medi-Cal beneficiaries for information if they need it to renew their Medi-Cal. It is necessary that Medi-Cal beneficiaries respond to county requests in a timely manner. This will make sure DPSS has the most current information it needs to renew their Medi-Cal coverage.

For more information about how Medi-Cal beneficiaries can update their personal information and/or renew their Medi-Cal coverage, please contact the Los Angeles County Department of Public Social Services (DPSS) at (866) 613-3777 TTY (800) 660-4026 or visit BenefitsCal at: [https://benefitscal.com/](https://benefitscal.com/)
DPSS is open Monday through Friday, excluding holidays, from 7:30 am – 7:30 pm and Saturdays from 8:00 am – 4:30 pm.

4.16 For More Information
For questions regarding the information provided in this chapter, please contact the Provider Solutions Center via phone at (866) 522-2736.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 5 – Utilization Management (UM)

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

5.0 Introduction

The L.A. Care Health Plan (L.A. Care) Utilization Management (UM) program serves to ensure that appropriate, high quality, cost-effective utilization of health care resources, including medical and behavioral, are available to Members in a timely manner. This is accomplished in a fair, impartial, and consistent manner void of discrimination through the systematic and consistent application of UM processes based on current, relevant medical review criteria and expert clinical opinion.

The processes for UM decision-making are based solely on the appropriateness of the care, services and the existence of coverage. There is a separation of medical decisions from fiscal and administrative management to ensure that fiscal and administrative management will not influence medical decisions. The UM process provides a system that ensures equitable access to high-quality health care across the network of Providers for all eligible Members by:

- Ensuring that requested services delivered are medically needed and consistent with diagnosis and level of care required for each Member taking into account any co-morbid condition that exists
- Defining the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Ensuring authorized services are covered under contract with the State of California regulatory bodies
- Coordinating thorough and timely investigations and responses to Member and Provider reconsiderations, disputes, appeals and grievances associated with utilization issues
- Ensuring UM policies and procedures are in alignment with the UM program and practices and compliant with contractual, regulatory, and accreditation requirements
- Monitoring utilization practice patterns of select Providers to identify trends and opportunities for improvement
- Monitoring both inpatient and outpatient care for possible quality of care deficiencies, and utilize indicator screening criteria, documenting and submitting all potential deficiencies to the Quality Improvement (QI) Department
- Identifying and addressing known or potential quality of care issues (PQIs) and trends that affect the health care and safety of Members and implement corrective action plans (CAPs) as needed
- Optimizing the Member’s health benefits by linking and coordinating services with the appropriate county/state sponsored programs
- Promoting and ensuring the integration of UM with quality monitoring and improvement, risk management, behavioral health and case management activities
Improving Provider and Member satisfaction by analyzing Member and Provider experience data and complaints, regarding the UM program, to identify opportunities and implement appropriate interventions for continuous improvement of services

Ensuring a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates Provider and Member input along with any regulatory changes, changes to current standards of care, and technological advances

Evaluating and monitoring the ability of delegates to perform UM activities and to monitor performance

5.1 Program Structure

5.1.A Delegation

Various UM activities are delegated to different entities through contractual arrangements, including but not limited to:

- American Specialty Health (ASH)
- Beacon Health Options (Beacon)
- Navitus Pharmacy Services
- Participating Physician Groups (PPGs)/Independent Practice Associations (IPAs)
- Plan Partners

The scope of delegated functions varies based on each entity and L.A. Care retains responsibility for providing authorization and coordination of services for all non-delegated functions.

For more information regarding the appropriate entity responsible for providing an authorization, please visit: https://www.lacare.org/providers/provider-resources/forms-manuals

5.1.B Authorization Exemptions

L.A. Care maintains a list of services that currently do not require authorization for services despite financial responsibility and delegation.

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

- Emergency medical services, screening and stabilization services as allowable under applicable rules and regulations and evidence of coverage for both in-network and out-of-network Providers
- Sensitive Services, including pregnancy screening and diagnosis and abortion/pregnancy termination, sexual assault, outpatient mental health counseling and treatment, family planning services, diagnosis and treatment of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) counseling and testing for both in-network and out-of-network Providers
- Preventive health services
- Non-medical Transportation (NMT) – For more information regarding transportation, please visit: https://www.lacare.org/members/member-support/transportation

5.1.B.1 Delegated entities reserve the right to create their own prior authorization exemptions for services where they hold financial responsibility. An updated list of authorization requirements for
services where L.A. Care holds financial responsibility, can be accessed using the prior authorization search located on our website at: [https://www.lacare.org/providers/provider-resources/prior-authorization-search](https://www.lacare.org/providers/provider-resources/prior-authorization-search).

For additional information regarding benefits guides for the varying lines of business (LOBs) and to learn more about the differentiation between Non-Medical Transportation (NMT) and Non-Emergent Medical Transportation (NEMT), please refer to Chapter 4 – Scope of Benefits.

5.1.C Validity

Authorizations are generally approved for 90 days with a disclaimer stating that authorizations are valid only if the Member is eligible on the actual date of service.

Providers can verify Member eligibility 24 hours a day, seven (7) days a week by calling the L.A. Care UM Department at (877) 431-2273 or by visiting the Provider Section at: [https://www.lacare.org/](https://www.lacare.org/).

For additional information on how to check Member eligibility, please refer to Chapter 2 – Membership and Membership Services.

5.2 Authorization Types

L.A. Care performs three (3) types of authorization requests:

5.2.A 1. Prior Authorization/Pre-Service (Prospective Review)

Prior Authorization/Pre-Service is the formal process requiring an L.A. Care Provider to obtain advance approval for coverage of specific services or procedures. It allows for benefit and Medical Necessity determination, 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.

This includes, for example, but is not limited to the following:

- Ambulatory or outpatient procedures (hospital-based, ambulatory surgery center)
- Ancillary referrals
- Elective admissions
- Office-based procedures
- Physician administered drugs and infusions

UM staff evaluates select proposed treatment plan and request, determines benefit eligibility and medical necessity using approved UM criteria, suitability of location, and level of care prior to the approval of service delivery for select diagnoses and procedures.

Pre-service review requests are generated by the Member’s Provider, either primary care physician (PCP) or specialist (SPC), and submitted to L.A. Care or its delegated Provider either by mail, fax, or other electronic submissions options (such as portals) if possible.

L.A. Care monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within the L.A. Care
network of Providers. Out-of-network requests are also used to evaluate Provider access and to determine if the local network requires enhancements to meet Member needs.

5.2.B 2. Concurrent Review/Hospital Admissions

Concurrent review requests occur 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. Concurrent review occurs during, or as part of, the clinical workflow to support point of care decisions.

They typically are associated with the following:

- Inpatient care (e.g. such as acute hospitalizations)
- Ongoing ambulatory care (e.g. such as home health)
- Residential treatment programs
- Skilled nursing and sub-acute facilities

Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists do not require prior authorization (Medi-Cal and Medicare). For commercial health plan Members, the standard is whether the enrollee himself/herself reasonably believed he/she had an emergency medical condition, and does not require prior authorization to visit the emergency room.

5.2.B.1 Member Transfers

Emergency health care services are available and accessible within the service area 24 hours a day, seven (7) days a week. L.A. Care and its delegates provide 24-hour access for Providers to coordinate a transfer in circumstances where the Member has received emergency services and is stabilized, but requires services the current Provider does not offer. Please contact L.A. Care or its respective delegate UM Department to facilitate a Member transfer or visit: https://www.lacare.org/providers/provider-resources/forms-manuals for more information.

5.2.B.2 Member Post Care

Post-stabilization care for inpatient level of care and pre-approved elective admissions, with the exception of routine labor and delivery, require authorization. The notification of admission can be received by calling the L.A. Care UM Department:

- By Phone:
  L.A. Care UM Department at (877) 431-2273

- By Fax:
  (213) 438-5748

Providers can also reference the Provider Authorization and Billing Reference Guide at: https://www.lacare.org/providers/provider-resources/forms-manuals to determine how to contact extended delegates.

Please note that emergency room admissions to observation level of care do not require authorization for all LOBs. Additionally, emergency room admission (face) sheets are not considered a request for admission, but rather the notification of services rendered by an emergency room department. Please ensure notification includes the level of care to which the Member was admitted.
To ensure the medically necessity of the admission and continued stay, including the appropriateness of the level of care, bed type and care duration, all reviews are performed by a UM Nurse Specialists for the following:

- Acute care hospitalization
- Acute rehabilitation
- Long term acute care hospitalization
- Skilled nursing facility (SNF)

Requests for initial and continued authorization are reviewed concurrently throughout the stay as frequently as requested by the Provider. Providers are responsible to provide sufficient documentation with each request. Denied admissions for inpatient level of care will automatically default to observation level of care for claims purposes.

Objectives of continued stay:

- Ensure that established standards of quality care are met
- Ensure that services are provided in a timely and efficient manner
- Identify cases appropriate for Case Management
- Implement effective and safe discharge planning
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate

5.2.B.3 Member Discharge Planning

L.A. Care, or the responsible delegate, will determine the discharge date of an inpatient stay to be the earlier of the date specified for discharge in a Member’s chart or the date specified by L.A. Care in a written denial notice to the Hospital due to lack of ongoing medical necessity. At the time that a Member no longer meets inpatient level of care, but meets medical necessity criteria for lower level of care such as a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B), L.A. Care will issue a denial for continued acute inpatient level of care. If the Hospital has a contract for Acute Administrative Days, then a separate authorization may be issued for Acute Administrative Days while the patient awaits placement to a NF-A or NF-B.

In the event that there are delays in obtaining medically necessary procedures, L.A. Care will deny each day added to a Member’s length of stay resulting from the unavailability of operating room space, rescheduling of surgery for space-related reasons, inadequate nursing procedures, or the failure to obtain timely necessary ancillary or diagnostic services.

If during this review the UM staff identifies a potential Hospital Acquired Condition, the UM staff will proceed with submitting PQIs and document the finding in the claims section of the database.

UM staff shall begin discharge planning on the first business day after L.A. Care has been notified of the patient’s admission by utilizing available resources to monitor the Member’s status and plan for discharge. Discharge planning is a critical component of the UM process and shall include procedures to ensure that necessary care, services, durable medical equipment (DME) and supports are in place in the community for the Member once they are discharged from a hospital or institution.
5.2.C  3. Post-Service/Retrospective Review

Post-service/retrospective review requests occur after medical care or services have been received. The purpose of retrospective review is to validate appropriate level of care (procedure, location, timing) after services have been rendered and includes, but is not limited to: emergency procedures and events, reconsideration requests, and appeals and grievances response.

Retrospective reviews will only be conducted for emergency services where a delay in requesting the prior authorization would cause:

- Undo patient harm
- Rendering Provider is unaware L.A. Care is the primary payer for the services rendered
- Rendering Provider is unaware of the patient’s insurance status at the time the services are rendered

5.3 Utilization Management (UM) Review Process

5.3.A Review Criteria

L.A. Care applies written, objective, evidence-based criteria and considers the individual Member’s circumstance and community resources when making medical appropriateness determinations for behavioral health care, physical health care, and pharmaceutical services. The criteria is objective and consistent with sound principles and medical evidence. They are reviewed, developed, and approved annually with involvement from actively practicing health care practitioners, and the involvement of practitioners in the review and development is documented in the Utilization Management Committee (UMC) minutes. The UM review criteria is available for disclosure to Providers, Members, and the public upon request.

To obtain a copy of any L.A. Care UM criteria, UM procedure or UM process, practitioners, Providers, Members and their representatives, and the public may contact the L.A. Care Customer Solution Center or the L.A. Care UM Department:

- **By Phone:**
  - L.A. Care Customer Solution Center at (888) 839-9909
  - L.A. Care UM Department at (877) 431-2273

5.3.B Under-Utilization

L.A. Care does not reward Providers or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. There is a separation of medical decisions from fiscal and administrative management, to assure that fiscal and administrative management will not unduly influence medical decisions.

On an annual basis, L.A. Care distributes a statement to all its Providers, Members, and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to affirm that UM decision-making is based only on appropriateness of care and service.
5.3.C Third-Party Independent Medical Review

L.A. Care contracts with a third-party independent medical review organization that provides objective, unbiased medical determinations to support effective decision-making based only on medical evidence.

5.3.C.1 Guidelines for Review

Working with practitioners and Providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating Provider
- Age of Member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of service to include, but not limited to:
  - Availability of inpatient, outpatient and transitional facilities
  - Availability of outpatient services, includes contracted and non-contracted specialists and specialty centers
  - Availability of highly specialized services, such as transplant facilities or cancer centers
  - Availability of SNF, subacute care facilities or home care in the organization’s service area to support the patient after hospital discharge
  - Local hospitals’ ability to provide all recommended services
- Benefit coverage

5.3.C.2 Absence of Applicable Criteria

In the absence of applicable criteria, the L.A. Care UM medical staff may refer the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable), and characteristics of the local delivery system.

5.3.C.3 Review Documentation

Requests for authorization of services are to be submitted by the Provider of service to the L.A. Care UM department, or the delegated PPG, by mail, fax, or phone call. Pertinent data and information is required to enable a thorough assessment of Medical Necessity. If L.A. Care is the responsible party for authorization, please visit: [www.lacare.org/priorauth](http://www.lacare.org/priorauth) to find prior authorization forms and other information.

The following information should be provided on all requests:

- Member demographic information
- Provider demographic information
• Requested service/procedure to include specific Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) code(s)
• Member diagnosis (Using current International Classification of Disease (ICD) Code sets)
• Clinical indications necessitating service
• Pertinent medical history, treatment or clinical data including, but not limited to:
  o Office and hospital medical records
  o Diagnostic, laboratory, and radiologic testing results
  o Treatment plans and progress notes
  o Recent physical exam results
  o Operative and pathological reports
  o Rehabilitation evaluations
  o Consultation notes from treating physicians
  o Unique patient characteristics and information including psychosocial history
  o Information from family/social support network
  o Case management notes
  o Network adequacy information for out-of-network requests
• Location of service to be provided
• Requested length of stay for all inpatient requests
• Proposed date of procedure for all outpatient surgical requests

5.4 Determination Types

UM determinations are responses to requests for authorizations based on the approved, evidence-based UM clinical criteria. These include approvals and adverse determinations (Notice of Action). Adverse determinations include, but are not limited to, denials, modifications, extensions, and termination of services.

L.A. Care issues three (3) types of adverse determinations, which may occur at any time in the course of the review process:

1. Administrative
2. Benefit
3. Medical Necessity

5.4.A Administrative Denial

Administrative denials include requests that, for example, fail to follow administrative procedure, meet regulatory limitations or eligibility requirements.

The following may be reasons that an administrative denial is issued:

• Request is not submitted within a timely basis
• Member is not currently eligible/or was not eligible with L.A. Care at the time service was rendered
• Member has other health insurance, and that carrier is responsible for the service requested, or another Provider must authorize the service requested
• Covered under other state programs using Carve-Out Notices
5.4.B Adverse Determination (Modifications, Delay, Extension, Denial)

The adverse notifications must state the reason for the decision in terms specific to the Member’s condition or service request and in language that is easy to understand and references the criterion used in making the determination so the Member and Provider have a clear understanding of L.A. Care’s, or the PPG’s, rationale and enough information to file an appeal.

L.A. Care offers the practitioner the opportunity to discuss any adverse determination or potential adverse determination with the peer reviewer that initiated the adverse determination. Providers requesting to discuss the decision with the physician (or peer) reviewer, may call the L.A. Care UM Department:

- **By Phone:**
  L.A. Care UM Department at (877) 431-2273

5.4.C Dispute an Adverse Determination

If a Provider believes the determination is not correct, the Provider has the right to appeal the decision on behalf of the Member by filing a grievance with L.A. Care.

The requesting Provider should submit a copy of the Member’s denial notice and a brief explanation of the concern with any other relevant information to the address below or by fax:

- **By Mail:**
  L.A. Care Health Plan
  Attn: Appeals and Grievances Department
  1055 W. 7th Street, 10th floor
  Los Angeles, CA 90017

- **By Fax:**
  (213) 438-5748

For more information on the various appeals and grievances processes, please refer to Chapter 18 – Appeals and Grievances.

5.5 Independent Medical Review (IMR)

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

- Denials, modifications, terminations, delays in service or treatment not considered medically necessary
- Experimental or investigational treatment
- Claims denials for emergency or urgent medical services that have been received

For more information on appeals, please refer to Chapter 18 – Appeals and Grievances.

5.6 Timeliness of Utilization Management (UM) Decisions

L.A. Care, or the delegated PPG, makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. L.A. Care measures the timeliness of
decisions from the date when the organization receives the request, even if not all the information necessary to make a decision is available. L.A. Care documents the date when the request is received and this counts as day zero (0), even if a non-urgent request is received after business hours.

5.6.A Requests can be considered non-urgent/routine or urgent:

1. Non-Urgent/Routine Requests
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.

2. Urgent/ Expedited Requests
A request for medical care or services in instances where a Provider indicates or L.A. Care or its delegate determines, that the standard request timeframe may seriously jeopardize the Member’s life or health or ability to attain, maintain or regain maximum function. When a pre-service request is marked as urgent (expedited) on the request form, and the request does not appear to meet the standard for an urgent (expedited) request, UM staff will forward the request to a physician reviewer. Only a Physician Reviewer can make a determination whether the request is urgent (expedited) or routine based on the presenting referral.

5.7 Continuity of Care (COC)
L.A. Care Members may request continuity of care (COC) with an out-of-network Provider when:

- New Members are transitioning into L.A. Care and are in the middle of care
- Members are receiving care from a contracted Provider who is terminated from the network

Only Members with certain kinds of health problems or conditions can get COC:

<table>
<thead>
<tr>
<th>Problem or Condition</th>
<th>Member’s COC Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Condition (e.g. pneumonia)</td>
<td>As long as the condition lasts</td>
</tr>
<tr>
<td>Serious Chronic Condition (e.g. severe diabetes or heart disease)</td>
<td>No more than 12 months. Usually until the Member completes a period of treatment and servicing Provider can safely transfer the Member’s care to another Provider</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>During Pregnancy and immediately after the delivery (the post-partum period)</td>
</tr>
<tr>
<td>Terminal Illness</td>
<td>For the duration of the terminal illness</td>
</tr>
<tr>
<td>Care of a Child under three (3) years</td>
<td>For up to 12 months</td>
</tr>
<tr>
<td>An already scheduled surgery or other procedure (e.g., knee surgery or colonoscopy)</td>
<td>The surgery or procedure must be scheduled to occur within 180 days of the Provider or Hospital leaving L.A. Care</td>
</tr>
</tbody>
</table>
L.A. Care approves COC requests when all of the following criteria are met:

- Member demonstrates an existing relationship with the Provider;
- Provider is willing to provide ongoing services;
- Provider is willing to accept the payment offered from L.A. Care; and
- Provider meets applicable professional standards and has no disqualifying quality of care issues

For more information on COC, please visit the DHCS at: [https://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx](https://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx)

Members and Providers seeking COC should call L.A. Care’s Customer Solution Center to make the request:

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cal MediConnect (CMC)</td>
<td>(888) 522-1298</td>
</tr>
<tr>
<td>L.A. Care Covered/Direct (LACC/D)</td>
<td>(855) 270-2327</td>
</tr>
<tr>
<td>Medi-Cal (MCLA)</td>
<td>(888) 839-9909</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>(844) 854-7272</td>
</tr>
</tbody>
</table>

### 5.8 Behavioral Health Treatment (BHT) and Applied Behavioral Analysis (ABA)

L.A. Care ensures the provision of Mental Health and Substance Use Disorder (Behavioral Health) services in collaboration with our Managed Behavioral Organization, Beacon Health Options (Beacon), and the L.A. County Departments of Mental Health (DMH) and Public Health (DPH) as outlined in the table below:

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Outpatient Non-Specialty (mild to moderate)</th>
<th>Outpatient Specialty (mild to moderate)</th>
<th>Substance Use Disorder Services</th>
<th>Inpatient Mental Health</th>
<th>BHT/ABA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cal MediConnect (CMC)</td>
<td>Beacon</td>
<td>DMH</td>
<td>DPH</td>
<td>Beacon</td>
<td>Beacon</td>
</tr>
<tr>
<td>L.A. Care Covered (LACC)</td>
<td>Beacon</td>
<td>Beacon</td>
<td>Beacon</td>
<td>Beacon</td>
<td>Beacon</td>
</tr>
<tr>
<td>Medi-Cal (MCLA)</td>
<td>Beacon</td>
<td>DMH</td>
<td>DPH</td>
<td>DMH</td>
<td>L.A. Care</td>
</tr>
<tr>
<td>Medicare FFS or Medicare Advantage (MA) – (primary) &amp; L.A. Care Medi-Cal - (secondary)</td>
<td>Medicare FFS or MA Plans</td>
<td>DMH</td>
<td>DPH</td>
<td>Medicare FFS or MA Plans</td>
<td>Medicare FFS or MA Plans</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>Beacon</td>
<td>Beacon</td>
<td>Beacon</td>
<td>Beacon</td>
<td>Beacon</td>
</tr>
</tbody>
</table>

For Behavioral Health Outpatient Non-Specialty, common services needed include, but are not limited to:

- Individual therapy
- Group therapy
- Medication management

For Behavioral Health Outpatient Specialty, common services needed include, but are not limited to:

- Intensive outpatient
- Partial hospitalization program
- Intensive case management
For BHT, common services include, but are not limited to ABA and a variety of related evidence-based treatments that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction and promote, to the maximum extent practicable, the functioning of a beneficiary.

5.8.A PPGs/PCPs continue to be responsible for the following services:

- Outpatient medication management
- Medication assisted treatment for substance use disorders
- Brief counseling/support/education
- Routine screenings including, but not limited to:
  - Emotional health
  - Substance misuse
  - Alcohol Misuse Screening and Counseling (AMSC)
  - Developmental screening
  - Autism screenings
  - Maternal mental health screening
  - Childhood trauma screenings

5.9 Behavioral Health Contact Information

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Health Options</td>
<td>(877) 344-2858</td>
<td>(866) 422-3413</td>
</tr>
<tr>
<td>L.A. Care Behavioral Health Treatment Program</td>
<td>(888) 347-2264</td>
<td>--</td>
</tr>
<tr>
<td>L.A. County Department of Mental Health</td>
<td>(800) 854-7771</td>
<td>(562) 863-3971</td>
</tr>
<tr>
<td>L.A. County Department of Public Health/Substance Abuse Prevention and Control</td>
<td>(844) 804-7500</td>
<td>--</td>
</tr>
</tbody>
</table>

For additional information pertaining to behavioral health, please refer to Chapter 19 – Behavioral Health.

5.10 Utilization Management Forms

Providers can find important utilization forms on the L.A. Care website at: https://www.lacare.org/providers/provider-resources/forms-manuals

5.11 For More Information

For questions regarding the information provided in this chapter, please contact the Utilization Management Department via phone at (877) 431-2273.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 6 – Quality Improvement (QI)

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

6.0 Introduction

L.A. Care Health Plan’s (L.A. Care) Quality Improvement (QI) Department is designed to objectively and systematically monitor and evaluate the quality, safety, appropriateness, and outcome of equitable care and services delivered to our Members. The QI department utilizes a population management approach to Members and Providers, in addition to collaborating with local, state, and federal public health agencies and programs, Providers, and other health plans.

L.A. Care quality committees oversee various functions of the QI Program. Providers are expected, if requested, to participate in the QI Program sub-committees.

QI is responsible for:

- Maintaining an organization-wide accreditation through National Committee for Quality Assurance (NCQA)
- Monitoring of Healthcare Effectiveness Data and Information Set (HEDIS) interventions to improve equitable clinical care
- Operating and overseeing the L.A. Care portfolio of incentive and Pay-for-Performance (P4P) Provider programs
- Ensuring that L.A. Care contracted Providers cooperate with quality initiatives, including but not limited to: providing medical records, submitting supplemental data when appropriate, and completing corrective actions or action plans when performance falls below minimum performance standards

6.1 Committee Structure

L.A. Care annually prepares a comprehensive QI Program that clearly defines L.A. Care QI structures and processes designed to improve the quality and safety of equitable clinical care and services it provides to its Members.

L.A. Care quality committees oversee various functions of the QI program. The committees serve as the major mechanism for intradepartmental collaboration for the QI program. Network Providers can participate in many of L.A. Care’s QI Committees.

6.2 Quality Oversight Committee (QOC)

The Quality Oversight Committee (QOC), which reports to the Board of Governors through the Compliance and Quality Committee, is a cross-functional L.A. Care staff committee that is the cornerstone for quality
improvement steering and decision-making within the organization. The QOC is responsible for aligning organization-wide QI goals and efforts prior to program implementation, and monitoring the overall performance of the L.A. Care QI infrastructure.

6.2.A The QOC conducts the following activities:

- Assures compliance with the requirements of accrediting and regulatory agencies, including but not limited to, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), NCQA and Covered California
- Escalates concerning issues and ensures follow-up per protocols, policies, and procedures
- Improves quality, safety, and equity of care and service to Members
- Identifies appropriate performance measures, standards, and opportunities for performance improvement
- Ensures that root causes analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions
- Ensures that the information available to the Plan regarding accessibility, availability, and continuity of care (COC) is reviewed and evaluated, including but not limited to, information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services
- Ensures that opportunities for improvement are prioritized and closed based on the analysis of performance data
- Reviews the analysis and evaluation of QI activities of other committees or staff, identifies needed actions
- Reviews and refines current strategic projects and performance improvement activities to ensure appropriate collaboration for outcomes 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 to L.A. Care cross-functional staff regarding quality-related delegated oversight activities, such as reporting requirements, on a quarterly basis
- Reviews, modifies, and approves policies and procedures
- Reviews and approves the QI program description, QI work plan, quarterly QI reports, and evaluation of the QI program

6.3 Joint Performance Improvement Collaborative Committee (Joint PICC) and Physician Quality Committee (PQC)

The primary objective of the Joint Performance Improvement Collaborative Committee (Joint PICC) and Physician Quality Committee (PQC) is to ensure network Provider participation in the QI program through planning, design, and review of programs, QI activities, and interventions designed to improve performance.

For example, the Joint PICC and PQC review and approve the updated Clinical Practice Guidelines so that the QOC members know that the guidelines have been approved. Upon approval, the updated information is posted here: [https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines](https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines). Providers will be notified of the updates in the next newsletter, which includes a link to the updated guidelines.
6.3.A The Joint PICC/PQC conducts the following activities:

- Provides an opportunity for L.A. Care to collaborate with the Provider community and gather feedback on equitable clinical and service initiatives
- Reports to the QOC through the QI Medical Director (or designee)
- Serves as an advisory group to the L.A. Care QI infrastructure for the delivery of healthcare services to L.A. Care members.

Participation in the Joint PICC and PQC, including committee membership, is open to network Providers representing a broad spectrum of appropriate primary care specialties serving L.A. Care Members, including, but not limited to, Providers 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 Practice and Preventive Health Guidelines

L.A. Care systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from professionally recognized standards of care from both government and non-government organizations for disease and health conditions identified as most salient to its membership for the provision of preventive, acute or chronic medical and behavioral health services.

L.A. Care does this by reviewing annually, or as-needed, changes to guidelines through Joint PICC and PQC. L.A. Care will share this information through its provider newsletter via the Pulse and/or Progress Notes. In addition, L.A. Care will have resources for Providers to review monthly regarding webinars and changes to guidelines throughout the year.

6.4.A Providers shall review the Clinical Practice and Preventive Health Guidelines adopted by the L.A. Care Joint PICC and PQC to ensure care meets professionally recognized standards of practice.

Providers are expected to review these items monthly and may reach out to the QI Department with questions via email at quality@lacare.org.

Providers can access these guidelines, along with tools to assist Providers in Member care around COVID-19 and mental health toolkits here: https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines

6.5 Service Measures

L.A. Care expects its network Providers to comply and align with the L.A. Care QI Program and participate in QI’s monitoring, evaluating, and performance improvement activities. L.A. Care measures equitable clinical performance through HEDIS. L.A. Care expects its network Providers to assist L.A. Care in continuously improving its HEDIS rates. Providers are also expected to cooperate with the annual HEDIS data collection efforts and keep encounter data current and accurate.

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 Providers, and Provider satisfaction.
6.5.A The following data sets are collected annually:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Qualified Health Plan Enrollee Engagement Survey (QHP-EES)
- Health Outcomes Survey (HOS)

6.5.B Providers are required to cooperate with L.A. Care’s efforts to improve Member outcomes and comply with the requirements of NCQA, DHCS, DMHC, CMS, HEDIS, and any other applicable regulatory or accrediting agency through the following:

- Respond in a timely manner to all requests for Member records
- Submit encounter data for services provided utilizing the appropriate codes according to current HEDIS specifications
- Submit supplemental data when appropriate
- Participate in or conduct improvement efforts for HEDIS and other clinical measures and Member experience
- Utilize reports provided by L.A. Care through the Provider Portal or other means
- Utilize resources provided by L.A. Care, including Member educational materials, HEDIS guides, and webinars/trainings
- Document immunizations through the California Immunization Registry (CAIR)
- Comply with all state and federal directives

Providers can request a complete written copy of the L.A. Care QI Program by calling the QI Department at (213) 694-1250 ext. 4027 or by email at quality@lacare.org.

6.6 Access to Care Standards
Access to timely, comprehensive, equitable, and quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing unnecessary disability and premature death. All Providers are responsible for ensuring Members have access to services 24 hours a day, 365 days a year. L.A. Care regularly monitors and audits the appointment and access standards identified in Chapter 3 – Access to Care.

Access to Care Quick Tips can be found here:

For more detailed information on Access to Care standards, please refer to Chapter 3 - Access to Care.

6.7 Minimum Site Hours (Requirements)
Providers must offer hours of operation to all L.A. Care Members that are no less than the hours of operation offered to non-L.A Care members. L.A. Care has established minimum site hours’ requirements for PCPs. A violation of the Requirements would show that the Provider has not delivered adequate access, such that the Provider would be deemed ineligible to participate in the L.A. Care network.
6.7.A The Requirements are as follows:

1. Each Provider must be physically present and available to see Members or accessible through virtual or tele-medicine at each site where Members are assigned for a minimum of eight (8) hours per week.
2. Providers who have more than one (1) office location (site) may receive Member assignment only at approved sites(s) where they are available to see Members a minimum of eight (8) hours per week.
3. A Provider may be assigned Members at no more than four (4) sites, and each site must be open to see Members for a minimum of 16 hours per week.

L.A. Care may conduct unannounced site visits or phone calls at any time to verify Provider compliance.

For more detailed information on Minimum Site Hours (Requirements), please refer to Chapter 3 - Access to Care.

6.8 Initial Health Assessment (IHA)

The following section/sentence is only applicable to (as denoted between the asterisks): Cal MediConnect (CMC) and Medi-Cal Los Angeles (MCLA).

*The Initial Health Assessment (IHA) is a comprehensive assessment that is completed during a Member’s initial encounter with a selected or assigned PCP, appropriate medical specialist, or non-physician medical Provider, and must be documented in the Member’s medical record. The IHA enables the Member’s PCP to assess and manage the acute, chronic, and preventative health needs of the Member.

6.8.A Providers shall complete an IHA or complete a history and physical examination and an Individualized Health Education Behavioral Assessment (IHEBA) for each new Member within 120 calendar days of enrollment and within 60 calendar days for Members 18 months or younger. Providers are encouraged to continue offering and completing the IHA and all its required components, whether in person or during virtual visits.

For more detailed information on Member assessments, please refer to Chapter 9 – Health Education.

6.9 Potential Quality of Care Issue (PQI)

L.A. Care has a mechanism in place for thorough, appropriate, and timely resolution of Potential Quality of Care Issues (PQI) related to potential QOC or potential quality of service (QOS) issues that may affect the Member’s health outcome.

Providers shall report any quality concern with a potential or suspected deviation from accepted standards of care to the L.A. Care QI Department by submitting a referral for further investigation.

6.9.A Provider’s responsibilities include the following:

- Providers shall provide, ensure, and monitor the safety and quality of services provided to L.A. Care Members
- Providers shall have a policy and procedure for collecting and providing information on safety and quality
Providers shall report any quality concern with a potential or suspected deviation from accepted standards of care to the L.A. Care QI Department by submitting a PQI referral to the email at PQI@lacare.org for further investigation. PQI referral forms can be found here: https://www.lacare.org/sites/default/files/la2138_referral_quality_care_issues.pdf

6.10 Critical Incidents

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a person.

L.A. Care has a process in place to report Member critical incidents related to an adverse event. Critical Incident cases are referred to the Provider Quality Review (PQR) team for clinical evaluation, investigation, and tracking.

6.10.A Critical Incident Reporting

Providers serving Members shall be vigilant in listening and watching for evidence of Critical Events/Incidents, and reporting them appropriately to the authorities and L.A. Care as soon as they are identified, and within 48 hours of the incident. Definitions of critical events can be found on page two (2) of the Critical Incident Report form at the link below.

6.10.B Categories of Critical Events/Incidents for which reporting is required are:

- Abuse (CI001)
- Neglect (CI002)
- Exploitation (CI003)
- Life-threatening Event (CI004)
- Disappearance (CI005)
- Suicide Attempt (CI006)
- Unexpected Death (CI007)
- Restraint or Seclusion (CI008)

Delegated Participating Physician Groups (PPGs) must also provide (by the due date agreed upon) a quarterly Critical Incident Report to the L.A. Care QI Department by email at CI@lacare.org.


6.11 For More Information

For questions regarding the information provided in this chapter, please contact the Quality Improvement Department via phone at (213) 694-1250 ext. 4027 or by email at Quality@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 7 – Credentialing

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

7.0 Introduction

L.A. Care Health Plan’s (L.A. Care) Credentialing Department is responsible for ensuring that all health care Providers in our network are licensed, meet minimum criteria and performance standards, and are approved to receive reimbursements from L.A. Care for the health care services they deliver to our Members.

Key Functions:

- Working with accrediting agencies, as well as state and federal regulatory agencies, to verify that all appropriate documentation is current, and to validate professional qualifications
- Evaluating the quality of these Providers’ health care delivery systems to confirm that appropriate protocols and procedures are in place to render quality care and service
- Monitoring the delegated activities of credentialing and recredentialing for all contracted Providers
- Monitoring any sanctions, complaints, and quality issues, and taking action against Providers when occurrences of poor quality are identified

Prior to participation in the L.A. Care network and as part of the L.A. Care ongoing monitoring process, Providers are required to meet and comply with the credentialing requirements as outlined in the L.A. Care credentialing criteria and the standards of the National Committee on Quality Assurance (NCQA), Department of Health Care Services (DHCS), and Centers for Medicare and Medicaid Services (CMS).

7.1 Provider Requirements

The L.A. Care Credentialing Department verifies continuous eligibility of all Providers to ensure they have the legal authority, relevant training, and experience to provide care to our Members. Credentials are documented evidence of licensure, education, training, experience, or other qualifications.

7.1.A Information obtained from a primary source, or its authorized agent, is reviewed by the Credentialing Department to ensure it meets all state and federal regulations and accreditation standards. Practitioners, Providers, individuals, and businesses must participate in and be in good standing with the Medicare and Medicaid programs. All Providers, individuals, and businesses appearing on the monthly Office of Inspector General (OIG), Suspended and Ineligible (S&I), Medicare Preclusion List, and the Excluded Parties List System (EPLS) are ineligible from participation in the L.A. Care network.

L.A. Care does not contract, credential, refer, or pay claims to Providers who have opted out of participation in the Medicare and Medicaid programs.
7.1.A.1 Practitioners, Providers, individuals, and businesses must not be:

- Debarred
- Disenrolled/decertified
- Precluded
- Sanctioned
- Suspended
- Terminated
- Excluded from participation in any federal or state funded programs

Additionally, all identified Providers are removed from the network and reported to the appropriate business units, agencies, and Regulatory Affairs and Compliance Department.

7.2 Credentialing Requirements

The Credentialing Department validates the eligibility of Providers to ensure they are trained and qualified to perform procedures and provide services in the area of specialty as outlined in the Provider’s agreement with L.A. Care.

Providers must meet the minimum eligibility criteria for initial and recredentialing approval to join or remain in the L.A. Care network.

7.2.A Providers must:

1. Submit completed credentialing applications and provide supporting documentation
   - Credentialing applications and reapplications are required to include a list of all practice locations for which the Provider will service an L.A. Care Member
   - Also, it must include facility office hours, Provider’s specific hours onsite, National Provider Identifier (NPI) for each Provider, and tax ID for claims billing

2. Provide evidence of a valid license to practice in the State of California

3. Have a valid Drug Enforcement Administration (DEA) license and be able to dispense schedules II through V, as applicable to their specialty type
   - If a Provider is unable to dispense (schedules II through V), or schedules according to their Provider type, they must have an agreement with a practitioner (who is contracted and credentialed with L.A. Care) and who is able and willing to dispense (schedules II through V) or schedules according to their Provider type to L.A. Care Members
   - The practitioner willing to dispense (schedules II through V) or schedules according to their Provider type must be present at the same site as the Provider who is unable to dispense these schedules
   - The agreement must be signed and dated by the contracted Provider providing coverage, and a copy of the agreement must be submitted to the L.A. Care Credentialing Department

4. Have current professional or general liability insurance coverage in the minimum amount of $1 million per occurrence and $3 million aggregate

5. Have clinical privileges in good standing at their primary admitting facility and not have any history of loss or limitation of clinical privileges or disciplinary action(s)
• If a Provider does not have clinical privileges, they must submit a written agreement for inpatient coverage for the Members that should or may require hospitalization
• The arrangement must be with a Provider participating in the L.A. Care network with an appropriate specialty

6. All primary care physicians (PCPs) must have a valid Facility Site Review (FSR) completed within 36 months of initial and recredentialing
7. Must maintain licensure or certifications in good standing
8. Must be enrolled in CMS or DHCS fee-for-service (FFS) or DHCS Ordering, Referring and Prescribing (ORP), depending on Provider type
9. Promptly must notify the L.A. Care Credentialing Department of any changes in information submitted as part of the credentialing eligibility criteria, and submit these changes no later than 15 business days from the date of action

7.2.B Participating Providers must satisfy the L.A. Care recredentialing standards for continued participation in the network. Each Provider is required to be recredentialed within 36 months beginning on the date of the previous credentialing decision. Noncompliant Providers will be presented to the Credentialing/Peer Review Committee for administrative termination. If administrative termination occurred due to non-compliance of meeting recredentialing eligibility criteria, the Provider must reapply in order to re-join the L.A. Care network by submitting a letter of interest, and will be required to undergo initial credentialing.

7.2.C All Providers in the L.A. Care network must maintain a current license at all times, in the area of their provider type or practice. Credentialing will conduct monthly oversight and monitoring to ensure that all network Providers renew licensure prior to expiration. If a provider fails to renew their license by the expiration date, the following steps will be initiated:

7.2.C.1 If the identified Provider has Member enrollment:
• Close Provider’s panel to new Members upon license expiration.
• Notify Participating Physician Group (PPG) of expiration and possible reassignment of members.
• Remove assigned Members from unlicensed Provider within five (5) business days following license expiration, if not renewed.
• Reassign members to a qualified licensed and credentialed Provider.
• Remove unlicensed Provider from the L.A. Care network.

7.2.C.2 If the identified Provider does not have Member enrollment:
• Close Provider’s panel to new Members.
• If Provider has not renewed their license by the fifth business day following the expiration date, the unlicensed Provider will be removed from the L.A. Care network.

7.2.D Providers shall submit credentialing documents to the L.A. Care Credentialing Department in writing or by email.

• By Mail:
  L.A. Care Health Plan
  Attn: Credentialing Manager
7.3 Credentialing Requirements for Hospitals

Each hospital shall remain throughout its term of the agreement, accredited by The Joint Commission (TJC) or another similar nationally and CMS recognized accrediting body. The hospital shall also submit indicator data relevant to TJC Indicator Measurement System to L.A. Care. The data shall be submitted on a timely basis and shall meet the applicable reasonable standards the accrediting body has for completeness and reliability.

The Credentialing Department will reconfirm the hospital’s credentialing requirements every 36 months, at a minimum. Credentialing confirms hospitals are compliant with requirements by validating the hospital’s accreditation is in good standing with a nationally recognized agency. Hospitals must be accredited and enrolled in CMS Medicare and the DHCS FFS Medicaid program to remain contracted in the L.A. Care network.

7.3.A If the status or level of accreditation changes, then within 10 business days of this change, the hospital shall submit written notice of such change to the L.A. Care Credentialing Department.

7.3.A.1 The written notice should include the following:

1. Copy of the accreditation survey or re-survey and all deficiencies noted
2. Corrective action plan developed
3. Date of the re-survey

7.3.A.2 Hospitals are required to maintain valid accreditation and failure to do so will result in termination. Hospitals shall submit credentialing documents to the L.A. Care Credentialing Department in writing by mail or email.

- By Mail:
  L.A. Care Health Plan
  Attn: Credentialing Manager
  1055 W. 7th Street, 10th Floor
  Los Angeles, CA 90017

- By Email:
  Credinfo@lacare.org

7.4 Provider Extenders

Contracted Providers are required to ensure all employed extenders who will support the physician in treating an L.A Care Member must also meet credentialing eligibility and pass credentialing approval before seeing or treating any L.A. Care Members.
7.4.A Employed extenders include the following:

- Physician Assistants
- Nurse Practitioners
- Certified Nurse Specialists
- Certified Nurse Midwives

Employed extenders must have a completed and signed delegation agreement with a Provider who is credentialed and contracted in the L.A. Care network.

7.5 Adverse Issues, Complaints, and Sanctions

L.A. Care maintains a comprehensive ongoing monitoring process of Provider sanctions, complaints, and adverse issues between credentialing cycles to ensure appropriate action is taken when instances of poor quality are identified or the professional conduct of a Provider is, or is reasonably likely to be, detrimental to Member safety.

The state sanctions or limitations on professional licensure reports are reviewed within 30 calendar days of the release of the report. Supporting documentation for any identified Providers is prepared by the Credentialing Department for review by the Chair of Credentialing/Peer Review Committee to determine if the sanction or limitation poses any imminent danger to the safety, health, or welfare of L.A. Care Members.

7.5.A Any identified Providers are informed through a letter, directly or through their contracted entity, as appropriate. The Chair will determine what response or corrective action plan (CAP), if any, is required from the Provider or contracted entity. This information is forwarded to the Provider Data Unit (PDU), the Special Investigation Unit (SIU), and any other department impacted by the committee decision to take appropriate action, as directed by the Credentialing Committee.

Based upon the sanction type, additional safeguards may be put in place to ensure there is no potential risk to L.A. Care Members.

7.5.B Appropriate action will be taken to improve care deficiencies which may include, but is not limited to, the following:

- Panel closures to new Members
- Panel closures to specified age range
- Panel closures to specified gender
- Provider audits
- Provider monitoring
- CAP
- Removal from the L.A Care network

All issues identified are reviewed by the Credentialing/Peer Review Committee. Adverse actions determined to be reportable are reported to the appropriate agencies as directed by the Credentialing/Peer Review Committee in accordance with all state and federal regulations, accreditation standards, and the policies and procedures of L.A. Care.

7.5.C Provider must notify Credentialing, promptly and no later than 14 calendar days from the occurrence of any of the following:
• Receipt of written notice of any adverse action taken or pending by the Medical Board of California, including but not limited to, any accusation filed, temporary restraining order issued, or imposition of any interim suspension, probation or limitations affecting Provider's license to practice medicine;
• Any adverse action taken by any Healthcare Organization which resulted in the filing of a Health & Safety Code Section 805 report with the Medical Board of California, or with the National Practitioner Data Bank;
• The denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of medical staff membership or clinical privileges at any Healthcare organization;
• Any material reduction in professional liability insurance coverage;
• Receipt of written notice of any legal action including, without limitation, any filed and served malpractice suit or arbitration action;
• Conviction of any crime (excluding minor traffic violations);
• Receipt of written notice of any adverse actions taken by the Medicare or Medicaid programs, including but not limited to, fraud and abuse proceedings or convictions.

7.6 Delegation Agreement

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 ensuring that those functions are performed appropriately.

7.6.A Any delegation of credentialing and recredentialing activities must be pursuant to a mutually agreed-upon, written, and signed agreement between L.A. Care and the delegate. If the agreement does not contain an effective date, L.A. Care will consider the signature date (meaning the date of the last signature) as the mutually agreed-upon effective date. This requirement also applies when a delegate sub-delegates credentialing and recredentialing activities.

7.6.B The delegate must have an established credentialing program and policies and procedures, all of which are consistent with L.A. Care, NCQA, DHCS, and CMS standards.

7.7 Delegation of Credentialing

L.A. Care, at its sole discretion, may delegate credentialing and recredentialing activities to entities with established credentialing programs and policies consistent with L.A. Care policies and procedures, NCQA accreditation standards, and state and federal regulatory requirements. Credentialing and recredentialing activities that are delegated are reviewed annually by the Credentialing Department according to specifications described in a mutually agreed-upon delegation agreement and the California rules of Delegation of Quality Improvement (QI) Activities.

7.7.A L.A. Care will:

• Retain responsibility for credentialing and recredentialing Providers in its network, whether it delegates all or part of these activities
• Retain the right, based on quality issues, to approve, suspend, and terminate individual Providers in situations where it has delegated decision making
• Determine, at its sole discretion, to delegate credentialing functions regardless of audit results or scores
7.7.B L.A. Care may delegate any credentialing activities and, upon the decision to do so, shall ensure that the
degraded entity passes a pre-delegation assessment and continues to meet all L.A. Care requirements on an
ongoing basis by reviewing monthly and quarterly credentialing activity reports, as well as conducting annual
degradation oversite audits.

7.7.C L.A. Care retains the right to perform a pre-delegation assessment of any entity that will be sub-
degraded to perform credentialing activities. L.A. Care must be given prior notice of intent to sub-delegate
before a delegate enters into an agreement to sub-delegate credentialing activities.

7.8 Audit Activities
In the event that the Credentialing Committee determines significant deficiencies are occurring or reoccurring,
or if a delegate fails to correct previously identified deficiencies related to performance, the delegate may be
subject to a focus audit. Upon request by L.A. Care, the PPG or delegated entity shall provide copies of
credentialing documentation, on-site access to the delegate’s files, and records pertaining to credentialing
activities performed on behalf of L.A. Care. Access is provided as necessary for L.A. Care to monitor and
assess the delegate’s performance of the delegated activities. The delegate also agrees to provide access to
any authorized regulatory or accrediting agency or contracted entity with L.A. Care.

7.8.A Upon completion of a pre-contractual assessment or annual oversight audit, the Delegation Oversight
Department will analyze and score the audit appropriately, identifying any deficiencies.

- If the score falls within established thresholds, no CAP will be required
- If deficiencies are identified, a CAP will be required
- If a delegate has not cured the identified deficiencies within allotted time granted or if L.A. Care
determines the deficiencies are reoccurring or the delegate is identified as having continuous non-
compliance with meeting requirements, the delegate may be subject to de-delegation of the
credentialing activities

7.8.B If a delegate fails to complete the CAP and has gone through the exigent process which results in de-
degradation, the delegate cannot appeal and must wait one (1) year to reapply for pre-delegation audit.

7.9 Participating Physician Group (PPG) Required Reporting
The following section/sentence is only applicable to (as denoted between the asterisks): Participating
Physician Group (PPGs).

*PPGs or the delegated entity must submit quarterly credentialing/recredentialing and termination activity
reports to L.A. Care’s Credentialing Department by the 15th day of the month following the close of each
quarter. In addition, upon notification of any adverse event, sanction, suspension, exclusion, debarment, or
decertification, the L.A. Care Credentialing Department will notify the respective delegated entity of its
responsibility with regard to delegation of credentialing activities.

The notification will clearly delineate what is expected from the PPG or delegated entity with regard to the
adverse event that has been identified.

7.9.A The notice will include, but will not be limited to, the following:

- Actions taken by the PPG or delegated entity
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Chapter 8 – Provider Network Management (PNM)

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

8.0 Introduction
L.A. Care Health Plan’s (L.A. Care) Provider Network Management (PNM) Department is responsible for contracting and provider relations. PNM acts as the liaison and primary point-of-contact between L.A. Care and its provider network. The provider network consists of executed active contractual agreements between L.A. Care and the following provider types (this is not an exhaustive list, and for illustrative purposes only):

- Ancillaries
- Community-Based Adult Services (CBAS)
- Hospitals
- Participating Physician Groups (PPGs)
- Physicians
- Skilled Nursing Facilities (SNFs)
- Specialty Health Plans, for the following services: behavioral health, dental, vision, chiropractic and acupuncture
- TransHealth
- Vendors, for the following services: telehealth and transportation

Contracted Participating Providers are assigned to a specific Provider Network Account Manager when the contract is initially executed. If you do not know your Account Manager, please email ProviderRelations@lacare.org to inquire.

8.1 Provider Agreement
From time-to-time, L.A. Care may require the Provider to submit a copy of their downstream subcontracted health care provider fully executed contract(s) to ensure the contract complies with applicable regulations, the Provider's agreement with L.A. Care, the Universal Provider Manual (UPM), L.A. Care's Policies and Procedures, and L.A. Care's contracts with government agencies. Unless otherwise specified, Providers should submit requested contract(s) to their assigned Provider Network Account Manager.

8.1.A L.A. Care may request from its Providers a fully executed copy of any agreement between the Provider and Provider's management services organization (MSO) or any subcontractor providing administrative functions for the provision of delegated service(s) managed by the MSO or subcontractor for Provider, including but not limited to, claims payment or adjudication services, utilization management (UM) services or authorization determination services. Unless otherwise requested, Providers must submit copies to their assigned Provider Network Account Manager or the PNM Department.
8.2 Newly Contracted Participating Physician Groups (PPG)

The following section/sentence is only applicable to (as denoted between the asterisks): Participating Physician Groups (PPGs).

*Newly contracted PPGs are required to submit their entire provider network in an electronic format acceptable by L.A. Care for the initial provider load process. Thereafter, the PPG must submit changes to its network and verify its network as provided below. For both the initial submission and subsequent changes to the PPG's network, this can be submitted through L.A. Care’s electronic provider loading process. Failure to submit required roster will result in Provider non-compliance. *

In addition to the requirement above, for more information on the data required to meet regulatory reporting requirements, please visit the Delegation Oversight Delegated Entities Manual here: https://www.lacare.org/sites/default/files/la3369_delegation_oversight_manual_202103.pdf

Document may be amended from time to time, subject to prior notification.

8.3 Provider’s Point-of-Contact

Providers should identify a primary point-of-contact with sufficient knowledge of the Provider's practice, the Provider's services, and the agreement with L.A. Care. Should the point-of-contact change, Providers can notify L.A. Care in writing within five (5) business days' prior notice. This information can be sent to their assigned Provider Network Account Manager.

8.4 Important Updates

Providers must notify L.A. Care in writing, 90 calendar days prior to implementation of major changes, such as, but not limited to, a change in the following:

- Name
- Location
- Ownership
- Management Service Organization (MSO)
- Professional, executive level staffing, legal counsel, chief executive officer (CEO), chief operating officer (COO), chief financial officer (CFO), chief medical officer (CMO), and select administrative staffing
- Modification or expansion of services provided
- Facility/Provider licensure or certification, including Board Certifications
- Accreditation Status
- National Provider Identifier (NPI)
- Tax ID

8.4.A Adding of new facilities and/or changes in location is subject to prior approval by L.A. Care, including a facility site review as required under applicable laws. Failure to notify L.A. Care of these important updates could result in Provider non-compliance. To notify L.A. Care, Providers must contact their assigned Provider Network Account Manager or the PNM Department.
8.5 Provider Network Management (PNM) Contact Information

Providers may communicate with L.A. Care in writing, by phone, or email.

- **By Mail:**
  L.A. Care Health Plan
  Attn: Provider Network Management
  1055 W. 7th Street, 10th Floor
  Los Angeles, CA 90017

- **By Phone:**
  Provider Solution Center at (866) 522-2736

- **By Email:**
  Assigned Provider Network Account Manager or ProviderRelations@lacare.org

All notices that a Provider wants to submit under the contract should be sent to and in accordance with the Notice section of the Provider’s agreement.

8.6 Provider Network Changes

Providers must notify L.A. Care of all changes to its network of providers within 90 calendar days prior to such change or immediately upon receipt of notice from its affiliated Providers or sub-delegated Providers, whichever is earlier, and provide periodic updates as requested by L.A. Care of its network by utilizing the L.A. Care Provider Portal.

8.7 Changes to Service Locations or Scope of Services

Providers can submit anticipated changes to service locations and/or changes in scope of services provided within 90 calendar days’ written notice to their assigned Provider Network Account Manager or the PNM Department (for PPGs or MSOs) or via the Provider Portal.

8.8 Provider Panels

Changes to a Provider’s panel (ability to accept new members, accepting current members only, etc.) must be submitted via email from the PPG to the Provider Network Account Manager and/or Provider Data Associate. Providers may not close their panels or network, or partially close their panels or network to any certain age group or category of Members, or not accept the assignment of Members of a certain age group or category, or Members with certain personal characteristics or residential geography, unless specifically authorized by L.A. Care.

8.9 Primary Care and Mid-Level Practitioner Capacity

Primary Care Physicians, including practitioners of general medicine, family practice, internal medicine, obstetrics and gynecology (OB/GYN) and pediatrics (PCPs), 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 a total of more than 5,000 Members, including membership
assigned across all product line, Plan Partners, or PPG contracts within the L.A. Care network. Please note that physician panels are closed at 95% of capacity.

8.9.A Mid-Level Extender Capacity is as follows:

<table>
<thead>
<tr>
<th>Number of PCP</th>
<th>Number of Mid-Level Extenders</th>
<th>Maximum Membership Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PCP</td>
<td>No Extenders</td>
<td>2,000</td>
</tr>
<tr>
<td>1 PCP</td>
<td>1 Extender</td>
<td>3,000</td>
</tr>
<tr>
<td>1 PCP</td>
<td>2 Extenders</td>
<td>4,000</td>
</tr>
<tr>
<td>1 PCP</td>
<td>3 Extenders</td>
<td>5,000</td>
</tr>
<tr>
<td>1 PCP</td>
<td>4 Extenders</td>
<td>5,000</td>
</tr>
</tbody>
</table>

8.10 Reporting Directory Inaccuracies

L.A. Care maintains both printed and online versions of its Provider Directory.

Members, potential enrollees, Providers, and members of the public may identify and report possible inaccurate, or incomplete, information currently listed in the L.A. Care Provider Directory by calling the Provider Solution Center at (866) LACARE6 or (866) 522-2736.

8.10.A L.A. Care shall promptly investigate any reports that information listed in its Provider Directory is inaccurate and update the Provider Directory, as applicable.

8.10.B Providers may also report Provider Directory inaccuracies, directly to their assigned Provider Network Account Manager or on a fillable form on L.A. Care’s website.

8.11 Updates to the Provider Directory

8.11.A Online Provider Directory is updated weekly, or more frequently, if required by federal law when informed of and upon confirmation by L.A. Care of any of the following:

- A contracting Provider is no longer accepting new Members, or other change in the panel status
- A Provider is no longer under contract
- A Provider’s practice location or other information has changed
- Any other information that affects the content or accuracy of the information published in the Provider Directory

The online Provider Directory is available on the L.A. Care website to the public, potential enrollees, Members, and Providers without any restrictions or limitations.

8.11.B Printed Provider Directory is updated monthly. Members, potential enrollees, Providers, and members of the public may request a printed copy of the Provider Directory by contacting L.A. Care through its toll-free telephone number (866) LACARE6 or (866) 522-2736, electronically, or in writing. The printed copy of the Provider Directory will be sent to the requester postmarked no later than five (5) business days following the date of the request and may be limited to the geographic region in which the Member lives or works, unless otherwise specified by the requestor.

8.11.C Removing a Provider from the Provider Directory
L.A. Care shall delete a Provider from the directory upon confirmation of any of the following:
- Provider has retired or otherwise has ceased to practice
- Provider is no longer under contract with L.A. Care or an affiliate
- If a provider does not verify information as requested by L.A. Care Health Plan

8.11.D If a Provider renders services through a contract with a PPG, then the Provider should contact their contracted PPG and the PPG will notify L.A. Care of any changes to information necessary to update the provider directory in compliance with applicable laws and regulations.

8.12 Provider Compliance with Required Updates to the Provider Directory
L.A. Care, at least annually, will review and update the entire Provider Directory. Each calendar year, each PPG will validate their provider network. 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. Updated provider directories are located on the L.A. Care website. Directories are also available to Providers in hard copy upon request.

8.12.A L.A. Care’s notice to its Providers for failure to timely respond to a request to verify and update their information shall include all of the following:
- The information L.A. Care has in its directory regarding the Provider, including a list of networks and plan products that include the contracted Provider
- Instructions on how the Provider can update the information in the Provider Directory using the L.A. Care online interface

8.13 Hospital Privileges
If a Provider has any changes to their hospital privileges, the Provider should inform their contracted PPG. PPG will inform L.A. Care via email through their Provider Network Account Manager or Provider Data Associate.

8.14 Provider’s Responsibility
Upon receipt of a request to verify their information, a Provider must submit its response within 30 business days. The response shall confirm that the information in the Provider Directory is either current/accurate, or update the required information, including whether or not the Provider is accepting new Members. General acute care hospitals shall be exempt from this requirement.

8.14.A In the event, the Provider fails to provide the response within 30 business days, L.A. Care shall take the following steps:
- Attempt to verify whether the Provider’s information is correct or requires updates for a maximum of 15 business days. L.A. Care shall document the receipt and outcome of each verification attempt.
- If L.A. Care is unable to verify the Provider’s information, L.A. Care shall notify the Provider, at least 10 business days in advance of removal, that the Provider will be removed from the Provider Directory.
- The Provider shall be removed from the Provider Directory at the next required update of the Provider Directory after the 10 business day notice period.
8.14.B If the Provider responds before the end of the 10 business day notice period, the Provider shall not be removed from the Provider Directory. Upon completion of verification of or submission of changes to the information, the Provider shall receive an electronic acknowledgment from L.A. Care.

8.15 Economic Profiling
Providers must not engage in economic profiling. Medical decisions rendered by qualified medical Providers shall be unhindered by fiscal and administrative management.

8.16 After-Hours System
Providers are required to have an after-hours call system in place, if applicable, that ensures that Members can reach the Provider or another on-call medical professional with medical concerns or questions, 24 hours a day, seven (7) days a week, including holidays and weekends. In addition, Providers shall ensure that applicable staff are available to address UM issues to assist Members, affiliated Providers, and L.A. Care after hours, on weekends, and holidays. Providers are responsible for promptly responding to such after-hours calls received.

8.16.A If requested by L.A. Care, the Provider must demonstrate their monitoring activities. This information should be submitted to the assigned Provider Network Account Manager or the PNM Department.

8.17 Provider Training
L.A. Care will notify Providers of training and education sessions, including regulatory required trainings. Information on how to register and participate in the session(s) will be provided before the training session.

Providers will be required to register, attend, and designate appropriate staff for the training and educational session. For additional information please refer to Chapter 20 – Provider Training.

PPGs which are delegated activities in their agreements, for more information on regulatory required Provider Trainings, please visit the Delegation Oversight Delegated Entities Manual here:


8.18 Provider Grievance
Providers seeking to file a grievance with L.A. Care may do so by contacting their assigned Provider Network Account Manager, the PNM Department or may find guidance in Chapter 18 – Appeals and Grievances.

PPGs which are delegated activities in their agreements, for more information on the minimum standards for Appeals and Grievances, please visit the Delegation Oversight Delegated Entities Manual here:


8.19 For More Information
For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the PNM Department via email at ProviderRelations@lacare.org. For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 9 - Health Education

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

9.0 Introduction
The L.A. Care Health Plan (L.A. Care) Health Education Unit is dedicated to improving the Members’ health status by providing wellness and disease prevention programs and literature, directly and at no-cost, to Members and ensuring they have access to culturally and linguistically appropriate resources and health care.

9.1 Provider Responsibility
Providers are responsible for ensuring the use of the Individual Health Education Behavioral Assessment (IHEBA), also referenced as “IHEBA” or “Staying Healthy.” The assessment tool sponsored and approved by the Department of Health Care Services (DHCS) is called the Staying Healthy Assessments (SHA).

9.1.A Staying Healthy Assessments (SHA)
Providers must administer the SHA to all new L.A. Care Members within 120 days of enrollment as part of the Initial Health Assessment (IHA). 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. Providers please note: Members have the right to not answer any SHA assessment questions and to refuse, decline, or skip the entire assessment. Member refusal must be documented on the SHA.

9.1.B Annual Assessments
The SHA must be re-administered to adults and seniors every three (3) to five (5) years. Annual administration is encouraged for 12-17 years and seniors due to rapidly changing risk factors. The SHA must be reviewed annually for all age groups in the interval years between administrations.

9.1.C Staying Healthy Assessments (SHA) Tools
For more information on SHA tools, please visit:

http://www.lacare.org/providers/provider-resources/manuals-forms/staying-healthy-forms

On this page Providers can view and download assessment tools:

- DHCS SHA resource links
- Downloadable forms - regular or writable Portable Document Format (PDF)
- Online training

Hard copies of the SHA may be ordered in larger quantities via the Health Education Material portal. Additional tools and resources such as health education materials in multiple languages are also available to order online. For questions related to completing the SHA, please email: healthed_info_mailbox@lacare.org
9.2 Provider Education

The following section/sentence is only applicable to (as denoted between the asterisks): Participating Physician Groups (PPGs).

*The L.A. Care delegated Participating Physician Groups (PPGs) are responsible for educating their network of Providers and staff on health education requirements and available L.A. Care health education services, as listed in this chapter.

9.2.A Methods may include, but are not limited to:

- Fax blasts
- Meetings
- Newsletters
- On-site visits
- Provider mailings
- Seminars or other trainings
- Website postings

9.2.B The content of Provider Education should include, but is not limited to the following:

- Communication to Providers of both applicable regulatory agencies and the L.A. Care Health Education Program requirements
- Establishing a SHA requirement
- 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:
  - Availability of materials in alternative formats
  - Cultural and linguistic appropriateness
  - Medical accuracy
  - Reading level and field testing (if applicable)
  - Qualified health educator oversight *

For more information on Provider Training for all Provider types, please refer to Chapter 20 – Provider Training or for questions, email the External Learning Department at ExternalLearning@lacare.org.

9.3 Health Education Programs

The L.A. Care 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.

9.3.A The programs are available at no cost to Members:

- **Diabetes Prevention Program**
  L.A. Care identifies pre-diabetic Members to provide in-person and/or online health education and coaching to help Members lower their risk for diabetes through healthy lifestyle choices and weight loss.
• **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
  - Promotional items
  - Automated phone calls with messages targeted to the audience
  - Thank you cards which also help Members remember they received a flu shot

• **Health in Motion Program**  
  The L.A. Care Health in Motion program offers an array of skill-based, interactive wellness workshops and group appointments in various locations throughout Los Angeles County. The L.A. Care Registered Dietitians and Health Educators assist Members unable to attend in-person workshops in managing their conditions and health status via telephonic consultations.

  - **Topics of expertise include the following:**
    - Diabetes Self-Management Education
    - Medical Nutrition Therapy
    - Pre-Diabetes
    - Senior health topics such as fall prevention and osteoporosis, among others
    - Smoking cessation
    - Weight Management

• **Healthy Mom Program**  
  - L.A. Care conducts Member outreach services to new mothers in order to educate them on the importance of postpartum visits and assist with scheduling an appointment with their obstetrician.
  - L.A. Care offers interpreting and transportation services as additional services in order to encourage attendance. Some L.A. Care Members may be eligible for various incentives depending on their coverage.

• **Healthy Pregnancy Program**  
  L.A. Care identifies pregnant Members to conduct telephonic outreach to provide educational materials and assistance. L.A. Care educates them on the importance of prenatal visits and assists with scheduling an appointment with their obstetrician. Some L.A. Care Members may be eligible for various incentives depending on their coverage.

• **Smoke-Free Program**  
  Adult L.A. Care Members who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, inhaler, nasal spray, Bupropion SR, Varenicline) receive health education mailings that include smoking cessation health education materials and community resources that offer free in-person education and over-the-phone counseling provided by [California Smokers Helpline](https://www.ca.gov/smokefree).

• **Asthma, Diabetes and/or High-Risk Pregnancy Education**  
  “L.A. Cares About Asthma,” “L.A. Cares About Diabetes” and “Healthy Pregnancy” are programs focusing on education and support. Identified Members are sent a welcome letter inviting them to create an account for the L.A. Care health and wellness portal, My Health in Motion™ (MyHIM).
MyHIM houses multiple resources including health education materials and videos, access to health coaches via messaging, and self-paced workshops. Health education materials and access to telephone consults are available for members unable to access MyHIM online. To refer a Member, please use the Health Education, Cultural and Linguistic Services referral link below.


Please fax completed referral form to L.A. Care at (213) 438-5042.

For more detailed information on Healthy Living and Prevention for Members, please visit: https://www.lacare.org/healthy-living/health-resources/healthy-living-prevention

9.4 Health Education Resources
L.A. Care makes available free hard copy health education materials in multiple topics and languages for its Providers.

Health Education topics include the following:

<table>
<thead>
<tr>
<th>Health Education Topics</th>
<th>Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Injury Prevention</td>
</tr>
<tr>
<td>Dental</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Parenting</td>
</tr>
<tr>
<td>Exercise</td>
<td>Perinatal/Pregnancy</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>HIV/STD Prevention</td>
<td>Tobacco Prevention/Cessation</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Weight Management and more</td>
</tr>
</tbody>
</table>

9.4.A Providers can order health education materials for Members on the Health Education Portal that can be accessed by the link below. Providers must create an account to access and order L.A. Care health education materials. Once an account is created, Providers can select the Member’s language and quantity needed, free of charge. Written health education materials provided by L.A. Care comply with the guidelines set forth by DHCS.

To order free materials for Members, please visit: http://healtheducation.chi.v6.pressero.com/login

9.5 Community Resource Centers (CRC)
In 2019, L.A. Care and Blue Shield of California Promise Health Plan (Blue Shield Promise) Promise committed a combined $146 million over five (5) years to develop and expand a Community Resource Center (CRC) network across Los Angeles County. By the end of 2022, the health plans will jointly operate 14 centers. The CRCs offer a broad array of no-cost programming, classes and resources to help health plan Members and others in the community stay active, healthy and informed. The centers also provide on-site support from
community social service organizations focused on addressing social determinants of health, such as food and income security.

CRCs are not only open to health plan Members, but to everyone in the community. Visitors get access to a variety of health care and community resources. The centers also offer a wide variety of exercise, nutrition and health management classes in a safe, fun and inclusive space for local Members and residents at no cost.

9.5.A Appointment Scheduler

For Members who would like to visit one (1) of the centers, the CRC appointment scheduler tool can be used to schedule an appointment online, please visit: https://visitcrc.lacare.org/s/

9.5.B Resources Currently Offered at the Centers

- Free WiFi for Telehealth Services
  - Free WiFi from a private room using Member’s own device
  - L.A. Care and Blue Shield Promise Members have exclusive access to a dedicated room where they can take advantage of their Teladoc benefit using L.A. Care’s device to consult with a Provider for non-emergency health issues
- Assistance Programs
  - Assistance Programs L.A. Care Community Link is a tool to access resources for Members, like food and housing assistance
- Medi-Cal Enrollment Support
  - Enrollment specialist on-site to assist with applicants applying for health coverage
- Virtual Classes Offered*
  - Classes for kids and family
  - Fitness and Exercise Classes
  - Health Education Classes
  - Nutrition and Healthy Cooking Classes

*Please refer to the CRC website for the most up-to-date information regarding re-opening and live, in-person and virtual classes.

- YouTube Channel for the CRC virtual classes can be located here: https://www.youtube.com/channel/UC7gl-PNZQz9w1Ju2ArTT9mg/
- For more information on the CRCs, please call L.A. Care at (877) 287-6290 or visit: https://www.lacare.org/healthy-living/community-engagement/community-resource-centers

9.6 Nurse Advice Line (NAL)

The Nurse Advice Line (NAL), is a service provided by L.A. Care free of charge, and is intended to give Members general health information, education, advice and to assist Members in taking a more informed role in decisions regarding their health care options. The line is available 24 hours a day, seven (7) days a week with registered nurses who follow medical doctor reviewed algorithms when triaging symptomatic calls. When Members call the NAL, they may also choose to get information about a health issue through the Health Education Audio Reference (HEAR) Library.

9.6.A The HEAR library has pre-recorded messages on health topics that provide information you need to help:
• Administer self-care
• Identify warning signs
• Prevent illness

For more information on the HEAR library and for simple directions on how to use it, please visit:


Members may also chat with a live nurse by logging into their online account here: L.A. Care Connect Member Login

Providers are encouraged to share this information with Members.

• L.A. Care Nurse Advice line (NAL): (800) 249-3619 TTY (711)
• Anthem Blue Cross Nurse Line: (800) 224-0336 or TTY (711)
• Blue Shield of California Promise Health Plan Nurse Advise Line (NAL): (800) 609-4166 or TTY (711)
• Kaiser Permanente Appointment and Advise Center: (888) 576-6225 TTY (711)

9.7 For More Information

For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at ProviderRelations@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 10 – Cultural and Linguistics (C&L)

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

10.0 Introduction
The L.A. Care Health Plan (L.A. Care) Cultural and Linguistic Services Unit (C&L) provides translation and interpreting services to help Members understand healthcare information and improve Member to Provider communication.

Key Responsibilities:

- Ensures access to quality interpreting services at the key points of contact and Member Informing Documents (also known as Vital Documents) in Members’ preferred language and format.
- Supports Providers and their office staff in providing culturally and linguistically appropriate care to Members through education and trainings.
- Oversees Providers’ compliance with California state and federal C&L statutes and regulations through ongoing monitoring.
- Provides technical assistance to Providers to help them better meet the cultural and linguistic needs of our Members.

10.1 Cultural and Linguistic (C&L) Program
Providers will ensure that Members receive health care and services in a C&L appropriate manner that complies with the requirements and performance standards set forth in the applicable federal and California state statutes, regulations, the L.A. Care contract, and Universal Provider Manual (UPM).

Providers shall have office policies and procedures regarding C&L activities noted in this Chapter.

10.2 Language Assistance and Auxiliary Services
Providers shall use multiple methods to make no-cost language assistance and auxiliary services available to Members with limited English proficiency (LEP) and/or disabilities at all medical and non-medical points of contact. Language assistance and auxiliary services methods shall include, but are not limited to the use of qualified bilingual Providers and staff, telephonic and face-to-face interpreting services, American Sign Language (ASL) interpreters, Text Telephone Relay (TTY) and video relay services, and written Member Informing Documents (also known as Vital Documents) in the threshold languages and alternative formats such as large print, audio, Braille and accessible electronic format (data CD).
10.3 Assessing Bilingual Language Proficiency

Providers shall identify, assess, and track the language proficiency of bilingual Providers and office staff (clinical and non-clinical), who communicate with LEP Members in their primary language. The language proficiency assessment must be standardized to evaluate the qualifications of bilingual staff. Qualified bilingual staff shall have the proficiency in speaking and understanding both spoken English and at least one (1) other spoken language, including any necessary specialized vocabulary, terminology, and phraseology, and the ability to effectively, accurately, and impartially communicate directly with LEP Members in their preferred language.

Qualified bilingual staff must be designated to provide oral language assistance as part of the staff’s current assigned job responsibilities. If a bilingual member of the staff acts as an interpreter and/or translator, they must meet the qualifications of a qualified interpreter and/or translator described in the sections below.

10.3.A Providers shall maintain evidence of bilingual staff language proficiency on file.

10.4 Interpreting Services and Auxiliary Services

Providers shall ensure that Members have access to timely interpreting services 24 hours a day, seven (7) days a week, in any language requested by Members including American Sign Language (ASL) at no-cost to Members at both medical and non-medical points of contact.

10.4.A To ensure communication is complete, accurate, and kept confidential, interpreting services must be provided by qualified interpreters.

Qualified interpreters must adhere to generally accepted interpreter ethics principles, including client confidentiality promulgated by the California Healthcare Interpreting Association (CHIA) or the National Council on Interpreting in Health Care (NCIHC), proficiency in speaking and understanding both spoken English and at least one (1) other spoken language, and ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language and English, using any necessary specialized vocabulary, terminology and phraseology.

10.4.B Key responsibilities include the following:

- Providers shall offer no-cost interpreting services even when Members are accompanied by friends and/or family members.
- Providers shall strongly discourage Members from using friends and/or family members, especially minors, as interpreters.
  - Adult friends and family members may only be used to facilitate communication if specifically requested by the Member after offering free interpreting services or in an emergency involving an imminent threat to the safety or welfare of the Member.
  - The use of minors as interpreters should only be allowed in extraordinary circumstances, such as medical emergencies involving an imminent threat to the safety or welfare of the Member where there is no qualified interpreter available.
- Providers will never require or suggest Members to provide their own interpreter.
- Providers shall document the Member’s preferred language and request or refusal of interpreting services in the Member’s medical chart.
10.5 Requesting Interpreting Services

L.A. Care’s interpreting services are available to Providers contracted directly with L.A. Care and Participating Physician Groups (PPGs).

To request a no-cost face-to-face interpreter on a Member’s behalf (including ASL), Providers can call the L.A. Care Customer Solution Center at the phone numbers listed below, at least 10-15 business days prior to the Member’s medical appointment. If the date, time, or location of an appointment is changed, call the Customer Solution Center immediately. Face-to-face interpreting services for multiple medical appointments could be made at a time, as long as the appointments are within three (3) months from the time of the request.

- CMC:  (888) 522-1298 (TTY 711)
- LACC/D:  (855) 270-2327 (TTY 711)
- MCLA:  (888) 839-9909 (TTY 711)
- PASC-SEIU:  (844) 854-7272 (TTY 711)

To access no-cost telephonic interpreting services for Members, call one (1) of the following L.A. Care Interpreting line numbers to be connected with an interpreter. The services are available 24 hours a day, seven (7) days a week.

- Providers:  (855) 322-4034
- PPGs:  (855) 322-4022

10.5.A Providers contracted with a delegated entity other than PPGs shall contact their delegated entity for face-to-face and/or telephonic interpreting services.

10.6 Referral to Culturally and Linguistically Appropriate Services

Providers shall refer Members to community services and programs that are capable of meeting the cultural and linguistic needs of Members.

To access L.A. Care’s online community resource directory, please visit the L.A. Care Community Link at: https://communitylink.lacare.org/

Additionally, Providers can refer Members to culturally and linguistically appropriate community services using the Health Education Referral Form located here: http://www.lacare.org/sites/default/files/hecls-referral-form-1217.pdf

10.7 California Relay Service (CRS) – 711

Providers may use California Relay Service (CRS) to communicate with Members that are deaf and hard of hearing. To access CRS, please dial the number 711. CRS is free and available 24 hours a day, seven (7) days a week. The services are for remote communications and not for in-person encounters.

10.8 Language Assistance Notice (Tagline) and Non-Discrimination Notice (NDN)

Tagline is a short translated notice about the availability of no-cost language assistance and auxiliary services and how to access the services in the following 18 non-English languages for CMC and MCLA and 15 non-English languages for LACC/D and PASC-SEIU.
Please see below for a list of the identified languages:

<table>
<thead>
<tr>
<th>Arabic</th>
<th>Hmong</th>
<th>Korean</th>
<th>Spanish</th>
<th>Vietnamese</th>
</tr>
</thead>
<tbody>
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<td>Armenan</td>
<td>Hindi</td>
<td>Lao*</td>
<td>Russian</td>
<td>Ukrainian*</td>
</tr>
<tr>
<td>Chinese</td>
<td>Japanese</td>
<td>Mien*</td>
<td>Tagalog</td>
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</tr>
<tr>
<td>Farsi</td>
<td>Khmer</td>
<td>Punjabi</td>
<td>Thai</td>
<td>--</td>
</tr>
</tbody>
</table>

*Lao, Mien, and Ukrainian do not apply to LACC/D and PASC-SEIU.

10.8.A Providers shall post a translated language assistance (tagline) signage along with a non-discrimination notice (NDN) in a noticeably visible font size at a key point of contact where it is visible to Members. Member Informing Documents (Vital Documents) must include a tagline and a NDN appropriate for each line of business (LOB). Please see the Translation Services and Alternative Formats section below for the list of Member Informing Documents.

To order language assistance notice (tagline) signage, please see the Cultural and Linguistic Tools and Resources section below for details.

10.8.B Providers contracted with a delegated entity other than PPGs shall contact their delegated entity for language assistance notice (tagline) signage.

10.9 Translation Services and Alternative Formats

If translation services are delegated, Providers shall send fully translated written Member Informing Documents (also known as Vital Documents) in threshold languages to all limited English proficient (LEP) Members that speak the identified threshold languages and alternative formats (e.g. large print, audio, Braille) on a routine basis. Providers shall enable Members to make standing requests in a specified threshold language and alternative format.

10.9.A Upon request, Members shall receive a written translation within 21 days. If a Member requests written Member Informing Documents in a non-threshold language, reasonable accommodations must be made, including but not limited to, providing oral translation of written informing documents using interpreting services.

10.9.B The threshold languages required by lines of business (LOBs) are as follows:

- CMC and MCLA (11 threshold languages):
  1. English
  2. Arabic
  3. Armenian
  4. Chinese
  5. Farsi
  6. Cambodian (Khmer)
  7. Korean
  8. Russian
  9. Spanish
 10. Tagalog
 11. Vietnamese
10.10 Member Informing Documents (also known as Vital Documents)

The written Member Informing Documents include, but are not limited to, the following:

- Applications
- Consent forms
- Enrollment forms
- Evidence of coverage
- Formulary
- Letters with any eligibility, benefit, or membership activities information
- Marketing materials
- Notice of change
- Preventive health reminders
- Provider directories
- Standardized and non-standardized notice of adverse benefit determination letters (notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal)
- Summary of benefits

10.10.A To ensure that translation is complete, accurate, and kept confidential, documents must be translated, edited, and proofread by a qualified translator. Additionally, qualified translators must adhere to generally accepted translator ethics principles, including client confidentiality, proficiency in writing and understanding both written English and at least one other written non-English language, and the ability to translate effectively, accurately, and impartially to and from such language and English, using any necessary specialized vocabulary, terminology and phraseology.

10.10.B L.A. Care provides translated notice of adverse benefit determination (NOA) templates. Delegated entities including PPGs fully translated NOA letters including the inserted Member’s specific information in the NOA template. Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 for additional requirements and timelines pertaining to translated NOA letters.

To obtain the translated NOA templates, language assistance notice (taglines) and NDN, delegated entities, including PPGs, can email: DOACM@lacare.org. Delegated entities including PPGs must insert their own contact information in the templates.

10.11 Cultural and Linguistic (C&L) Service Trainings

Providers, Provider office staff, Providers who serve CMC Members as part of the Interdisciplinary Care Team (ICT), and any staff with direct interaction with Members shall receive onboarding and ongoing training on language assistance requirements, cultural competency, and disability sensitivity training.
10.11.A The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of the following:

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender Identity</th>
<th>National Origin</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancestry</td>
<td>Health Status</td>
<td>Physical or Mental Disability</td>
<td>Sex</td>
</tr>
<tr>
<td>Color</td>
<td>Language</td>
<td>Physical or Mental Identification</td>
<td>Sexual Orientation</td>
</tr>
<tr>
<td>Creed</td>
<td>Marital Status</td>
<td>Race</td>
<td></td>
</tr>
</tbody>
</table>

10.11.B The education and training contents must include, but are not limited to, federal and California state language assistance laws and requirements, how to access the language assistance and auxiliary services to comply with the obligations, reflection on their own cultures and values, and how they relate to delivery of services to those with differing beliefs and practices (such as beliefs about illness and health, methods of interacting with Providers and the health care structure, traditional home remedies, and literacy needs). Additionally, education and training contents must include training on competency and sensitivity, as required when serving diverse populations such as Members with disabilities and their accessibility and accommodations.

L.A. Care offers C&L trainings and an educational toolkit to Providers contracted directly with L.A. Care and PPGs. To request C&L trainings, please email: CulturalandLinguisticsServices_Mailbox@lacare.org.

10.11.C Providers contracted with a delegated entity other than PPGs shall contact their delegated entity for C&L trainings.

For more information on the educational toolkit, please visit: https://www.lacare.org/sites/default/files/CL_Provider_Toolkit.pdf

10.12 Reporting Requirements

Reporting shall be submitted, as specified in the contract, via the L.A. Care File Transfer Protocol (FTP) site or emailed to the C&L Unit at CL_Reports_Mailbox@lacare.org.

10.12.A Annual and Quarterly Reporting Timeframes are as follows:

<table>
<thead>
<tr>
<th>Annual Reports</th>
<th>Quarterly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;L program description</td>
<td>Translation and Alternative format</td>
</tr>
<tr>
<td>Bilingual staff list</td>
<td>Face-to-face and/or telephonic interpreting</td>
</tr>
<tr>
<td>January 31st</td>
<td>C&amp;L referral</td>
</tr>
<tr>
<td></td>
<td>Quarter 1 on May 15th</td>
</tr>
<tr>
<td></td>
<td>Quarter 2 on August 15th</td>
</tr>
<tr>
<td></td>
<td>Quarter 3 on November 15th</td>
</tr>
<tr>
<td></td>
<td>Quarter 4 on February 15th</td>
</tr>
</tbody>
</table>
Reports must be provided using either L.A. Care’s reporting template or L.A. Care’s format requirements. For the most up-to-date reporting templates, FTP site, and reporting quarterly submissions, please email CL_Reports_Mailbox@lacare.org.

10.13 Cultural and Linguistic (C&L) Tools and Resources

The following tools and resources are available on the L.A. Care online order form:

- Tagline (Language Assistance Notice) signage
- Telephonic interpreting card
- C&L provider toolkit “Providing Language Services for Diverse Populations”

10.13.A How to order:

1. Go to L.A. Care’s online order form at: http://healtheducation.chi.v6.pressero.com/login
2. Create an account
3. Create a username and password
4. Complete portal profile
5. Login into the L.A. Care Health Education, Cultural & Linguistic Materials Portal
6. Select an item and enter quantity
7. Add order to shopping cart
8. Review order summary and proceed to checkout
9. Shipping will require three (3) - five (5) business days via the United States Postal Service (USPS)
10. An email confirmation will be sent to the email on file

10.14 For More Information

For questions regarding the information provided in this chapter, please contact the C&L Unit via email at CulturalandLinguisticsServices_Mailbox@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 11 – Finance

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

11.0 Introduction
The L.A. Care Health Plan (L.A. Care) Finance Department is responsible for how revenue is received, spent and tracked for all L.A. Care operations. This section covers guidelines for financial reports, requirements, and other related issues.

11.1 Balance Billing
Balance billing is the practice of billing a Member the difference between the reimbursed amount for a covered service and a higher amount the Provider wants as payment. Balance billing L.A. Care Members is prohibited by law in most circumstances. It includes asking a Member to enter into a private agreement or waiving their right to balance billing protection, charging deductibles, co-pays, or other administrative fees. No contracted Provider or affiliate will demand or collect money for covered services except for authorized co-payments.

11.2 Records, Reports, and Inspection
Each Provider must actively monitor its affiliated Provider network to measure their financial stability. Copies of all reports including findings, recommendations, corrective action plans (CAP) and other information regarding these reviews, must be provided to L.A. Care upon request.

11.2.A These books and records will include, without limitation, all physical records originated or prepared under the performance of a Participating Physician Group (PPG) or other Provider agreement, including, but not limited to:

- All books of account
- All medical records
- All reports submitted to the Department of Managed Health Care (DMHC)
- Encounter data
- Financial records
- Working papers
- All subcontracts

11.2.B The Provider’s books and records must be maintained for a minimum of 10 years from the end of the fiscal year in which its L.A. Care contract expires or is terminated. In the event the Provider has been notified by the DMHC or other applicable regulatory agency that it has initiated an audit or investigation of L.A. Care, the Provider, or the agreement, the Provider will retain these records for the greater of the above timeframe or until the matter under audit or investigation has been resolved.
11.3 Records
All Providers must maintain all books, records, and other pertinent information that will ensure their compliance with the L.A. Care agreement and regulatory agency requirements for 10 years from the end of the fiscal period in which its agreement with L.A. Care terminates. These books, records, and other information must be maintained in accordance with generally accepted accounting principles (GAAP). Also, they must conform to applicable federal and state law and Department of Health Care Services (DHCS) and DMHC regulations.

11.3.A These books and records will include without limitation all physical records originated or prepared under the performance of the agreement including, but are not limited to:

- All books of account
- All medical records
- All reports submitted to DMHC
- Affiliate subcontracts
- Any other documentation pertaining to medical and non-medical services rendered to Members
- Any reports deemed necessary by L.A. Care, regulatory agencies, and DMHC to ensure compliance
- Encounter data
- Financial records
- Hospital discharge summaries
- Medical charts and prescription files
- Records of emergency services and other information as requested by L.A. Care and DMHC to disclose the quality, appropriateness, and/or timeliness of health care services provided to Members
- Reports from contracted and non-contracted Providers
- Working papers
- All subcontracts

11.3.B Each Provider will maintain all books and records necessary to disclose how the Provider is fulfilling and discharging its obligations under their L.A. Care agreement and their responsibilities as defined by applicable regulatory agencies.

These books and records must be maintained to disclose the following:

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

11.4 Inspection of Records and Facilities
At any time during normal business hours, the Provider must allow L.A. Care, DMHC, and any authorized state or federal agency to inspect, evaluate and audit any and all books, records, and facilities maintained by the Provider and its affiliates. These records pertain to services rendered under the Provider agreement and are subject to confidentiality restrictions.
11.5 Reimbursement Services and Reports
In accordance with the provisions of the Provider's subcontracts, the Provider will perform all normal reimbursement services, including:

- Those relating to the payment of capitation
- Processing and payment of any claims on a fee-for-service (FFS) basis
- Administration of any stop-loss and risk-sharing programs
- Any other payment mechanisms

Claims processing may be delegated to Providers in cases where utilization management is delegated.

11.5.A Upon L.A. Care's request, the Provider will submit payment records, summaries, and reconciliations with respect to L.A. Care Members. This includes any other payment compensation reports which the Provider customarily provides to its affiliates.

11.6 Monthly Eligibility List (E-List)
The monthly eligibility list (E-List) is a Member-level roster of all eligible Members assigned to the Provider, which includes all Primary Care Physician (PCP) and Member demographics.

11.7 Monthly Capitation Input Report
The monthly Capitation Input Report is a Member-level detailed Provider payment file, which includes the corresponding capitation rate for each Member, as well as PCP and Member demographics.

11.7.A Summarized Statement – Capitation
For any Provider that has a capitation compensation arrangement under its agreement with L.A. Care, it is L.A. Care’s obligation to pay those Providers any capitation payments due for any respective Members assigned to the Provider, for the participating line of business (LOB). Payments shall be subject to L.A. Care’s receipt of its monthly capitation payment from DHCS, Covered California, CMS, or other payer agency.

For each Member assigned to the Provider according to the E-list, L.A. Care shall pay Providers a monthly, Per Member, Per Month (PMPM) Capitation Payment according to the Member’s aid category/rate group as outlined in the Provider's compensation schedule within their agreement.

L.A. Care shall make payment to applicable Providers within 15 business days of L.A. Care’s receipt of its monthly payment from DHCS, Covered California, CMS, or other payer agency.

11.8 Monthly and Quarterly Claims Reporting
Delegated Providers will submit a self-reported Monthly and Quarterly Claims Timeliness Report to L.A. Care for each contracted LOB. Pursuant to AB 1455 regulations, Claims Settlement Practices and Dispute Resolution Mechanism, delegated claims payers must submit quarterly reports to their contracted health plans. The delegated payer’s Principal Officer(s) must sign or personally transmit those reports to the plans.

11.8.A The Monthly Claims Timeliness Report, that is the first two (2) months of each quarter are due to the health plans on or before the 15th calendar day of each month following the month being reported.
11.8.B The Quarterly Claims Timeliness Report is due for both the third (3rd) month of the quarter and the quarter itself as follows:

<table>
<thead>
<tr>
<th>Calendar Quarter</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>April 30</td>
</tr>
<tr>
<td>Second</td>
<td>July 31</td>
</tr>
<tr>
<td>Third</td>
<td>October 31</td>
</tr>
<tr>
<td>Fourth</td>
<td>January 31</td>
</tr>
</tbody>
</table>

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. Please submit these reports via e-mail at AB1455ClaimsReportetal@lacare.org.

11.9 Financial Statements
As required by the Minimum Financial Solvency Standards, and as requested by L.A. Care, delegated Providers must submit the following financial documents by the stated timeframe below:

1. Submit a copy of its Quarterly Financial Statements within 45 calendar days after the close of each quarter.
2. Submit a copy of its annual financial statements audited by an independent certified public accountant (CPA) within 150 calendar days after the close of each fiscal year end for PPGs and within 180 calendar days after the fiscal year end for Capitated Hospitals.

11.9.A The financial statements must include, but are not limited to, a Balance Sheet, Income Statement, Statement of Changes in Net Worth, and a Cash Flow Statement prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Please send these financial statements to the L.A. Care Financial Compliance Department via e-mail: FinancialReports@lacare.org

11.10 Minimum Financial Solvency Standards
Each delegated Provider must maintain adequate financial resources to meet its obligations as they become due. Delegated Providers contracted with L.A. Care must be solvent at all times, and maintain the following solvency standards:

1. PPG and its affiliates will estimate and document on a monthly basis the organization’s liability for incurred, but not reported (IBNR) claims. The monthly IBNR can be estimated using a lag study, an actuarial estimate, or other reasonable method.
2. PPG and its affiliates must maintain, at all times, a positive working capital (current assets net of related party receivables less current liabilities).
3. PPG and its affiliates must maintain, at all times, a positive Tangible Net Equity (TNE).
4. PPG and its affiliates must maintain a "Cash to Claims Ratio" of 0.75.
5. PPG and Capitated Hospitals prepare and submit quarterly financial statements within 45 calendar days after the close of each quarter end.
6. PPGs prepare and submit annual audited financial statements within 150 calendar days after the close of each fiscal year.
7. Capitated Hospitals prepare and submit annual audited financial statements within 180 calendar days after the close of each fiscal year end.
8. Capitated Hospitals must maintain at all times a positive Operating Margin (operating income (loss) / total operating revenues).

11.10.A On a discretionary basis, the L.A. Care Financial Compliance Department, federal or state agencies, have the right to periodically schedule audits. This is to ensure compliance with financial solvency, insurance requirements, Centers for Medicare and Medicaid Services (CMS), and regulations per the California Code of Regulations. Financial solvency standards apply to the entity as a whole. Therefore, audits will be conducted for all books of business. This includes those LOB(s) not contracted with L.A. Care. The Provider must facilitate access to the records necessary to complete the audit. Other document requests may include the Provider’s annual audited financial statements and annual profit and loss (P&L) statements.

11.10.B Delegated Providers must actively monitor its affiliated network of Providers to measure their financial stability. Copies of all reports, including findings, recommendations, CAPs, and other information regarding these reviews must be provided to the L.A. Care Financial Compliance Department quarterly. If requested, these financial documents and any other required reports will be made available to CMS, DMHC, DHCS and any other regulatory agencies.

11.10.C Providers shall also immediately notify L.A. Care if an affiliated Provider is unable to meet its financial obligations and shall forward any findings, recommendations, reports, and other information as requested by L.A. Care. Requested items should be submitted in writing to the L.A. Care Financial Compliance Department within 30 days as stated in their agreement with L.A. Care and should include the following:

1. Details of the failing financial condition
2. The CAP to address the financial condition
3. Timeline to accomplish the deficiency
4. Most current financial statements

11.10.D In the event the delegated Provider discovers that any of its affiliates experienced any event which materially alters the affiliates’ financial situation or threatens its solvency, the delegated Provider must notify L.A. Care no later than five (5) business days from discovery.

11.11 Insurance
Delegated Providers are responsible for the total costs of care rendered to Members.

11.11.A Each Provider must maintain adequate insurance as follows:
1. **Directors and Officers Insurance:**
   PPGs must purchase a Directors and Officers (D&O) policy coverage for claims made against directors and officers of the company and must be written on a claims made basis. Minimum liability limits are $100,000 for each claim and $100,000 in aggregate for each policy period.

2. **Errors and Omissions Insurance:**
   PPGs must purchase Errors and Omissions (E&O) Insurance that covers managed care activities. The insurance policy shall be written on a claims made basis. Minimum liability limits are $100,000 for each claim and $100,000 in aggregate for each policy period.

3. **General Liability Insurance:**
   PPGs must have a policy in force for General Liability Insurance which is maintained at minimum amounts acceptable to L.A. Care. This covers any property loss not covered under any lease agreement with the landlord or contract agreement with the management company. Minimum liability limits are $100,000 for each claim and $300,000 in aggregate under each policy period.

   Capitated Hospitals must have a commercial general liability (Board Form Coverage) in amounts and in a form necessary to reasonably protect against loss from claims arising out of Hospital's business activities.

4. **Professional Liability Insurance:**
   Delegated Providers must purchase and have a policy in force for Professional Liability Insurance for each affiliated Provider.

   For PPGs, the coverage must cover limits of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate for the year of coverage or such other amount acceptable and permitted by L.A. Care in writing.

   As an alternative the Provider may purchase a Federal Tort Claims Act (FTCA). In lieu of acquiring Professional Liability Insurance, the Provider may submit to L.A. Care with evidence of liability protection under the FTCA by the Bureau of Primary Health Care in accordance with the Public Health Service Act. However, the Provider must ensure that only those covered under Professional Liability or the FTCA render services to Members.

   For Capitated Hospitals, the coverage must cover limits of not less than $5,000,000 per occurrence and $10,000,000 in aggregate for the year of coverage. Hospital’s Professional Liability Insurance shall be either “claims made” or “per occurrence” at the discretion of the Hospital; provided that if Hospital elects “claims made” coverage, it shall provide tail coverage upon the expiration or termination of its contract with L.A. Care with such commercially reasonable limits and for such commercially reasonable time period as the parties mutually agree.

5. **Stop-Loss Insurance:**
   The Provider will acquire Stop-Loss Insurance in effect to adequately cover the PPG or Provider catastrophic cases in a reasonable amount acceptable to L.A. Care and in accordance with the applicable laws, regulations, and industry standards. Minimum coverage is set at $30,000 plus 50% of any medically necessary billed charges.
6. **Independent Certified Public Accounting (CPA) Firm Liability Insurance:**
   The PPG must engage a CPA firm with adequate Liability Insurance. The PPG will verify that the independent CPA firm conducting its financial statement audit maintains Professional Liability Insurance. The CPA firm must at minimum maintain $250,000 Professional Liability in aggregate, at its own expense throughout the term of this agreement and for the year of coverage. Any other amount of coverage must be acceptable to and permitted by L.A. Care in writing.

**11.11.B** Providers must send copies of the insurance policies within five (5) business days of a written request by L.A. Care.

**11.12 License**
The Provider must obtain an AM Best rated coverage, A- or greater, from a California licensed insurer. L.A. Care must be listed as an additional insured party. When requested in writing by L.A. Care, the Provider or affiliate will return a copy of the insurance certificate within five (5) business days and return certificates to the L.A. Care Financial Compliance Department.

**11.13 For More Information**
For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at ProviderRelations@lacare.org.

*For information tailored to our Direct Network Providers,*

*please reference the Direct Network Contracted Provider Reference Guide.*
Chapter 12 – Claims and Payment

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

12.0 Introduction
The L.A. Care Health Plan (L.A. Care) Claims Department works with key stakeholders to record, review, and process formal requests for payment in order to pay the Provider appropriately for the care they provide to L.A. Care Members.

Key responsibilities include:

- Verification of services
- Verification of claim validity
- Determination of whether the cost of a procedure is covered
- Reviews resubmitted claims
- Researches questions involving billing, care and treatment

Main functions include:

- Processing, auditing, and adjusting all professional and facility medical claims, provider disputes, prepayment, and post payment audits
- Troubleshooting claims that have been identified as needing additional work in the areas of referral authorization and contracting or Provider set-up
- Ensuring that claims are processed in line with L.A. Care policies, contracts, and regulatory guidelines
- Filing the required Quarterly Claims Settlement Practices Report Summary

For more information on Claims, please visit: https://www.lacare.org/providers/claims-edi/submitting-claim

12.1 Member Eligibility and Claim Status
L.A. Care makes it easy for Providers to check Member eligibility and verify claim status.

All Providers should verify Member eligibility at the point of service and all services are subject to eligibility on the date of service. Verification of an individual’s membership and eligibility status is necessary to assure that payment is made to the Provider or affiliate for health care services rendered.

12.1.A Member eligibility confirmation and/or verifying the status of a claim can be conducted in two (2) ways:

- L.A. Care Provider Portal
  1. Register for access to the Provider Portal here: https://www.lacare.org/providers/provider-central/la-care-provider-central
2. Sign-in to the Provider Portal at: [https://www.lacare.org/](https://www.lacare.org/)

3. From menu, select option: **Member Eligibility Verification**

4. Complete the Member information marked with an asterisk, as required

5. Click: **Submit** to disclose Member eligibility information

6. Please note: Providers can also check claim status from the same menu options

7. From menu, select option: **Search All Claims** or **Search a Claim**

8. Enter requested claim information marked with an asterisk, as required

9. Click: **Submit** to see claim status

- **L.A. Care Provider Solution Center** at (866) 522-2736

  1. Select option: one (1) for **Eligibility**, two (2) for **Claims Status**, three (3) for **Payment Dispute**, four (4) for **Prior Authorization**, and five (5) for **Contracting**

  2. Follow Interactive Voice Response (IVR) instructions

  3. Enter requested Member information

  4. IVR will telephonically disclose Member information

  5. For further inquiries, Providers can stay on the line to speak with a representative during business hours: Monday thru Friday (8:00 AM to 6:00 PM PST).

12.2 Claim Forms

To access claim forms, please visit: [https://www.lacare.org/providers/provider-resources/forms-manuals](https://www.lacare.org/providers/provider-resources/forms-manuals) and select **Claim Forms** on the online expanding menu.

Available claim forms include:

- CMS 1500 Claim Form
- CMS 1500 Claim Form - Instructions
- Provider Dispute Resolution Request Form

12.3 Claims Submission (Billing)

In order to ensure timely processing and payment of submitted claims, Providers must complete all the required information as outlined below.

Provider should submit completed claims to L.A. Care with all the required information in one (1) of the two (2) options below:

- Hard Copy (Paper) Claims
- Electronic Claims

12.4 Hard Copy (Paper) Claim Submission

Providers must submit paper claims on the latest CMS 1500 form for professional services and a UB-04 form for facility services. This form is maintained by the National Uniform Claim Committee (NUCC), an industry organization in which the Centers for Medicare and Medicaid Services (CMS) participates.

All paper claims which L.A. Care is financially responsible for should be mailed to the following address:
12.5 Electronic Claim Submission

L.A. Care encourages Electronic Data Interchange (EDI) claim submission. EDI is the electronic interchange of business information using a standardized format and process, which allows a company to send information to another company securely and electronically, rather than on paper.

Advantages of using EDI for submission of claims:

- Ability to submit claims 24 hours a day/seven (7) days a week
- Reduction of data entry and payment errors
- Immediate verification of claims received
- Expedited claims adjudication and payment
- Reduced administrative expenses

12.5.A Two (2) Ways to Submit Claims Electronically

Submitting claims electronically with a clearinghouse is a safe and secure method of submitting claims to L.A. Care.

Electronic billing options:

1. Change Healthcare
   - Change Healthcare is a healthcare technology company that offers services to help simplify billing, collection and payment processes for payers and Providers. L.A. Care has contracted with Change Healthcare to become the exclusive clearinghouse for the submission of all EDI claims at a cost to Providers.
   - To register or for questions regarding the submission process of a claim, Providers can call the Change Healthcare Customer Support line at (877) 363-3666 or visit: https://www.changehealthcare.com/
   - Please note: L.A. Care’s Payer ID: LACAR

2. 3rd Party Billing Service or Clearinghouse that bills directly through Change Healthcare

For more information on EDI or claims information, please visit: https://www.lacare.org/providers/claims-edi/submitting-claim

12.6 Electronic Funds Transfer (EFT) – Direct Deposit

Electronic funds transfer (EFT) is the electronic transfer of money from a bank account to another, either within a single financial institution or across multiple institutions. Otherwise known as “direct deposit.”

Advantages of using EFT for claims payments:

- Faster payments
Universal Provider Manual
Serving Los Angeles County

- Electronic payments (including capitation/incentives)
- Same-day access to funds
- No lost or stolen checks
- Access to the Electronic Remittance Advice (ERA)

For general questions or concerns about EFT, Providers can email: EDI_Shared_Services@lacare.org

12.7 PaySpan Health
L.A. Care has partnered with PaySpan Health to offer a solution that delivers EFT or automated clearinghouse (ACH), ERA, analytics, and much more. This solution gives Providers access to remittance and claims details online, and a straightforward reconciliation of payments to reduce costs and improve cash flow. Providers interested in receiving their payments by direct deposit should register with PaySpan Health. For first time users, a registration code will need to be requested before the registration process can be completed.

To request a new registration code:

1. PaySpan Registration Code: https://www.payspanhealth.com/ProviderPortal/Registration

After registration, Providers should log into their account and follow the steps below to add L.A. Care as a new payer to their account.

1. Log into your PaySpan Health account
2. Click: Your Payments
3. Click: Reg Codes under the Manage Panel
4. The Manage Reg Codes screen will display
5. Click: Manage Preferences button on the right side of the page
6. Use the drop-down menu to designate a Preferred Account for all tax ID numbers listed
7. User must have Manage Reg Codes feature in order to access this manage preferences button

Providers should allow 10 business days for full activation and initiation of EFT/ERA receipt. For questions or issues, Providers can call PaySpan Health at (877) 331-7154 to speak to a Provider Services Specialist.

12.8 Claim Billing Requirements and Resources
Before L.A. Care can process a claim, it must include all the required information and be “clean” of any errors. Providers can use the following documents as a guide to identify the requirements for a clean claim submission.

To view the clean claim billing and coding requirements, Providers can select the following links:

- Clean Claims Billing CMS 1500 Form: https://www.lacare.org/sites/default/files/Clean%20Claim%20Billing%20Requirements%20CMS%201500%20PDF.pdf
- Clean Claims Billing UB-04 Form: https://www.lacare.org/sites/default/files/clean_claim_billing_requirements_ub_04_20190425.pdf
12.8.A Claims must include information and/or guidelines as indicated by the following websites:

<table>
<thead>
<tr>
<th>Regulatory Agency or Organization</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid Services (CMS)</td>
<td><a href="https://www.cms.gov/">https://www.cms.gov/</a></td>
</tr>
<tr>
<td>Department of Health Care Services (DHCS)</td>
<td><a href="https://www.dhcs.ca.gov/">https://www.dhcs.ca.gov/</a></td>
</tr>
<tr>
<td>Department of Managed Health Care (DMHC)</td>
<td><a href="https://www.dmhc.ca.gov/">https://www.dmhc.ca.gov/</a></td>
</tr>
<tr>
<td>National Uniform Billing Committee (NUBC)</td>
<td><a href="https://www.nubc.org/">https://www.nubc.org/</a></td>
</tr>
</tbody>
</table>

12.9 Timely Filing
Submitted claims must be completed with all required information to ensure timely processing and payment as stipulated in the Provider’s agreement.

Timely filing of a claim is a claim submitted accurately for authorized Provider services to L.A. Care as soon as possible, but no later than the timeframes provided below unless otherwise specified by L.A. Care.

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Timely Filing Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC</td>
<td>Within 365 days from the date of service</td>
</tr>
<tr>
<td>LACC/D</td>
<td>Within 180 days from the date of service</td>
</tr>
<tr>
<td>MCLA</td>
<td>Within 180 days from the date of service</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>Within 180 days from the date of service</td>
</tr>
</tbody>
</table>

Failure to submit a claim timely could result in the denial of a claim, unless the Provider can demonstrate good cause for the delay in timely submission.

12.10 Claim Processing Timeframes
L.A. Care Providers who are responsible for processing claims should process a clean claims payment according to the guidelines specified by CMS, DHCS, and DMHC, and within the timeframes provided below:

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Timely Processing of a Clean Claim</th>
<th>Regulatory Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC</td>
<td>30 calendar days</td>
<td>CMS and DHCS</td>
</tr>
<tr>
<td>LACC/D</td>
<td>45 working days</td>
<td>DHCS and DMHC</td>
</tr>
<tr>
<td>MCLA</td>
<td>30 to 45 working days</td>
<td>DHCS and DMHC</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>45 working days</td>
<td>DHCS and DMHC</td>
</tr>
</tbody>
</table>

12.11 Claims Timeliness Report
Providers will submit a self-reported Monthly and Quarterly Claims Timeliness Report to L.A. Care for each contracted line of business (LOB). The monthly Claims Timeliness Report is due 15 calendar days after the
prior month. The quarterly Claims Timeliness Report is due within 30 calendar days after each quarter. Delegated payer’s principal officer(s) must sign or personally transmit those reports to L.A. Care. The reports must include a statement attesting to the accuracy of the information.

If the aggregate results for the quarter do not meet or exceed the on-time standard for the LOB, then the Days Receipt on Hand (DROH) must be reported and a corrected action plan (CAP) must be attached.

Please submit these reports electronically to AB1455ClaimsReportetal@lacare.org.

12.12 Misdirected Claims

Misdirected claims are claims submitted to another entity other than L.A. Care. Erroneously misdirected claims should be submitted to L.A. Care within 10 working days via US mail or electronic submission. The Provider should include a written confirmation of the original claim and the date it had knowledge of the misdirection.

Misdirected claims received by L.A. Care that are the financial responsibility of one (1) of L.A. Care’s delegated entities will be forwarded to the appropriate delegate within 10 working days. For claims forwarded to delegates, the date of receipt shall be the working day when the claim is first delivered to the delegate as the party responsible for adjudicating and paying the claim. The exception is for CMC: the date of receipt is the date stamped on the claims by L.A. Care.

12.12.A For claims that do not involve emergency services or care, and if the Provider is contracted with a capitated Provider, within 10 working days of receipt, L.A. Care will either:

1. Send the claimant a notice of denial with instructions to bill the capitated Provider, or
2. Forwards the claim to the appropriate capitated Provider

For claims that do not involve emergency services or care, and if the Provider is not contracted with a capitated Provider, within 10 working days of receipt, L.A. Care will forward the misdirected claim to the appropriate capitated Provider.

Providers have two (2) options to submit misdirected claims:

- **By Mail:**
  L.A. Care Health Plan
  Attn: Claims Department
  P.O. Box 811580
  Los Angeles, CA 90081

- **By Electronic Submission:**
  Change Healthcare

For information on how to submit misdirected claims electronically, Providers that have an account with Change Healthcare can visit www.changehealthcare.com or call the Customer Support line at (877) 363-3666.
12.13 Financial Responsibility

L.A. Care uses a delegated model for many of its Providers. The term “delegated model” describes when financial risk for healthcare services is transferred from L.A. Care to health care providers (e.g. physicians or hospitals). For those Providers for which L.A. Care has a delegation agreement, in order to determine who is responsible for paying a claim and to avoid misdirected claims, Providers can refer to Exhibit B, of the Division of Financial Responsibility (DOFR) in their agreement with L.A. Care. The DOFR specifies what entity is responsible for paying a claim.

To view a sample of the Participating Physician Group (PPG) Medi-Cal DOFR, please visit: https://www.lacare.org/sites/default/files/medi-cal-shared-risk-amendment-template.pdf

Irrespective of who is at financial risk for the services rendered, Providers are still responsible for complying with and obtaining prior authorization for services (except Emergency Services), coordinating care, and timely and accurate submission of claims.

For more information on who is the authorized payor, please see the links below:


12.14 Coordination of Benefits

1. Primary Payor
   According to the Coordination of Benefits rule, another payor may be primarily or secondarily responsible for the payment of Covered Services rendered to Members. In those situations, Providers should submit claims in accordance with coordination of benefit rules as follows:

   - Bill a payor that may be the primary under applicable Coordination of Benefit rules for Provider Services provided to Members when information regarding such primary payor becomes available. When another payor besides L.A. Care is primary, Providers should follow the primary payor’s billing rules.
   - If L.A. Care is determined to be the primary payor, L.A. Care will pay the Provider in accordance with the applicable contract, fee schedule, or Usual, Customary, and Reasonable (UCR) rate for services provided to Members without regard to the obligations of any secondary payors. Providers should not seek additional reimbursement from any secondary payors or from Members, except for deductibles, co-payments, or co-insurance amounts owed by Members under the terms of the Member’s benefit plan.
   - For more information on CMS Coordination of Benefits, please visit: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits
   - For more information on Medi-Cal Coordination of Benefits, please visit: Medicare/Medi-Cal Crossover Claims Overview (medicare)
2. Secondary Payor
In the event that L.A. Care is not the primary payor, but rather the secondary payor because of Coordination of Benefits, Providers should submit a clean claim to L.A. Care within 180 calendar days from the date of the primary payor’s determination. In the submission, Providers must include the primary payor’s RA that includes the following:

- Name of Primary payor (ex Noridian)
- Date of Primary payor’s payment
- Amount paid by the primary payor
- Primary payor’s denial that includes denial rational

L.A. Care, as a secondary payor, will coordinate benefits with the primary payor. L.A. Care may pay:

- Deductibles
- Co-insurance and
- Co-payments for covered services up to the lower amount of its fee schedule or the Medicare/other insurance-allowed amount
- Medicare Non-covered services – if covered under Medi-Cal and/or is included in a Provider’s contract or the Member’s evidence of coverage (EOC)
- Welfare and Institutions Code limits Medi-Cal’s payment of the deductible and coinsurance to an amount which, when combined with the Medicare payment, does not exceed the Medi-Cal fee-for-service (FFS) rate

3. Co-Insurance
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 as the secondary payor.

Providers have two (2) options to submit secondary claims:

- **By Mail:**
  L.A. Care Health Plan
  Attn: Claims Department
  P.O. Box 811580
  Los Angeles, CA 90081

- **By Electronic Submission:**
  Change Healthcare

For information on how to submit secondary claims electronically, Providers that have an account with Change Healthcare can visit [www.changehealthcare.com](http://www.changehealthcare.com) or call the Customer Support line at (877) 363-3666.

4. CMC Payments
The following section/sentence is only applicable to (as denoted between the asterisks): Cal MediConnect (CMC)
*For coordination of CMC claims payments, L.A. Care will create a new claim for the Medi-Cal portion for the secondary processing. CMC claims payments will be processed with two (2) Remittance Advice (RA):

- First: Medicare benefits will be processed
- Second: Medi-Cal benefits will cover the final payment

Providers should follow the standard claims processes as outlined throughout this chapter. *

12.15 Fee-for-Service (FFS) Claims

Providers should be aware that some Members who seek services such as referrals for care and treatment, including emergency services, may not be assigned to you, and should not be discriminated against. Provider should administer/arrange applicable and medically necessary and/or authorized services in the same manner as it would another Member seeking care and treatment. Provider should bill the entity that is responsible for payment of Covered Services provided to such Members.

L.A Care will adjudicate all claims for Covered Services rendered on a FFS basis within 30 calendar days or up to 45 working days of receipt of a clean claim, depending on LOB. Should L.A. Care deny a claim, L.A. Care will notify the Provider in writing of the denial and the reasons. The denial should also set forth the appeal process that the Provider may take to seek payment of the claim.

### Line of Business

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>LACC/D</td>
<td>45 working days</td>
</tr>
<tr>
<td>MCLA</td>
<td>30 calendar days, up to 45 working days</td>
</tr>
<tr>
<td>PASC-SEIU</td>
<td>45 working days</td>
</tr>
</tbody>
</table>

12.16 Balance Billing

Balance billing is the practice of billing a Member the difference between the reimbursed amount for a covered service and a higher amount the Provider wants as payment. Balance billing L.A. Care Members is prohibited by law. It includes asking a Member to enter into a private agreement or waiving their right to balance billing protection, charging amounts in excess of the Members cost sharing obligation or other administrative fees. No contracted Provider or affiliate will demand or collect money for covered services except for authorized deductibles, co-payments, co-insurance, or non-covered services agreed to by a Member.

12.16.A Providers are prohibited from billing MCLA Members with the exception of share of cost (SOC). Providers are prohibited from balance billing CMC Members, as they have no financial liability. Providers can only bill LACC/LACCD/PASC-SEIU Members for authorized deductibles, co-payment, co-insurance, or non-covered services agreed to by a Member.

Providers who engage in balance billing may be subject to sanctions by L.A. Care, CMS, DHCS, and other industry regulators.

For more information on financial topics, please refer to Chapter 11 – Finance.
12.17 Share of Cost (SOC)

The following section/sentence is only applicable to (as denoted between the asterisks):
L.A. Care Medi-Cal (MCLA).

* A Share of Cost (SOC) is the amount of money an individual is responsible to pay towards their medical related services, supplies, or equipment before Medi-Cal will begin to pay.

Providers should perform an eligibility verification transaction every month for each Medi-Cal recipient residing in a facility. The monthly eligibility verifications transaction will show how much the Member’s monthly SOC is, if applicable. This is the amount a Member must pay for the month. If a Member has not spent any of the SOC in the month, the facility should bill the Member for the entire SOC.

12.17.A Share of Cost (SOC) for Non-Covered Services

Members that have spent their part of the SOC on “non-covered” medical or remedial services or items, the facility is to subtract those amounts from the Member’s SOC and bill the Member in an amount equal to the Member’s remaining SOC. Medical expenses incurred during the month by new Members while outside the facility, may also reduce the amount which that facility bills to the Member. *

12.18 Overpayments

From time to time, L.A. Care will audit its claims payments to ensure compliance with applicable laws, rules, regulations, policies and procedures, including ensuring compliance with coordination of benefits, fraud, waste and abuse, and third party liability. If L.A. Care has paid a claim in error, L.A. Care shall have the right, upon prior written notice, to recoup such amounts from future payments.

Upon identification of an overpayment or “finding,” a detailed notice is generated identifying the discovery, as well as the reason for the finding and is sent to the Provider. The detailed letter includes options for the Provider regarding refunds and/or retraction.

12.18.A To redress overpayments itemized in an Improper Payment Findings notice, Providers should reply to L.A. Care within 30 working days of receipt to acknowledge and reimburse the stated overpayments.

A non-response from a Provider within 30 working days, shall:

- Constitute an acceptance of the overpayment details provided in the Improper Payment Findings notice
- L.A. Care shall deduct from future payments, and/or pursue any remedies to collect the overpayments
- All such offset details will be included in every applicable RA accompanying prospectively adjudicated claims

Providers who wish to avoid any such offsets against future claims, should reimburse the total overpayment amount noted in the Improper Payment Findings notice by mailing a check with a copy of the letter they received to:
Should a Provider agree to have the overpayment amounts deducted from future claims payments, they should sign and date the Improper Payments Findings notice and a copy of the letter should be faxed to L.A. Care at:

- **By Fax:**
  (213) 438-5058

Providers who wish to dispute the overpayments identified in the Improper Payments Findings, can send a written dispute, along with any supporting documentation to L.A. Care by fax or US mail at:

- **By Fax:**
  (213) 438-5057
- **By Mail:**
  L.A. Care Health Plan
  P.O. Box 811610
  Los Angeles, CA 90081

For questions or concerns, Providers can call the L.A. Care Provider Solution Center to discuss their options.

- **Phone:**
  Provider Solution Center at (866) 522-2736, option three (3) for **Payment Disputes**

### 12.19 Provider Dispute Resolution (PDR)

A Provider dispute is a written notice challenging, appealing or requesting reconsideration of a claim's initial determination. Providers have a right to file a dispute in writing to L.A. Care within 365 calendar days of the health plan's last action or, in the case of inaction, within 365 calendar days after the time for contesting or denying claims has expired.

L.A. Care makes available to all Providers a fast, fair and cost-effective dispute resolution mechanism in relation to the following payment determinations and contracted or non-contracted Provider issues.

L.A. Care will consider the following claims:

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

Providers should submit a written notice to L.A. Care via US mail or another physical delivery for a dispute relating to the adjudication of a claim or a billing determination.
Disputes can be sent to the following address:

- **By Mail:**
  L.A. Care Health Plan  
  Attn: Provider Disputes  
  P.O. Box 811610  
  Los Angeles, CA 90081

**12.19.A Acknowledgment of Receipt of Dispute**
Upon receipt, L.A. Care will review the claim dispute and provide a response via US mail within 15 working days of the date of receipt by L.A. Care. Electronically submitted claim disputes will be acknowledged within two (2) working days.

**12.19.B Dispute Determinations**
L.A. Care will issue a written determination stating the outcome decision for its determination within 45 working days after the receipt of a clean dispute.

**12.19.C Required Information for Provider Payment Dispute Notices**
Should a Provider have a dispute with L.A. Care in connection with a claim payment, the Provider can first submit a written notice to L.A. Care’s Provider Disputes.

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 notice identifying the missing information necessary to consider the dispute.

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

1. Provider name, the tax identification number under which services were billed and contact information.
2. 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.
3. If the payment dispute is not about a claim, a clear explanation of the issue and the Provider’s position on the issue should be provided.
4. If the payment dispute involves a Member or a group of Members, the name(s) and Member ID number(s), or Client Identification Number(s) (CIN) of the Member(s).
5. Second Level Disputes must state, “Second Level Dispute” and include a copy of the first level dispute filing and determination.

Providers should 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.
12.19.D Second Level Disputes

If Providers remain unable to resolve their billing and payment issues, L.A. Care makes available to all Providers, a second level dispute process. A second level dispute can be submitted within 365 calendar days from the last action date. Second level disputes must include a copy of the first level dispute filing and determination from the delegated entity.

Second level disputes must be sent to the following address:

- By Mail:
  L.A. Care Health Plan
  Attn: Provider Disputes
  P.O. Box 811610
  Los Angeles, CA 90081

L.A. Care will acknowledge receipt of disputes by mail within 15 working days of the date of receipt by L.A. Care, and a written determination stating the outcome decision for its resolution will be sent to the Provider within 45 working days after the receipt of a clean dispute.

12.20 Capitation (Cap) Deduct Dispute Process

Providers may submit a Capitation (Cap) Deduct request to L.A. Care when they are in receipt of a denial from one (1) of L.A Care’s delegates and/or an underpayment is made for a service that is the financial responsibility of a delegated entity.

12.20.A Cap Deduct disputes should be submitted on a Provider Dispute Form and must be Labeled “Cap Deduct Request” and include the following:

- Claim Image
- Explanation of benefits (EOB) stating L.A. Care is Financially responsible (misdirected claims)
- Additional supporting document such as proof of timely filing, medical records for Utilization Management (UM) review, 1st level dispute determination.

12.20.B Cap Deduct Disputes will be validated based on the information provided. If a Cap Deduct is valid, then L.A. Care will proceed with sending a 10-day capitation deduction letter to the delegated entity:

- If L.A. Care does not receive a response within 10 working days, the claim will be processed and a Cap Deduct written determination will be issued to reflect the outcome.
- If the claim is processed by the delegated entity, the written determination will reflect the outcome.
- If additional information is requested by the delegate, the Cap Deduct dispute will be upheld and will be forwarded to the delegated entity.

12.20.C L.A. Care will acknowledge the Cap Deduct Dispute by mail within 15 working days of the date of receipt by L.A. Care, and a written determination stating the outcome of the decision will be sent to the Provider within 45 working days after the receipt of a clean dispute.

Cap Deduct Disputes must be sent to the following address:
12.21 Capitated Provider - Claims Dispute
The following section/sentence is only applicable to (as denoted between the asterisks): Participating Physician Group (PPG) and Capitated Hospitals.

*Capitated Providers, such as a PPG, should establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted Provider disputes that, at a minimum, provide the following:

1. Provider disputes should be submitted utilizing the same number assigned to the original claim
2. Contracted Provider disputes should be submitted in a manner as outlined in the Provider’s contract with L.A. Care
3. Non-contracted Provider disputes should be submitted in a manner consistent with the directions for obtaining forms and instructions for filing a Provider dispute attached to the L.A Care Capitated Provider’s notice that the claim was denied or adjusted *

12.22 Appeals and Grievance Process for Claims Dispute
If a Provider is delegated for appeals and grievance processing, the Provider will implement an appeals and grievance process for review of the Provider and Member claims disputes that comply with the time limits and other regulatory requirements.

The dispute procedure and any amendments must be approved by L.A. Care and meet CMS, DHCS, and DMHC regulatory requirements, as appropriate.

If not delegated for appeals and grievance processing, the Provider will promptly forward any grievance or appeals to the L.A. Care Appeals and Grievances Coordination Unit.

- By Mail:
  L.A. Care Health Plan
  Attn: Appeals & Grievances Coordination Unit
  P.O. Box 811640
  Los Angeles, CA 90081

For more information on grievances, please refer to Chapter 18 – Appeals and Grievances.

12.23 Third Party Tort Liability (TPL) and Estate Recovery
Third Party Tort Liability (TPL) means the responsibility of persons other than the contractor or the Member for payment of claims for injuries or trauma sustained by Members. Providers that discover or become aware of a potential TPL case, should work with L.A. Care to coordinate its recovery activities.

Accidents or illnesses, which may result in TPL or estate recovery, should be reported by the Provider to L.A. Care within five (5) business days of the discovery being made.
12.23.A Should L.A. Care request details of the services provided, the Provider will submit the following information within 15 days of the date of the request and will include the following information:

1. Member name
2. CIN
3. Social Security number
4. Date of birth
5. Provider name
6. Date(s) of service
7. Diagnosis code and/or description of illness/injury
8. Procedure code and/or description of services rendered
9. Amount billed by a subcontractor or out-of-plan Provider to PPG (if applicable)
10. Date of denial and reasons (if applicable)

12.23.B In the event that a Provider receives any request by subpoena from attorneys, insurers, or beneficiaries for copies of bills, the Provider will furnish L.A. Care with a copy of any document released within five (5) days of the release.

Providers will send the following information to L.A. Care:

- Name of requesting party
- Address
- Contact number

No Provider should attempt to recover a TPL or estate recovery for an L.A. Care Member.

12.24 For More Information

For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at ProviderRelations@lacare.org or call the Provider Solution Center at (866) 522-2736.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 13 – Encounters

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

13.0 Introduction
The L.A. Care Health Plan (L.A. Care) Encounter Data is the information submitted by health care Providers that documents both the clinical conditions they diagnose and the services and items delivered to L.A. Care Members to treat these conditions.

Providers are responsible for gathering, processing, and submitting Encounter Data in a timely, accurate and complete manner for the services provided to their Members.

13.1 FinThrive (formally TransUnion Healthcare)
Measuring care quality is necessary, and errors in Encounter Data documentation, even minor ones, can result in claims denials, Provider payment delays, and duplicate work. To assist Providers with the proper formatting, as well as timely and accurate submissions of their Encounter Data, L.A. Care has contracted with FinThrive, a data clearinghouse company.

Provider Encounter Data must be submitted electronically following the Encounter Data specifications established by FinThrive. Providers must submit Encounter Data directly to FinThrive.

FinThrive is offered by L.A. Care to its contracted Providers, free of charge.

13.2 Submitting Encounter Data
Complete, accurate, and timely Encounter Data is key for determining needed changes and improvements in health related programs. L.A. Care also uses Encounter Data for monitoring and oversight functions including Healthcare Effectiveness Data and Information Set (HEDIS) reporting, capitation rate development, and for meeting various regulatory requirements.

When a Provider uses FinThrive (formally TransUnion Healthcare) to process its Encounter Data, FinThrive Healthcare will convert the Provider’s Encounter Data into the appropriate format to meet L.A. Care’s specifications.

13.2.A To use FinThrive services, Providers are required to:

1. Submit Encounter Data to FinThrive within the parameters required by FinThrive
2. Submit their Encounter Data at least once a month
3. Submit data using the National Standard Codes; L.A. Care will only accept the National Standard Codes
Providers shall not:

1. Submit encounters derived from denied claims
2. Report any misdirected claims as encounters to L.A. Care to avoid encounters being rejected as duplicates. The entity responsible for payment per Division of Financial Responsibility (DOFR) should be responsible for reporting the encounter to L.A. Care.

13.2.B To get started and for more information on FinThrive (formally TransUnion Healthcare), please reach out to the L.A. Care FinThrive representative:

- **Account Executive:**
  Doris Bermejo – Senior Consultant, Business Operations

- **By Phone:**
  (310) 337-8511

- **By Email:**
  [Doris.Bermejo@finthrive.com](mailto:Doris.Bermejo@finthrive.com)

- **By Website:**
  [https://finthrive.com/](https://finthrive.com/)

13.3 For More Information

For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at [ProviderRelations@lacare.org](mailto:ProviderRelations@lacare.org).

*For information tailored to our Direct Network Providers, please reference the [Direct Network Contracted Provider Reference Guide](#).*
Chapter 14 - Marketing

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

14.0 Introduction

The L.A. Care Health Plan (L.A. Care) Marketing Department involves creating, communicating, and delivering health information and interventions using Member-centered strategies to protect and promote the health of diverse populations.

L.A. Care will develop and coordinate the distribution of educational materials focused on program benefits as well as improving Members’ overall health status and disease management. Materials will also be designed to increase awareness and choice of L.A. Care.

14.1 Marketing Activities and Standards

Contracted Providers that want to create and use marketing materials and/or conduct marketing activities, shall receive prior approval from the L.A. Care Compliance, Material Review (CMR) Unit before working with the Marketing Department to design and implement marketing materials and/or activities. The Provider shall submit the materials to the L.A. Care CMR Unit at MMCommunications@lacare.org. For information on the L.A. Care CMR reviewing timeframes, including timeframes when review of a regulatory agency is required, please see section below for Review Process and Timeframes specifications.

14.1.A Marketing materials include any informational materials that perform one (1) or more of the following actions:

- Promotes an organization
- Provides enrollment information for an organization
- Explains the benefits of enrollment in an organization
- Describes the rules that apply to enrollees in an organization
- Explains how Medicare or other services are covered under an organization, including conditions that apply to such coverage
- Communicates various membership operations policies, rules and procedures

Marketing materials also include materials that are produced in various mediums, by or on behalf of L.A. Care, its employees, network Providers, agents or contractors that can reasonably be interpreted as intended to market the plan to potential enrollees. Marketing materials are generally distributed to L.A. Care’s entire service area.

14.1.A.1 All marketing and/or Member outreach materials, developed by the Provider, requires submission to the L.A. Care CMR Unit for review and approval prior to use.

The marketing and/or Member outreach material submission requires the following:
1. Final/Clean content in Word format
2. Reading level assessment – material must be at a 6th grade reading level or below.

   Please note: Requests without the readability results will not be processed until the assessment is provided.

3. For Revised materials (previously approved material that require revisions) – submission must include a final/clean version and redline version that has the track changes to reflect changes.

   Please note: Revised material submissions without a redline version will not be processed until the redline version is provided.

14.1.A.2 Review Process and Timeframes

- The assigned CMR, Compliance Advisor will process the material submission within seven (7) business days from the date of receipt.
- CMR, Compliance Advisor will determine if material submission is required to be submitted to regulatory agencies based on contract requirements and/or other applicable regulations.
- Provider(s) will be notified when materials are approved by L.A. Care and/or the approving regulatory agencies. Please see below for specific approval timeframes per entity after L.A. Care’s submission, if required:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS</td>
<td>45 calendar days</td>
</tr>
<tr>
<td>DHCS</td>
<td>60 calendar days</td>
</tr>
<tr>
<td>DMHC</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>L.A. Care</td>
<td>07 business days</td>
</tr>
</tbody>
</table>

14.1.B 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 logo. Should a Provider desire to use the L.A. Care name or logo and upon obtaining approval from CMR, the Provider shall submit a request to the L.A. Care Sales & Marketing Department via email at HealthPlanFieldRepresentative@lacare.org.

14.1.B.1 The email request should include the following:

1. Provider’s office manager name or Participating Physician Group (PPG)
2. Purpose of request or campaign
3. Line of business (LOB)
4. Contact name
5. Phone number
6. Email address

Upon receipt, the Marketing department will review the request and send an approval or denial via email to the Provider.
### 14.2 Marketing Guidelines for Providers

The CMR Unit 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 system.

#### 14.2.A

The purpose of this section is to ensure that all marketing materials used by L.A. Care’s Providers have been approved by Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and/or Department of Managed Health Care (DMHC) as applicable.

#### 14.2.B

“Do’s and Don’ts” marketing guidelines include the following:

<table>
<thead>
<tr>
<th>Do’s:</th>
<th>Don’ts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and follow all of L.A. Care’s marketing policies and procedures.</td>
<td>Don’t engage in marketing activities or use materials without prior written approval from L.A. Care and the appropriate regulating agency.</td>
</tr>
<tr>
<td>Forward to L.A. Care a letter of agreement or a Memorandum of Understanding (MOU) regarding intended marketing activities taking place on the premises or any other facility.</td>
<td>Don’t misrepresent your business, yourself, or L.A. Care or any health care agency or health plan through false statements or claims, or misrepresent or disparage the program or other health plans.</td>
</tr>
<tr>
<td>Submit all potential marketing materials and planned activities to the L.A. Care Sales &amp; Marketing Department to secure necessary approval prior to implementation.</td>
<td>Don’t mislead enrollees to entice them to select a specific doctor or medical facility. Don’t make disparaging written/oral statements aimed at competitors – including the use of false performance data for comparison.</td>
</tr>
<tr>
<td>Ensure the language and information used in marketing materials is clear, simple (at 6th grade reading level or below) and communicates that enrollees have choices.</td>
<td>Don’t make claims that a health plan or medical facility has been endorsed or recommended by L.A. Care, a governing agency or organization that has not certified its endorsement in writing.</td>
</tr>
<tr>
<td>Ensure marketing efforts are done appropriately within outlined guidelines and do not violate governing regulations.</td>
<td>Don’t offer monetary or incentives to prospects as an enticement to enroll with a contracted health plan or to become a patient at your medical facility. Don’t engage in marketing activity on any unauthorized premises.</td>
</tr>
<tr>
<td>Provide L.A. Care with substantial time for (internal and appropriate regulators) review of material submissions and approval. Ensure that materials accurately describe the program and Provider involvement.</td>
<td>Don’t coerce, intimidate, or threaten prospects into enrolling with a health plan or to choose your medical facility.</td>
</tr>
<tr>
<td>Ensure L.A. Care marketing materials are available for distribution to Members or prospective Members.</td>
<td>Don’t allow staff or pay independent agents to engage in door-to-door marketing or solicit via phone or mail to enroll with a health plan or to select your facility.</td>
</tr>
<tr>
<td>Ensure that staff involved in marketing material development and activities are trained and have a copy of the marketing policies and procedures.</td>
<td>Don’t engage in marketing practices that discriminate against prospective Members based on race, creed, color, marital status, religion, age, sex, national origin, sexual orientation, ancestry, pre-existing physical or mental handicap or health status.</td>
</tr>
<tr>
<td>Ensure that staff who come in contact with L.A. Care Members have had appropriate marketing training and understand guidelines, set forth by L.A. Care and regulatory agencies.</td>
<td>Don’t use information that has derogatory language, comments or implications or that makes misleading comparisons. Also, do not use any satisfaction or “Best Plan” data that is not substantiated by a credible third party and that is solely based on the contracting plan’s assessment of itself and competitors.</td>
</tr>
</tbody>
</table>
For detailed information regarding CMS and Covered California marketing guidelines, please visit:

- [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines)
- [https://www.coveredca.com/agents/marketing-and-branding/](https://www.coveredca.com/agents/marketing-and-branding/)

### 14.3 Failure to Comply

L.A. Care may impose sanctions on a Provider for any violation of the terms and conditions of this section or contract, in accordance with marketing guidelines from CMS, DHCS, and/or DMHC.

**14.3.A** If a Provider fails to request an approval for the use of L.A. Care’s name, material, or logo, the Provider may be subject to the consequences of non-compliance.

For questions or concerns regarding marketing restrictions as they apply to the use of L.A. Care’s name or logo, Providers can contact the L.A. Care Sales & Marketing Department via email at HealthPlanFieldRepresentative@lacare.org.

### 14.4 Publications Produced by L.A. Care (for Providers)

L.A. Care is committed to providing its contracted Providers with the latest information about policy and regulatory changes, education and training opportunities, as well as updates on clinical best practices.

**14.4.A** For more information, Providers can find L.A. Care’s latest e-newsletters and publications on the L.A. Care website here:

- **Progress Notes** – is a quarterly print newsletter. Articles cover industry changes, health trends and new resources for Providers.
- **The Pulse** – is a bi-monthly email newsletter offering health news and information relevant to a Provider’s practice and Members.
- **Health Advisories** – news alerts and health advisories within Los Angeles County, especially those related to COVID-19.

### 14.5 For More Information

For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at ProviderRelations@lacare.org.

For information tailored to our Direct Network Providers, please reference the [Direct Network Contracted Provider Reference Guide](#).
Chapter 15 – Compliance Program Integrity

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

15.0 Introduction
The L.A. Care Health Plan (L.A. Care) Compliance Department is focused on providing exceptional service to our Members, Providers, and regulators. The Compliance Department includes:

- Internal Audit
- Privacy
- Regulatory Affairs and Governance
- Regulatory Reporting
- Risk Management and Operations Oversight and Business Continuity

The Compliance Department is focused on serving Members and Providers through:

1. Attention to contracts and other standards issued by regulatory agency requirements and;
2. Training programs, audits and monitoring activities, risk management, planning, and investigations.

For more information on Provider Policies and Compliance, please visit: https://www.lacare.org/providers/provider-resources/policies-compliance

15.1 Program Integrity Plan
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. Additionally, L.A. Care recognizes the importance of preventing, detecting, and investigating Fraud, Waste, and Abuse (FWA). These responsibilities are delegated to the Program Integrity Department, which includes the Special Investigation Unit (SIU), whose mission is to maintain adherence to the L.A. Care Anti-Fraud Plan to ensure the integrity of publicly funded programs.

15.2 Special Investigation Unit (SIU) Role 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 healthcare fraud investigators and subject matter experts who represent the following areas within the organization including, but not limited to, Legal Services, Compliance, Health Services, Finance, Claims, Member Services, Pharmacy and Formulary, and Credentialing. L.A. Care’s SIU’s goals are to organize and implement an anti-fraud strategy to identify and reduce costs to the plans, Providers, subscribers, enrollees, and others caused by fraudulent activities. The SIU also seeks to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. In addition to the SIU’s efforts to protect and preserve the integrity and availability of health care resources.
care resources for L.A. Care Members, stakeholders, and business partners, it also coordinates anti-fraud activities between L.A. Care and its Providers and the First Tier, Downstream, and Related Entities (FDRs) of its Providers.

### 15.3 Role of the Provider and Special Investigation Unit (SIU)

The SIU conducts audits of Providers, suppliers, or other healthcare service delivery entities to determine if services reimbursed are supported by documentation, which may include an assessment of clinical criteria and/or validating that appropriate coding was utilized. These audits typically involve either a medical records request or an unannounced on-site visit.

#### 15.3.A Medical Records Request

When deemed necessary for vetting an allegation or complaint under investigation, the SIU will conduct Provider, supplier, or other healthcare delivery entity audits to determine if services reimbursed are supported by documentation, are medically necessary, or are correctly coded. The SIU will request medical records from health care Providers, suppliers, and other healthcare delivery entities to support this endeavor. The medical records should be sent to the SIU within seven (7) business days from the date of request.

Medical records may include but are not limited to the following:

- Diagnostic reports
- Lab results
- Office visit notes
- Prescriptions
- Prior authorization forms
- Progress notes

#### 15.3.B Unannounced On-Site Inspection

When deemed necessary for vetting an allegation or complaint under investigation, the SIU may conduct an unannounced on-site visit. The SIU investigator will present a valid L.A. Care identification badge and request access to the Provider’s premises. The SIU investigator will specifically identify why they are present at the premises and what records they want to inspect.

#### 15.3.C Overpayment Recovery

In the event L.A. Care overpays for Provider Services, L.A. Care shall notify the Provider in writing of the overpayment. The overpaid amount shall be reconciled and adjusted in the next payment due to the Provider, following the date of determination the Provider was overpaid.

- If no such next payment is due to the Provider, then the Provider shall remit the amount of the overpayment to L.A. Care within 30 calendar days of the Notice of Action (NOA).
- If Provider owes money to L.A. Care, then L.A. Care shall apply any overpayments due to the Provider towards and against payments due to L.A. Care.

For more detailed information on overpayment recoveries, please refer to Chapter 12 – Claims and Payment.
15.4 Fraud Waste and Abuse (FWA)

**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.

15.4.A Examples of Fraud, Waste, and Abuse (FWA):

**Member/Beneficiaries:**
- Allowing someone else to use their identification card to get medical services
- Changing, forging, or altering a prescription
- Changing medical records
- Changing referral forms
- Identity theft
- Misrepresentation of eligibility status
- Prescription drug diversion and inappropriate use
- Prescription stockpiling
- Resale of medications on the black market

**Provider/Prescriber:**
- Billing a balance that is not allowed
- Billing for services that were not done
- Double billing, up-coding, and unbundling
- Forging a signature on a contract
- Intentionally submitting false claims
- Lying about credentials
- Pre- or post-dating a contract
- Underutilization – not ordering services that are medically necessary

15.5 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:

- The L.A. Care Regional Community Advisory Committee (RCAC) Meetings
- Member newsletters
- New Member handbook
Provider training

15.6 Reporting Potentially Fraudulent Activities to L.A. Care
Under the terms of the agreement between L.A. Care and the Provider, the Provider or its FDRs are required to report suspected cases of FWA. There are four (4) ways in which Providers and FDRs can report potential fraud:

1. **Compliance Helpline:**
The Compliance Helpline is available 24 hours a day, seven (7) days a week and can be used by L.A. Care Board members, employees, contractors, Providers, Members, and other interested persons to report all violations or suspected violations of law and/or the compliance program and/or questionable or unethical conduct or practices including, without limitation, the following:
   - Incidents of FWA
   - Criminal activity (e.g., fraud, kickback, embezzlement, theft, etc.)
   - Conflict of interest issues
   - Code of conduct violations

To file a report with the Ethics and Compliance Helpline:

1. Phone: (800) 400-4889 or

2. **In Writing:**
A written letter regarding potentially fraudulent activities can be sent to L.A. Care at:

L.A. Care Health Plan
Attn: Compliance Officer c/o Special Investigation Unit (SIU)
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

3. **SIU (Compliance Officer):**
The SIU is set up to receive and handle reports of all types of potentially fraudulent activities.

To file a report with the SIU Compliance Officer:

- Phone: (213) 694-1250, ext. 4292

4. **Provider Solution Center:**
If unable to report a potential FWA case by calling the above phone numbers, please call the L.A. Care Provider Solution Center for guidance at (866) 522-2736.

15.7 Referral Requirements
Regardless of what method is used to report FWA to L.A. Care, the following should be included:

1. Name of person reporting fraud or abuse (optional, but highly recommended)
2. Name, address, license, or insurance identification of suspect (if known)
3. Nature of complaint
4. Supporting documentation (optional)

15.7.A If FWA is found, the fraudulent incident or activity will be reported to the appropriate outside law enforcement and/or regulatory agency.

To report Covered California FWA:
Please email: StopFraud@covered.ca.gov or visit: https://www.coveredca.com/consumer-protection/

To report Medicare FWA:
Please visit: https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse

To report Medi-Cal FWA:
Please email the Department of Health Care Services (DHCS), text ‘STOP’ to the Medi-Cal Fraud Hotline at (800) 822-6222 or visit: https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

15.8 Non-Retaliation

Neither L.A. Care, nor any of its contracted entities, 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 a regulatory agency. Additionally, L.A. Care’s contracted entities shall require that its subcontractors abide by this non-retaliation policy.

15.9 Annual Fraud, Waste, and Abuse (FWA) 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 of FWA and General Compliance Training within 90 calendar days of hire/contracting and annually thereafter.

All Medicare Providers must use the training materials provided by Centers for Medicare and Medicaid Services (CMS). The materials can be accessible through the CMS Medicare Learning Network here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance

Providers that have met FWA certification standards through enrollment as a Medicare Provider are deemed to have met Medicare 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.

For more information on regulatory trainings, please refer to Chapter 20 – Provider Training.

15.10 Federal False Claims Act

The Federal False Claims Act is the government’s primary weapon in the fight against health care fraud. The majority of funds recovered come from the False Claims Act suits or settlements. The Federal False Claims Act permits a person who learns of fraud against the United States Government, to file a lawsuit on behalf of the 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.” Successful whistleblowers can receive anywhere from 15% to 50% of the total amount
recovered. Any person may bring a lawsuit called a “qui tam action” regardless of whether he or she has direct or first-hand knowledge of the fraud. However, if substantially the same allegations or transactions alleged in the claim were publicly disclosed, the court may dismiss the claim.

15.10.A The False Claims Act provides protection to employees, agents, or contractors who are retaliated against by an employer because of the employee’s, agent’s, or contractor’s participation in a qui tam action.

The protection is available to any employee, agent, or contractor who is:

- Demoted
- Fired
- Harassed
- Threatened or Otherwise discriminated against by his or her employer because the employee, agent, or contractor investigates, files, or participates in a qui tam action

This “whistleblower” protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against. California also has a state False Claims Act that is similar to the Federal False Claims Act.

15.11 Code of Conduct

L.A. Care is firmly committed to comply with its legal and ethical obligations under all state and federal laws and regulations, as well as its obligations with its state and federal contracts and grants. L.A. Care requires its Providers to operate in accordance with principles in the L.A. Care Code of Conduct.

The Code of Conduct is a guide to ensure compliance with the rules and regulations that govern our business. While the Code of Conduct is not designed to cover every possible situation, it does provide examples of everyday scenarios to assist Providers with proactively addressing issues.


15.12 Health Insurance Portability and Accountability Act (HIPAA)

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to specify privacy and security standards for Covered Entities (health plans, physicians, hospitals, and other health care providers). The HIPAA regulations improve the healthcare industry’s efficiency, improve health insurance portability, protect the privacy of Members, and ensure health information is kept secure. It also ensures that we notify Members of breaches of their protected health information (PHI).

15.12.A Covered Entities

Three (3) types of entities fall within the oversight of HIPAA regulations:

1. Health plans: Include HMOs (i.e., L.A. Care), health insurance companies, and other organizations that finance and deliver healthcare.
2. Clearinghouses: Intermediaries between health plans and providers responsible for the translation of non-standard transactions to standard transactions.
3. Providers: The healthcare Providers are the people or organizations that provide health services (e.g., physicians, clinics, hospitals).


Business Associates are individuals or organizations (e.g., lawyers, auditors, consultants, third-party administrators, healthcare clearinghouses, vendors, and contractors) performing certain functions/activities on behalf of Covered Entities. The Privacy Rule includes organizations or individuals contracted with Covered Entities, which perform specific functions that include accessing, using or disclosing PHI. However, employees or volunteers that work directly for a Covered Entity are not considered Business Associates, but have responsibility to comply with HIPAA on behalf of the Covered Entity. Business Associates must comply with all the provisions of HIPAA with respect to the PHI that they access, use, or disclose from or on behalf of the Covered Entity.

For more information and guidance on HIPAA, please visit: [https://www.hhs.gov/hipaa/index.html](https://www.hhs.gov/hipaa/index.html)

15.12.C Privacy Rule

The Privacy Rule of HIPAA determines how Covered Entities and their Business Associates access, use and disclose PHI. The Privacy Rule also requires that Covered Entities and their Business Associates limit (i.e., Minimum Necessary Standard) the amount of PHI that is used and disclosed to only the minimum amount necessary to do their job, and only to those who need the PHI to perform an allowable activity. It also specifies individual rights that allow Members to have control over the access to, and use and disclosure of PHI.

15.12.D Protected Health Information (PHI)

PHI is any information related to a Member’s health condition, care, or payment for care that identifies the person or provides a reasonable likelihood that the information may result in identification. PHI includes any individually identifiable health information used or disclosed by a Covered Entity or transmitted in any form or medium, whether sent electronically, orally, or on paper.

15.12.D.1 The 18 identifiers that make health information PHI are:

1. Names
2. Dates, except year
3. Telephone numbers
4. Geographic data
5. FAX numbers
6. Social Security numbers
7. Email addresses
8. Medical record numbers
9. Account numbers
10. Health plan beneficiary numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Web URLs
14. Device identifiers and serial numbers
15. Internet protocol addresses
16. Full face photos and comparable images
17. Biometric identifiers (i.e. retinal scan, fingerprints)
18. Any unique identifying number or code

15.12.E Minimum Necessary Standard

HIPAA requires that Covered Entities access, use or disclose only the minimum amount of PHI necessary to fulfill the allowable intended purpose of the access, use or disclosure. This requirement is called the “Minimum Necessary” standard.

15.12.F Use and Disclosure of Protected Health Information (PHI)

The Privacy Rule includes specific rights and protections against the misuse or inappropriate disclosure of Members’ PHI. Covered Entities and their Business Associates can use PHI for treatment, payment, and health care operations (TPO). In addition, there are other permissible disclosures that are for certain public interest and benefit activities (i.e., law enforcement, judicial and administrative proceedings, and health oversight activities). Outside of the permissible disclosures, authorization of the Member may be required.

15.12.G Member Rights

To empower individuals to have more control of decisions regarding their health and well-being, the Privacy Rule provides them with certain rights:

- Accessing PHI: Members have the right to access, review, and copy their PHI, request amendment of the information, and request an accounting of any disclosures made for purposes except TPO.
- Right to Amendment of PHI: Designated record set includes information that must be made available for access or amendment.
- Right to Accounts of Disclosure: Members have the right to request an accounting of non-routine disclosures a Covered Entity has made of their PHI.
- Right to Request Restrictions on Uses and Disclosures: Members may request restrictions on uses and disclosures of PHI except for TPO.
- Right to Request Confidential Communications: Members may request to receive communication of PHI at an alternative location or by alternative means.

For more information about HIPAA from the U.S. Department of Health and Human Services (HHS) and guidance, please visit: [https://www.hhs.gov/hipaa/index.html](https://www.hhs.gov/hipaa/index.html)

15.12.H Security Rule

The Security Rule is a set of regulations intended to protect the security of electronic Protected Health Information (ePHI) and to maintain the confidentiality, integrity, and availability of ePHI. This is achievable by implementing proper administrative, physical, and technical safeguards.

While the Privacy Rule safeguards PHI, the Security Rule protects a subset of information covered by the Privacy Rule. The subset is all individually identifiable health information a Covered Entity creates, receives, maintains, or transmits in electronic form. The Security Rule does not apply to PHI transmitted orally or in writing.
It also requires Covered Entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated users or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce, such as employees and volunteers. 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.

15.12.H.1 The Security Rule is intended to be scalable; in other words, at this time 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.

There are three (3) safeguard levels of security:

1. **Administrative safeguards** are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect ePHI and to manage the conduct of the Covered Entity’s workforce in relation to the protection of that information.

2. **Technical safeguards** are the technology and the policy and procedures for its use that protect ePHI and control access to it (i.e., access controls, audit controls, integrity, authentication, transmission security).

3. **Physical safeguards** deal with the protection of any electronic system, data, or equipment within the facility and organization. The risk analysis and risk management protocols for hardware, software, and transmission fall under this rule.

Organizational Requirements requires the implementation of business associate contracts or other arrangements be in place where appropriate, developing and enforcing policies and procedures, and documentation.

For more information about HIPAA from HHS and guidance, please visit: [https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html](https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html).

15.12.I Breach Notification Rule

As a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act, Covered Entities and Business Associates are required to disclose a breach related to unsecured PHI. In addition, Business Associates are required to report incidents and breaches directly to the Covered Entity within the contractual timeframe. Please review the Provider’s contractual requirements with L.A. Care for breach notification requirements.

Examples of accidental breaches include:

- A medical Provider sending or handing a Member the wrong file, allowing them to see another patient’s personal information; this includes faxes, electronic communications, or mail inadvertently sent to the wrong recipient
- A third-party overhearing a private PHI-containing conversation
- When computers holding unsecured PHI are improperly disposed of
- A medical Provider leaving a file open and unattended where it can be inadvertently viewed
- A billing error providing Member PHI to unauthorized parties
Examples of intentional breaches include:

- A medical Provider or Business Associate accessing PHI out of curiosity
- A medical Provider accessing PHI to use against another person for profit or other gain
- Information thieves stealing or prohibiting access to PHI via ransomware or other electronic attacks
- Thieves retrieving Member PHI from unsecured physical hardware that they stole

Please notify L.A. Care’s Privacy Officer of incidents/breaches directly to: PrivacyOfficer@lacare.org.

15.12.J Federal and State Guidance:
- California Privacy and Data Security Guidance: https://oag.ca.gov/privacy/


According to CMS, electronic transactions are activities involving the transfer of health care information for specific purposes. The HIPAA regulations have identified certain standard transactions for Electronic Data Interchange (EDI) for the transmission of PHI.

These transactions include the following:

- Claims and encounter information
- Claims status
- Coordination of benefits
- Eligibility
- Enrollment and disenrollment
- Payment and remittance advice
- Premium payment
- Referrals and authorizations

15.12.K.1 If a Provider engages in one (1) of the identified transactions electronically, they must comply with the standard for that transaction.

For CMS guidance, please visit: https://www.cms.gov/medicare/billing/electronicbillingeditrans

15.13 Health Insurance Portability and Accountability Act (HIPAA Violations)

The HIPAA act states that Covered Entities must keep personally identifiable information secure and private. This provision has made electronic health records safer for patients. HIPAA violations should be taken seriously. There are a few ways for Covered Entities and their Business Associate Agreement (BAAs) to avoid HIPAA violations.

To avoid the risk of violations, Covered Entities and BAAs should routinely:

- Conduct risk analysis
- Control device and media access
- Encrypt ePHI
- Have Policies and procedures in place to safeguard PHI
- Offer security awareness training to employees and workforce
15.13.A The penalties for violations of HIPAA Rules from a regulatory agency can be severe. The State Attorney General can issue fines up to a maximum of $25,000 per violation category. Providers who do not implement safeguards will increase their risk of right of access and HIPAA violations. A Provider is required to comply with all CMS Compliance Program Effectiveness requirements.

15.14 Resources and Websites
For privacy and health information guidance and resources, please see the list below:

<table>
<thead>
<tr>
<th>Name of Entity</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Department of Health Care Services</td>
<td><a href="https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx">https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx</a></td>
</tr>
<tr>
<td>California Department of Justice, Office of the Attorney General</td>
<td><a href="https://oag.ca.gov/">https://oag.ca.gov/</a></td>
</tr>
<tr>
<td>California Department of Technology</td>
<td><a href="https://www.ca.gov/privacy-policy/">https://www.ca.gov/privacy-policy/</a></td>
</tr>
<tr>
<td>L.A. Care Health Plan – Provider Policies and Compliance</td>
<td><a href="https://www.lacare.org/providers/provider-resources/policies-compliance">https://www.lacare.org/providers/provider-resources/policies-compliance</a></td>
</tr>
<tr>
<td>National Committee on Vital and Health Statistics</td>
<td><a href="https://ncvhs.hhs.gov/">https://ncvhs.hhs.gov/</a></td>
</tr>
<tr>
<td>National Institutes of Health</td>
<td><a href="https://privacyruleandresearch.nih.gov/">https://privacyruleandresearch.nih.gov/</a></td>
</tr>
<tr>
<td>National Institute of Standards and Technology</td>
<td><a href="https://www.nist.gov/">https://www.nist.gov/</a></td>
</tr>
</tbody>
</table>

15.14.A In addition to the federal privacy rules, providers in California must also comply with the Confidentiality of Medical Information Act (CMIA) as well as DHCS requirements.

15.15 For More Information
For questions regarding the information provided in this chapter, please contact the Compliance Department via email at LACareComplianceOfficer@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 16 – Pharmacy and Formulary

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

16.0 Introduction

The L.A. Care Health Plan (L.A. Care) Pharmacy and Formulary Department offers several resources and guidelines to assist Providers with prescribing medications to Members.

The Pharmacy and Formulary Department is responsible for helping L.A. Care contain the cost of prescription drugs while maintaining care quality.

Key responsibilities include:

- Managing the formulary of approved medications
- Updating the formulary with new recommendations and clinical guidelines
- Working with pharmacies and Providers

L.A. Care’s prescription drug formulary is designed to support positive Member health outcomes through the administration of pharmacy benefits, including high quality, cost-effective pharmaceuticals and supplies.

The goal of the formulary is to provide a comprehensive list of covered pharmaceutical benefits that enhances the prescribing practitioner’s and pharmacist’s ability to deliver optimal drug therapy to L.A. Care Members.

For additional pharmacy information and resources please visit: https://www.lacare.org/providers/provider-resources/pharmacy-services

16.1 Formulary (Drug List)

The formulary is a tool to promote cost-effective prescription drug use. Drugs and supplies on the L.A. Care formulary have been approved by the Pharmacy and Therapeutics Committee. The formulary is designed to represent a variety of clinically and economical pharmacotherapeutic options for Members.

Coverage of medications can vary from plan to plan and the drug list can change during the year. While most changes happen at the beginning of the year (January 1st), the formulary is subject to changes throughout the year as well, at which point it will be updated.

To view the complete list of formularies by line of business (LOB), please visit: https://www.lacare.org/providers/provider-resources/pharmacy-services/medication-adherence/list-covered-drugs

16.2 Drug Recalls and Withdrawals

Recalls are actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm’s own initiative, by the United States Food and Drug Administration (FDA) request, or by FDA order under
statutory authority. L.A. Care works closely with pharmacies and Providers to make sure the medications Members take are safe. When L.A. Care is notified that a medication has been recalled or withdrawn from the market, L.A. Care will notify the member and prescriber.

For more information on drug recalls and access to specific drug recall notifications, please visit: https://www.lacare.org/members/getting-care/pharmacy-services/drug-recalls-withdrawals

16.3 Medi-Cal Rx – Pharmacy Benefit Carve-Out

The following section/sentence is only applicable to (as denoted between the asterisks): L.A. Care Medi-Cal (MCLA).

*The Medi-Cal Pharmacy Benefits is carved out to the Department of Health Care Services (DHCS) through Medi-Cal Rx and will be managed by DHCS Pharmacy Benefit Manager (PBM), Magellan Medicaid Administration, Inc. (Magellan). Please note, Magellan is not a contracted vendor of the L.A. Care Provider Network.

This change will improve access to pharmacy services and standardize the Medi-Cal Pharmacy Benefit statewide. Medi-Cal Pharmacy Benefits will be administered through the fee-for-service (FFS) delivery system.

16.3.A Medi-Cal Rx Overview

Medi-Cal Rx includes pharmacy services billed as a pharmacy claim, including but not limited to:

- Outpatient drugs (prescription and over-the-counter), including Physician Administered Drugs (PADs)
- Enteral nutrition products
- Medical supplies

Providers should visit the DHCS website regularly for additional resources, implementation dates, and training opportunities, please visit: https://medi-calrx.dhcs.ca.gov/home/.

For questions about this information, please email DHCS Medi-Cal Rx Project Team at medi-calrxeducationoutreach@magellanhealth.com.

For assistance by phone, call the Medi-Cal Rx Customer Service Center at (800) 977-2273. *

16.4 Prescription Drug Prior Authorizations (PA)

Certain formulary medications and all non-formulary medications require a written Prior Authorization (PA) request to be submitted by the prescribing Provider for L.A. Care Members. Each PA request will be reviewed based on the individual Member’s need. Determination will be based on documentation of existing medical need. The PA criteria and the length of PA approval follow Centers for Medicare and Medicaid Services (CMS) regulations.

16.4.A Instructions on how to submit PA requests are located on the Prescription Drug Prior Authorization forms, which can be found at: https://www.lacare.org/providers/provider-resources/pharmacy-services/prior-authorizations
Prescribers may also access additional information regarding the formulary and the specific PA criteria on the coverage determination process from L.A. Care’s contracted Pharmacy Benefit Manager (PBM) and from Medi-Cal Rx – Magellan.

16.4.B Below are the PBM vendors that handle the processing of the pharmacy benefits and PAs by LOB:

- **Navitus Health Solutions**  
  LOB: CMC, LACC/D, PASC-SEIU  
  Phone: (844) 268-9785  
  Fax: (855) 878-9207  
  Website: [https://www.navitus.com/](https://www.navitus.com/)

- **Medi-Cal Rx – Magellan**  
  LOB: MCLA  
  Phone: (800) 977-2273  
  Website: [https://medi-calrx.dhcs.ca.gov/home/](https://medi-calrx.dhcs.ca.gov/home/)

For more information on generic substitution, step-therapy, quantity limits, and more, please visit: [https://www.lacare.org/members/getting-care/pharmacy-services](https://www.lacare.org/members/getting-care/pharmacy-services)

16.5 Pharmacy Appeals and Grievances

If a prescribing Provider would like to discuss a decision for a prior authorization/coverage determination denial with a clinical reviewer, or if the Provider does not believe the determination is correct, they have the right to appeal the decision on behalf of the Member. The prescriber must provide information to support the appeal on the basis of medical necessity.

16.5.A Pharmacy appeals for MCLA are handled through Medi-Cal Rx by Magellan.

- **Medi-Cal Rx – Magellan**  
  LOB: MCLA  
  Phone: (800) 977-2273  
  Website: [https://medi-calrx.dhcs.ca.gov/home/](https://medi-calrx.dhcs.ca.gov/home/)

For questions related to the formulary, prior authorizations, step-therapy, quantity limits, or therapeutic interchange, please call the appropriate PBM.

16.5.B For all other appeals that are not MCLA, Providers may also submit a copy of the denial notice and a brief explanation of the concern with any other relevant information to the address below:

- **By Mail:**  
  L.A. Care Health Plan  
  Attn: Appeals and Grievances Department  
  1055 W. 7th Street, 10th Floor  
  Los Angeles, CA 90017

For more information on Appeals and Grievances, please refer to Chapter 18 – Appeals and Grievances.
16.6 Benefit Coverage and Limitations

The following section/sentence is only applicable to (as denoted between the asterisks): Cal MediConnect (CMC).

16.6.A Supplemental Drug Coverage

*Medi-Cal will pay for certain medically necessary drugs not covered under Medicare Part D when they are prescribed by a participating licensed Provider acting within the scope of their licensure; these drugs are listed on the L.A. Care Drug Formulary, and are filled at a participating pharmacy.

16.6.A.1 Drugs commonly covered under supplemental drug coverage include, but are not limited to, the following:

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

16.6.B Drug Exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.”

16.6.B.1 These drugs include the following:

- Investigational/experimental drug products, or any drug product used in an investigational/experimental manner, unless certain requirements are met
- Drugs used for cosmetic purposes or hair growth
- Infertility agents, when used to treat infertility
- Foreign drugs or drugs not approved by the FDA
- Drugs when used for erectile dysfunction (only applicable to CMC and MCLA)
- Drugs not written on a prescription

16.6.C Transition Policy

The following section/sentence is only applicable to (as denoted between the asterisks): Cal MediConnect (CMC).

* In some cases, prescribers can provide Members with a temporary supply of a drug when the drug is not on the formulary or when use is restricted. This gives Members time to talk with their Provider about a formulary alternative and/or gives the Provider time to submit an exception to coverage request.

16.6.C.1 To receive a temporary supply of a drug, Members must meet the two (2) rules below:

1. The drug the Member has been taking meets any of the following criteria:
   - Was never on the formulary (drug list); or
   - Is no longer on the formulary (drug list); or
   - Is now limited in some way.
2. The Member must be in one (1) of these situations:

- Is new to the plan and does not live in a long-term care (LTC) facility -
  - L.A. Care will cover a supply of the drug one (1) time only during the first 90 days of membership in the plan. This supply will be for an approved month’s supply, or less if the prescription is written for a few days. Members must fill the prescription at a network pharmacy.

- Is new to the plan and lives in a LTC facility -
  - L.A. Care will cover a supply of the drug during the first 90 days of membership in the plan. This supply will be up to an approved month’s supply consistent with the dispensing increment, or less if the prescription is written for fewer days. *

For more detailed information on CMC Part D and Prescription Drugs, please visit: https://www.calmediconnectla.org/members/part-d-prescription-drugs

16.7 Mail Order Prescriptions

L.A. Care offers Members the option of getting up to a 90-day supply (or 100-day supply for CMC Members only) of select maintenance medications mailed to their home or alternate address through our prescription mail order program.

16.7.A Providers can call, mail, e-prescribe, or fax prescriptions to Ralphs Mail Order Pharmacy.

- **By Mail:**
  Mail prescription(s) to:
  Ralphs Pharmacy #22
  645 W. 9th St.
  Los Angeles, CA 90015

- **By Fax:**
  (213) 452-0834

- **By Phone:**
  Ralphs Pharmacy at (213) 452-0830

16.7.B Ralphs Pharmacy will begin working on the Member’s order once the prescription is received. Once the prescription is processed, the medication will be delivered to the Member within one (1) – three (3) days.

CMC Members may choose to use another Mail Order Pharmacy.

16.8 Pharmacy Network

A large number of pharmacies are available to Members across Los Angeles County. The network includes most major chain drug stores, retailers, and community pharmacies. Members should fill prescriptions at network pharmacies. The pharmacy list is updated monthly.

To locate a network pharmacy near a Member or Provider site, please visit the L.A. Care online pharmacy search tool here: https://www.lacare.org/members/getting-care/pharmacy-services/find-pharmacy
16.9 Specialty Pharmacy

L.A. Care has specific policies for use of specialty drugs. Specialty drugs are often high cost pharmaceuticals, which may require special handling by the manufacturer and/or the FDA, and their effectiveness is driven by coordinated clinical support for the Member. Most of these therapies require prior authorization, and for LACC/D and PASC-SEIU, most of these therapies must be dispensed by L.A. Care’s preferred specialty pharmacies. This is to ensure the patient achieves the optimal clinical benefit from the prescribed therapy.

16.9.A To learn more about specialty drug access and coverage determination for these drugs and therapies, prescribing Providers and pharmacies may call:

- **Navitus Health Solutions**
  LOB: CMC, LACC/D, PASC-SEIU
  Phone: (844) 268-9785
  Fax: (855) 878-9207
  Website: [https://www.navitus.com/](https://www.navitus.com/)

- **Medi-Cal Rx – Magellan**
  LOB: MCLA
  Phone: (800) 977-2273
  Website: [https://medi-calrx.dhcs.ca.gov/home/](https://medi-calrx.dhcs.ca.gov/home/)

16.10 Medication Therapy Management Programs

*Medication Therapy Management (MTM) is a service offered by L.A. Care Cal MediConnect at no additional cost to you or the Member. The MTM program is required by the Centers for Medicare and Medicaid Services (CMS) and is not considered a benefit. This program helps the Member to make sure that his/her medications are working. It also helps identify and reduce possible medication problems. L.A. Care encourages Providers to utilize the MTM program for their Members.

16.10.A To qualify for L.A. Care Cal MediConnect MTM program, Member must meet one (1) of the following two (2) qualification categories:

16.10.A.1 Qualification Category One (1):

- Member must meet ALL of the following criteria:
  - Have at least three (3) of the following conditions or diseases:
    - Bone Disease-Arthritis-Osteoporosis
    - Chronic Heart Failure (CHF)
    - Diabetes
    - Dyslipidemia
    - Hypertension
    - Mental Health-Depression
    - Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD)
  - Take at least eight (8) covered Part D medications
  - Medication costs
Part D medications greater than $4,696 per year

16.10.A.2 Qualification Category Two (2):

- Member is enrolled in the L.A. Care Drug Management Program (DMP)

MTM program qualification criteria are updated annually. For more up-to-date information, please visit: https://www.calmediconnectla.org/members/part-d-prescription-drugs or call the L.A. Care Provider Solution Center at (866) LACARE6 or (866) 522-2736 - 24 hours a day, (seven) 7 days a week, including holidays.*

16.11 Opioid Overutilization

Opioid utilization is monitored by L.A. Care and Navitus to reduce potentially inappropriate and unsafe use of opioids. Member specific reports are generated when pre-established overutilization criteria are met during a defined time period, and the reports are supplied to the appropriate Providers. The information is shared with Providers to increase awareness and facilitate next steps to address opioid overutilization. The program also improves Drug Utilization Review (DUR) controls at the point-of-sale, formulary management, case management, and overall utilization reviews.

16.11.A Please remember to refer to the Controlled Substance Utilization Review and Evaluation System (CURES) before prescribing opioids.

The following section/sentence is only applicable to (as denoted between the asterisks): Cal MediConnect (CMC), Homecare Workers Health Care Plan (PASC-SEIU), and L.A. Care Covered (LACC/D).

*L.A. Care also has an opioid overutilization program (also known as a Drug Management Program, or DMP, for CMC) that can help Members safely use their prescription opioid medications or other medications that are frequently abused. MCLA Members are excluded.

If the Member uses opioid medications from several Providers or pharmacies, we may talk to the prescribing physician(s and other Providers to make sure the use is appropriate and medically necessary. If L.A. Care decides that the Member is at risk for misusing or abusing the opioid or benzodiazepine medications, L.A. Care may limit how the Member can get those medications.

16.11.A.1 Limitations may include the following:

- Requiring the Member to get all prescriptions for those medications from one (1) pharmacy and/or from one (1) doctor
- Limiting the amount of those medications we will cover for the Member

16.11.B If L.A. Care decides that one (1) or more limitations should apply to the Member, a letter will be sent in advance to the Member. The letter will explain the limitations that should apply. The Member will have a chance to tell us which Providers or pharmacies they prefer to use. If a Provider thinks L.A. Care made a mistake, disagrees that the Member is at risk for prescription drug abuse, or disagrees with the limitation, Providers and the Member can file an appeal.

For more information, please call the Provider Solution Center at (866) LACARE6 or (866) 522-2736 - 24 hours a day, seven (7) days a week, including holidays.*
16.12 For More Information

For questions regarding the information provided in this chapter, please contact L.A. Care’s Provider Solution Center at (866) 522-2736 or to the following address:

- **By Mail:**
  L.A. Care Health Plan  
  Attn: Pharmacy & Formulary  
  1055 W. 7th Street, 10th Floor  
  Los Angeles, CA 90017

For information tailored to our Direct Network Providers, please reference the *Direct Network Contracted Provider Reference Guide*. 
Chapter 17 – Managed Long Term Services and Supports (MLTSS)

This chapter applies to the following lines of business: Cal MediConnect (CMC) and L.A. Care Medi-Cal (MCLA), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

17.0 Introduction
The L.A. Care Health Plan (L.A. Care) Managed Long Term Services and Supports (MLTSS) Department works with internal staff and external stakeholders to improve the way health care is provided to seniors, people with disabilities, people with chronic illness, people with other health conditions, and other at-risk Members.

MLTSS refers to a wide range of services that support people to live independently in the community.

17.1 Managed Long Term Services and Supports (MLTSS) Programs
There are five (5) programs under MLTSS. In addition, the MLTSS department manages the L.A. Care Palliative Care program:

1. Care Plan Options (CPO)
   Additional services that L.A. Care may arrange and pay for, for people who have Medicare and Medi-Cal. Some of these services include:
   - Emergency Response System
   - Home modification/maintenance
   - Nutritional services
   - Respite care

2. Community Based Adult Services (CBAS)
   A program where Members can go to a center during the day for assistance with their daily needs.

3. In-Home Supportive Services (IHSS)
   A California state program that provides homecare services to low-income seniors and persons with disabilities, allowing them to remain safely in their home.

4. Long Term Care (LTC)
   Service that provides medical, social, and personal care in either a facility or home for Members with medical or mental conditions who need constant, continuous care.

5. Multipurpose Senior Services Program (MSSP)
   An intensive case management program for seniors who are certified for nursing home placement, but wish to remain at home. The program provides both social and health care management services.
17.2 Care Coordination
Entities with appropriate identification and authorization issued by L.A. Care such as appropriate L.A. Care staff, a Member’s Primary Care Physician (PCP), and other Providers or vendors contracted with L.A. Care, should have access at any time upon request to the following:

- Provide oversight and facilitate coordination of care
- Conduct initial and ongoing assessments to ensure appropriate care delivery
- Provide coordination referrals and services in a culturally and linguistically appropriate matter
- Part of Care Management’s Interdisciplinary Care Team (ICT) to contribute to a multidisciplinary care plan that aligns with the needs expressed by the Member
- Facilitate and support connections with local community care services Providers

17.3 Long Term Care (LTC)
Long Term Care (LTC) is the provision of medical, social and personal care services in either an institution or private home. Most LTC services are provided in a Skilled Nursing Facility (SNF). The primary purpose of LTC is to assist the Member in the activities of daily living (ADLs), such as:

- Assistance with mobility
- Bathing, grooming and toileting
- Getting in and out of bed
- Feeding and/or preparing special diets
- Supervision of medication

17.3.A Referrals for LTC can come from various sources such as a PCP, Discharge Planner, Family Caregiver or ICT. LTC covers room and board at a SNF. SNF Providers are responsible for coordinating specialty services for LTC Members who need specialty care.

The L.A. Care MLTSS Department will assist LTC Members with transitions from LTC back to the community and coordinating other health plan benefits or community resources.

17.4 Skilled Nursing Facility (SNF)
A Skilled Nursing Facility (SNF) is an inpatient rehabilitation and medical treatment center staffed with trained medical professionals. They provide the Medically Necessary services of licensed nurses, physical, occupational and speech therapists. SNFs provide 24-hour care to residents whose primary need is for availability of skilled nursing care on an extended basis.

17.4.A Skilled Nursing Facility (SNF) Requirements
All contracted SNFs must do the following:

- Coordinate and cooperate with Participating Physician Group (PPG), Utilization Management (UM) and care coordinators regarding the Member’s care and treatment
- Participate and comply with UM programs assisting in the maintenance of statistical data, records, and reporting requirements regarding the care and treatment provided to the Member
- Be fully licensed and accredited by National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare and Medicaid Services
(CMS), Department of Health Care Services (DHCS), programs or any other applicable regulatory or accrediting agencies and bodies

- Not operate outside of established bed capacity and appropriate staffing
- Provide short and long-term services in a compassionate and caring manner

17.4.B Additionally, the SNF’s quality management requirements, including peer review, in accordance with federal state law should be enforced and adhered to at all times including the following:

- SNF shall permit the L.A. Care Quality Management and UM personnel direct and reasonable access to Members while institutionalized and to the medical and SNF’s records for those Members on a daily basis, or as required, so long as such access does not interfere with the Member’s medical treatment. Notwithstanding the foregoing, L.A. Care shall, in its sole discretion, retain the ability to prohibit any health professional or general service Provider from providing services to a Member, upon written notice to SNF.
- SNF shall cooperate and comply with L.A. Care Quality Management Program. L.A. Care shall have the right to attend SNF’s quality management meetings for that portion of the meeting relating to L.A. Care Members only. The SNF shall use reasonable efforts to provide L.A. Care with five (5) calendar days’ prior notice of such meetings.
- If the SNF is delegated quality improvement functions, the SNF shall be required to submit quarterly reports to L.A. Care outlining all quality improvement activities in a mutually agreed upon format, as applicable.
- There shall be collaboration to provide the best care possible for Members and to improve outcomes by the SNF to achieve their mission, vision, and goals. Licensed nursing care on a 24-hour basis, restorative, rehabilitative care, and assistance in meeting daily living needs along with appropriate referrals and/or transfer when the SNFs can’t meet Member needs shall also be provided to attain the best possible care and outcomes.

17.5 Palliative Care Program

Palliative Care is designed to provide pain and symptom management as well as other support services for advanced illness Members.

*The following section/sentence is only applicable to (as denoted between the asterisks): L.A. Care Medi-Cal (MCLA)*

*Palliative Care is a multidisciplinary approach to specialized social and medical care for people with serious and advanced illnesses. It focuses on providing Members with social services and mental health support and relief from the symptoms, pain, physical stress, and mental stress of a serious illness--whatever the diagnosis. The goal of Palliative Care is to improve the quality of life for both the Member and the family.

17.5.A Palliative Care Services

Palliative Care must include, at a minimum, the following six (6) services when Medically Necessary and reasonable for the palliation or management of a qualified serious illness and related condition:

1. Advance Care Planning
2. Care Coordination
3. Mental Health and Medical Social Services
4. Pain and Symptom Management
5. Palliative Care Assessment and Consultation
6. Palliative Care Team

17.5.B Eligibility

The benefit applies to Medi-Cal managed care Members who are not dually eligible for Medicare and Medi-Cal.*

17.6 Managed Long Term Services and Supports (MLTSS) Referral Forms

Providers can find important MLTSS referral forms on the L.A. Care website here:

- CBAS Face-to-Face Assessment Request Form: [https://www.lacare.org/sites/default/files/la2903_cbas_form_202012.pdf](https://www.lacare.org/sites/default/files/la2903_cbas_form_202012.pdf)
- Medically Tailored Meal (MTM) Physician Order Form: [https://www.lacare.org/sites/default/files/pl0731_mtm_dr_order_form_202003.pdf](https://www.lacare.org/sites/default/files/pl0731_mtm_dr_order_form_202003.pdf)
- MLTSS Referral Form: [https://www.lacare.org/sites/default/files/la2562_mltss_referral_form_202005.pdf](https://www.lacare.org/sites/default/files/la2562_mltss_referral_form_202005.pdf)
- Palliative Care Referral and Screening Tool: [https://www.lacare.org/sites/default/files/la3002_universal_pc_referral_form_202008.pdf](https://www.lacare.org/sites/default/files/la3002_universal_pc_referral_form_202008.pdf)

17.7 Member Transfers

Contracted SNFs shall facilitate transfers of the Members to or from a hospital when there is a change of level of care and take actions to notify L.A. Care, Member’s attending physician, and Member’s guardian or family members, within the timeframes established by CMS’ Structure and Process Measures and the agreement. Also, the SNF shall ensure that a copy of the hospital Discharge Summary is provided to the receiving facility, as well as the L.A. Care UM Department.

17.7.A Should a Provider fail to send L.A. Care a written discharge plan in a timely manner, it may result in termination from L.A. Care.

For questions or to submit discharge plans, please contact:

- **By Phone:**
  UM at (877) 431-2273
- **By Fax:**
  UM at (213) 438-5096

17.8 Discharging Members from Long Term Care

Contracted SNFs shall develop a discharge plan when the Member is no longer eligible for LTC services. L.A. Care must be informed by the SNF in writing using **DHCS Medi-Cal Long Term Facility Admission and Discharge form (MC171)** immediately, but no later than 72 hours from discharge. Should a Provider fail to notify L.A. Care timely, it may result in termination from L.A. Care.
17.8.A In the event a Member receiving LTC under this agreement expires, the SNF is required to notify L.A. Care using DHCS Medi-Cal Long Term Facility Admission and Discharge form (MC171) within two (2) hours of passing. Additionally, the SNF must assemble inventory and safeguard the Member’s personal effects during that time. Should a Provider fail to notify L.A. Care within two (2) hours of a Member’s death it may result in termination from L.A. Care.

17.8.B The written discharge plan (MC171) can be faxed to the UM MLTSS fax number below. Should a Provider fail to send L.A. Care a written discharge plan in a timely manner, per the specified timeframe(s) above, it may result in termination from L.A. Care.

For questions or to submit discharge plans, please contact:

- **By Phone:**
  UM at (877) 431-2273

- **By Fax:**
  UM at (213) 438-5096

17.9 For More Information

For questions regarding the information provided in this chapter, please contact the MLTSS Department via email at [MLTSS@lacare.org](mailto:MLTSS@lacare.org).

*For information tailored to our Direct Network Providers, please reference the [Direct Network Contracted Provider Reference Guide](#).*
Chapter 18 – Appeals and Grievances

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

18.0 Introduction
The L.A. Care Appeals and Grievances Department is dedicated to reviewing and facilitating Member and Provider grievance support as it relates to complaints, disputes, or dissatisfactions with the level of service or care that a Member has received.

In addition to grievances, the Appeals and Grievances Department also reviews appeals made by a Member, a Provider on behalf of the Member, or an appointed representative on behalf of the Member. An appeal can be made when a Member is dissatisfied with a service or has a dispute with the authorization of a service or the determination of coverage.

18.1 Member Grievances
A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Health Plan, or its Providers, regardless of whether remedial action is requested. If a Member is dissatisfied or has problems or questions with the services or care given by their Provider and cannot resolve them with the Provider, they have a right to file a grievance or complaint.

Examples of common Member grievances:

- Problems booking an appointment or having to wait a long time for an appointment
  - For more information on timely access standards, please refer to Chapter 3 – Access to Care
- Disrespectful or rude behavior by Providers, office, or other clinical staff
- Service or care received from L.A. Care

18.1.A Members also have the right to file an urgent grievance with the Department of Managed Health Care (DMHC) without filing a grievance with L.A. Care.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of health

18.2 How to File a Member Grievance
Members and Providers acting on behalf of a Member have many ways to file a grievance with L.A. Care:
• **By Mail:**
  L.A. Care Health Plan  
  Attn: Appeals and Grievances Department  
  1055 W. 7th Street, 10th Floor  
  Los Angeles, CA 90017

• **By Phone:**
  For (CMC) Members:
  Customer Solution Center at (888) 522-1298 (TTY 711)

  For (LACC/D) Members:
  Customer Solution Center at (855) 270-2327 (TTY 711)

  For (MCLA) Members:
  Customer Solution Center at (888) 839-9909 (TTY 711)

  For (PASC-SEIU) Members:
  Customer Solution Center at (844) 854-7272 (TTY 711)

• **By Fax:**
  L.A. Care Member Services Department at (213) 438-5748

• **By Online Grievance and Appeal Form:**
  [https://www.lacare.org/members/member-support/file-grievance/grievance-form](https://www.lacare.org/members/member-support/file-grievance/grievance-form)

18.2.A Should a Member express any form of dissatisfaction for any reason, whether orally or written, Providers must forward the complaint to L.A. Care within 24 hours of receipt to the following email addresses:

  • Urgent Request: Agexpedited@lacare.org
  • Non-Urgent Request: A&G_Intake@lacare.org

18.3 State Hearing
A State Hearing is another way a Member can file a grievance. The Member will present their case directly to the State of California. All L.A. Care Members have the right to ask for a State Hearing at any time within 120 calendar days of the incident.

Members must first go through the L.A. Care grievance process before applying for a State Hearing.

For more information about a State Hearing request, please call the California Department of Public Social Services (DPSS) at (800) 952-5253.
18.4 Expedited State Hearing
In cases of health services denials, a Member or Provider may request a faster decision through an Expedited State Hearing if a Member’s life, or health, or ability to attain, maintain, or regain maximum function could be seriously risked by going through a standard State Hearing.

Requests for Expedited State Hearings should be directed to:

- **By Mail:**
  Expedited Hearings Unit  
  California Department of Social Services State Hearings Division  
  744 P Street, MS 19-65  
  Sacramento, CA 95814

- **By Fax:**
  (916) 229-4267

For more information on DPSS State Hearings, please visit:  

18.5 Member Appeals
An appeal is different from a complaint. An appeal is a request for L.A. Care to review and change a decision that was made about coverage for a requested service for a Member. With written permission from a Member, a Provider can assist the Member and file an appeal.

18.5.A Appeals must be filed within 60 calendar days from the date on the Notice of Action (NOA) that was delivered to the Member or before the date L.A. Care states services will discontinue. Within five (5) days of receiving the appeal, L.A. Care will send a letter acknowledging they received it. Within 30 calendar days, L.A. Care will issue a decision on the appeal.

Members and Providers acting on behalf of a Member have many ways to file an appeal with L.A. Care:

- **By Mail:**
  L.A. Care Health Plan  
  Attn: Appeals and Grievances Department  
  1055 W. 7th Street, 10th Floor  
  Los Angeles, CA 90017

- **By Phone:**
  For (CMC) Members:
  Customer Solution Center at (888) 522-1298 (TTY 711)

  For (LACC/D) Members:
  Customer Solution Center at (855) 270-2327 (TTY 711)

  For (MCLA) Members:
  Customer Solution Center at (888) 839-9909 (TTY 711)
For (PASC-SEIU) Members:
Customer Solution Center at (844) 854-7272 (TTY 711)

- By Fax:
  L.A. Care Member Services Department at (213) 438-5748

18.5.B If a Provider needs an expedited decision to be made because the time it takes to resolve the appeal would put the Member’s life, health, or ability to function in danger, Providers can call L.A. Care and request an expedited review. L.A. Care will make a decision within 72 hours of receiving the appeal.

- By Phone:
  For (CMC) Members:
  Customer Solution Center at (888) 522-1298 (TTY 711)

  For (LACC/D) Members:
  Customer Solution Center at (855) 270-2327 (TTY 711)

  For (MCLA) Members:
  Customer Solution Center at (888) 839-9909 (TTY 711)

  For (PASC-SEIU) Members:
  Customer Solution Center at (844) 854-7272 (TTY 711)

18.6 Independent Medical Review (IMR)
A Member may request an Independent Medical Review (IMR) from DMHC to obtain an impartial review of a denial decision concerning:

- Denials, modifications, or delays in service or treatment not considered medically necessary
- Experimental or investigational treatment
- Claims denials for emergency or urgent medical services that a Member has received

Members, or Providers filing on behalf of a Member, have up to six (6) months from the date of the denial to file an IMR with DMHC. Providers will need to provide information to support the request for an IMR.

For information on the Utilization Management (UM) process, please refer to Chapter 5 – Utilization Management.

18.6.A When to File an Independent Medical Review (IMR)
Members, or Providers submitting on behalf of the Member, may file an IMR if they meet the following requirements:

- Member’s Primary Care Physician (PCP) says a health care service is medically necessary and it is denied; or
- Member received urgent or emergency services determined to be necessary and they were denied; or
- Member continues to see a network Provider for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- Disputed health care service is denied, changed or delayed by L.A. Care based in whole or in part on a decision that the health care service is not medically necessary, and/or
- Member filed a grievance with L.A. Care and the health care service is still denied, changed, delayed, or the grievance remains unresolved after 30 calendar days.

18.6.B Members must first go through the L.A. Care grievance process before applying for an IMR. In special cases, DMHC may not require an L.A. Care grievance before filing an IMR. The dispute will be submitted to a DHMC medical specialist if it is eligible for an IMR. The specialist will make an independent decision to determine whether or not the care is medically necessary. The copy of the IMR decision will come from DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

18.7 Non-Urgent Cases
For non-urgent cases, the IMR decision must be made within 30 calendar days. The 30-day period starts when your application and all documents are received by DMHC.

18.8 Urgent Cases
If the Member’s grievance is urgent and requires a fast review, Members, or a Provider acting on the behalf of a Member, may bring it to DMHC’s attention right away. A Member will not be required to participate in the L.A. Care grievance process.

18.8.A For urgent cases, the IMR decision must be made within seven (7) calendar days from the time the information is received.

Examples of urgent cases include:
- Severe pain
- Potential loss of life, limb, or major bodily function
- Immediate and serious deterioration of a Member’s health

For more information on the DMHC IMR process, please visit: https://dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx

18.9 Provider Information Request Notification
Often and at the investigatory stage of a Member grievance or appeal, a regulatory agency may request additional information from L.A. Care and its Providers. Once notified by the regulatory agency, the L.A. Care Appeals and Grievances Department will email or fax a Provider Information Request to the Provider requesting additional information on the Member’s grievance or appeal.

Examples of documents or evidence L.A. Care may request from Providers include, but are not limited to, the following:
- Authorizations
- Claims
- Denial Packets
- Medical Director Review
18.9.A Please note: requests for documents or evidence will vary and no two (2) cases are alike. It is the Provider’s responsibility to reply to the requests made by L.A. Care in the manner instructed on the Information Request Notification form.

18.9.B Steps to Ensure a Complete and Timely Response include the following:

1. Review the Provider Information Request form from L.A. Care and any accompanying list of requested documents or actions.
2. Acknowledge receipt of request within 30 minutes of receiving the request and include the following:
   - Acknowledgement of the due date and time
   - Name of person assigned to the case
   - Contact information for the person assigned to assist with the investigation
3. Contact the assigned L.A. Care Appeals and Grievance Specialist with any additional questions or concerns. The assigned specialist’s contact information will be on the Provider Information Request form.
4. Review the Provider Information Request form’s list of issues and ensure the documents required are complete and all issues have been addressed.
5. Ensure the Provider response, including documents or evidence, is sent by the deadline noted on the Provider Information Request form.
6. Providers should send all responses to the email address noted on the Provider Information Request form and copy the following email: CSC_RFI@lacare.org.

18.9.C Providers are responsible for submitting all requested information made by L.A. Care within the timeframe specified for each request to support an appeal and grievance investigation.

18.10 Pharmacy Appeals

If a prescribing Provider would like to discuss a decision for a coverage determination denial with a clinical reviewer, or if the Provider does not believe the determination is correct, Providers have the right to appeal the decision on behalf of the Member with L.A. Care’s contracted Pharmacy Benefit Manager (PBM) or with the Department of Health Care Services (DHCS) Medi-Cal Rx Magellan. The prescriber must provide information to support the appeal on the basis of medical necessity.

18.10.A Below is the PBM information that handles the determinations by line of business (LOB):

- **Navitus Health Solutions** (LOB: CMC, LACC/D, PASC)
  - Phone: (844) 268-9785
  - Fax: (855) 878-9207
  - Website: https://www.navitus.com/

- **Medi-Cal RX – Magellan** (LOB: MCLA)
  - Phone: (800) 977-2273
  - Website: https://medi-calrx.dhcs.ca.gov/home/
For questions related to the formulary, prior authorizations, step-therapy, quantity limits, or therapeutic interchange, please call the related PBM.

18.10.B Providers may also submit a copy of the denial notice and a brief explanation of the concern with any other relevant information to the address below:

- **By Mail:**
  L.A. Care Health Plan
  Attn: Appeals and Grievances Department
  1055 W. 7th Street, 10th Floor
  Los Angeles, CA 90017

For more information on pharmacy, please visit Chapter 16 – Pharmacy and Formulary.

18.11 Provider Claim Disputes
A Provider dispute is a written notice challenging, appealing, or requesting consideration of a claim. Providers have 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.

For more information on how to dispute a claim, please refer to Chapter 12 – Claims and Payments.

18.12 For More Information
For questions regarding the information provided in this chapter, please contact your designated Provider Network Account Manager or the Provider Network Management (PNM) Department via email at ProviderRelations@lacare.org.

For information tailored to our Direct Network Providers, please reference the *Direct Network Contracted Provider Reference Guide*. 
Chapter 19 – Behavioral Health

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

19.0 Introduction

The L.A. Care Health Plan (L.A. Care) Behavioral Health Department provides Mental Health and Substance Use Disorder Services through Primary Care Physicians (PCP), Behavioral Health Specialty Providers from Beacon Health Options (Beacon), Los Angeles County Department of Mental Health (DMH), and Los Angeles County Department of Public Health (DPH) based on level of care criteria and line of business (LOB). The goal is to ensure and facilitate the provision of appropriate medical and behavioral health care and services to L.A. Care Members. Mental health services may include treatment for anxiety, depression, or other behavioral health related conditions.

These services include, but are not limited to:

- Individual, group, and family mental health evaluation and treatment (psychotherapy)
- Outpatient services that include lab work, drugs, and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Psychological testing to evaluate a mental health condition
- Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment

Please note, it is the responsibility of the Provider to check and verify Member eligibility, inclusive of the corresponding LOB, in order to identify where the Member should be referred for services.

19.1 Behavioral Health Treatment (BHT)

L.A. Care covers BHT for Medi-Cal members under 21 years of age with a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary. This includes Applied Behavior Analysis (ABA) and similar evidence-based treatments. The services should maintain or improve the Member’s current condition.

19.1.A For MCLA only, the Provider network is contracted directly by L.A. Care and can be reached by calling the L.A. Care ABA Department.

For questions or concerns regarding autism spectrum disorder (ASD), please call or email:

- **By Phone:**
  L.A. Care ABA Department at (888) 347-2264

- **By Email:**
  ASDbenefit@lacare.org
19.1.B For all other lines of business, please contact Beacon (information below).

19.2 Mental Health Services
Mental Health Services may include treatment for anxiety, depression, or behavioral health problems. PCPs may provide Members with outpatient mental health services that are within the PCP’s scope. L.A. Care is responsible for outpatient mental health services to Members with mild to moderate impairment(s) resulting from a mental disorder.

Specialty Mental Health Services (SMHS) for Medi-Cal Members are provided through DMH. Members may receive services from Beacon or DMH based on level of care criteria with or without a referral from their Provider.

19.2.A Both Members and Providers can call Beacon to coordinate triage and access to care.

To contact Beacon:

- **By Phone:**
  Beacon Health Options at (877) 344-2858

To learn more about Beacon’s services, please visit: https://www.beaconhealthoptions.com/beacons-mental-health-services/

To locate a Beacon Provider, Providers can search here: https://www.beaconhealthoptions.com/find-a-provider/

19.3 Specialty Mental Health Services (SMHS)
L.A. Care PCPs will provide some outpatient mental health services, within the scope of their training and practice. SMHS may be needed for services beyond the Provider’s training and practice and may require a referral to a Provider that specializes in Serious Mental Illness. SMHS, including inpatient psychiatric hospitalization for MCLA, is the responsibility of the DMH.

19.3.A To contact the DMH Helpline:

- **By Phone:**
  (800) 854-7771 and select option one (1) for ACCESS Center services

For more information regarding the DMH, please visit: https://dmh.lacounty.gov/

19.4 Substance Use Disorder (SUD) - Preventive Services
Alcohol and Drug Screening Services are a benefit covered by L.A. Care for Members ages 11 and older that are provided by PCPs. For a list of validated screening tools, please refer to All Plan Letter (APL) 21-014.

19.4.A Both Medi-Cal and CMC Members may seek SUD Treatment from the DPH, Substance Abuse Prevention and Control (SAPC), with or without a referral from the Member’s PCP.
To contact DPH/SAPC:

- **By Phone:**
  (844) 804-7500

For more information on substance abuse treatment services, please access the links below:
http://publichealth.lacounty.gov/sapc/PatientPublic/Brochure.pdf
https://sapccis.ph.lacounty.gov/sbat/

**19.4.B** Both PASC and LACC Members may seek SUD Treatment from Beacon.

To contact Beacon:

- **By Phone:**
  Beacon Health Options at (877) 344-2858

To learn more about Beacon’s services, please visit: https://www.beaconhealthoptions.com/beacons-mental-health-services/

To locate a Beacon Provider, Providers can search here: https://www.beaconhealthoptions.com/find-a-provider/

**19.5 Transgender Health**

L.A. Care provides medically necessary Transgender Services (gender-affirming services) to our Members when they meet criteria for services, per APL 20-018 and pursuant to the clinical guidance of The World Professional Association for Transgender Health (WPATH) standards of care.

**19.5.A** Transgender services include the following:

- Behavioral health assessments for transgender services
- Medically Necessary hormone therapy
- Medically Necessary gender affirming surgery and procedures
- Preventive screenings (delegated to Member’s PPG/IPA)

For questions regarding the L.A. Care Transgender Health Program, please contact: transgenderhealthprogram@lacare.org.

**19.6 Behavioral Health Services Contact Information:**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Services</th>
<th>Phone Number and Website Information</th>
</tr>
</thead>
</table>
| Beacon Health Options | Mental Health (mild to moderate) and substance use disorder benefits (MH/SUD) BHT for all other LOBs | Beacon: (877) 344-2858  
Website: https://www.beaconhealthoptions.com/beacons-mental-health-services/ |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Services</th>
<th>Phone Number and Website Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCLA- Behavioral Health Treatment (BHT)</td>
<td>BHT for individuals under 21 years of age with recommendation</td>
<td>BHT: (888) 347-2264 Email: <a href="mailto:ASDBenefit@lacare.org">ASDBenefit@lacare.org</a></td>
</tr>
<tr>
<td>Los Angeles County Department of Mental Health (DMH)</td>
<td>Specialty mental health services are provided through DMH. For mental health referrals, Providers can contact DMH.</td>
<td>DMH: (800) 854-7771 Option 1 for ACCESS Center services Website: <a href="https://dmh.lacounty.gov/">https://dmh.lacounty.gov/</a></td>
</tr>
<tr>
<td>Los Angeles County Department of Public Health/Substance Abuse and Control (DPH/SAPC)</td>
<td>Treatment for alcohol and substance use disorders not covered by L.A. Care, Providers can visit the DPH/SAPC website.</td>
<td>DPH/SAPC: (844) 804-7500 Website: <a href="http://publichealth.lacounty.gov/sapc/">http://publichealth.lacounty.gov/sapc/</a> Pamphlet: <a href="http://publichealth.lacounty.gov/sapc/PatientPublic/Brochure.pdf">http://publichealth.lacounty.gov/sapc/PatientPublic/Brochure.pdf</a></td>
</tr>
</tbody>
</table>

19.7 For More Information
For questions regarding the information provided in this chapter, please contact the Behavioral Health Department at (844) 858-9940 or by email at BehavioralHealth@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.
Chapter 20 – Provider Training

This chapter applies to all lines of business: Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.

20.0 Introduction

The L.A. Care Health Plan (L.A. Care) Learning and Development Department offers no-cost workshops, online courses, and webinar trainings on several topics, as determined in L.A. Care’s sole discretion, including those that are required and/or requested by certain regulators, and on other generic training topics; some trainings offer continuing education credits to network Providers and certain staff. The trainings are provided as either instructor-led classroom training or online in a virtual setting. Provider training and education (goals, objectives, curricula, and implementation guidelines) are established by L.A. Care based on regulatory requirements.

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
- Comply with regulatory requirements
- Improve clinical/patient interaction
- Understand the needs of L.A. Care Members
- Updates to L.A. Care Policy and Procedures

In most cases, L.A. Care will notify Providers of the training and education sessions, including required regulatory training. Providers will be informed of how to register and participate in these training sessions before the event. It is the responsibility of the Provider to register, attend, and make any appropriate staff aware of these training sessions.

20.1 Provider Training and Education

The following section/sentence is only applicable to (as denoted between the asterisks): delegated Participating Physician Group (PPG), their Management Services Organizations (MSO), and affiliated Providers, as applicable.

* It is the responsibility of the PPG, per the PPG’s contract between L.A. Care and the PPG, that the PPG ensure that its staff, as applicable, complete certain training and education as required by applicable laws, regulatory agencies, and L.A. Care. It is the obligation of the PPG to provide or “downstream” the information about the training requirements and the availability of certain training from L.A. Care to its affiliated Providers and staff.
20.1.A New Provider Onboarding (Orientation)
PPGs are responsible for ensuring that all of their Primary Care Physicians (PCPs), Specialists (SPC), and applicable staff receive onboarding training and education, including those required by applicable regulatory bodies and the National Committee for Quality Assurance (NCQA).

In order to ensure that PPGs are conducting onboarding training for their newly contracted Providers, which is compliant with contractual requirements and regulatory guidelines, L.A. Care will require the PPG, or its MSO on behalf of the PPG, to submit monthly reports.

- 20.1.A.1 Monthly Training Reporting Instructions:
  1. Conduct onboarding and annual training to downstream to the providers and staff
  2. Document all trainings completed by each staff and/or downstream Providers, as applicable
     - Documentation must be kept on file and include, but are not limited to, sign-in sheets, attestations, and training materials, and policies and procedures
     - Onboarding training is considered valid for one (1) year of time; thereafter the Provider and/or staff, as applicable, must be trained on an ongoing basis
  3. Submit a report of newly contracted and trained PCPs, SPCs, and Mid-Level Providers to L.A. Care on the last business day of each month using the L.A. Care Monthly Training Report templates
     - Do not include: Office staff. Their training does not need to be submitted in the report, but must be tracked in order to provide evidence upon request by L.A. Care
     - Include: Per Diem “Locum Providers,” if they are physicians who treat patients
     - Include: Contracted affiliated Providers (i.e. hospitalists)
  4. Important timeframes:
     - Trainings MUST take place within 10 business days of active status
       - Active or “effective” status dates are driven by the Provider Onboarding policy of the PPG/MSO
  5. Failure to submit timely, accurate, and complete, monthly reports will be identified as non-compliant and may result in the PPG being placed on a Corrective Action Plan (CAP)
  6. Submit the Monthly Training Report to L.A. Care via email at: PNMTraining@lacare.org
  7. To inquire or request the L.A. Care Monthly Training Report template, L.A. Care Sign-in Sheet, and/or L.A. Care Attestation, please email: PNMTraining@lacare.org

L.A. Care will conduct quarterly, ad hoc, and annual audits of PPG’s records as necessary. These audits may include training reports, signed attendance sheets, attestations, training materials, policies and procedures, and may sample Provider records.

- 20.1.A.2 Provider Education

L.A. Care’s delegated PPGs are responsible for educating their network of downstream providers and staff on health education requirements and available L.A. Care health education services.

Methods for educating may include, but are not limited to:

- Fax blasts
20.1.B Annual Regulatory Required Courses

The completion of annual regulatory required training courses (e.g. Fraud, Waste, and Abuse, General Compliance) are the responsibility of all Providers as well as their affiliated providers and staff, including those who provide health or administrative services (e.g. Provider, office staff, and medical staff). All required trainings must be completed within ninety days of contracting/hiring and annually thereafter.

- 20.1.B.1 L.A. Care University

To extend accessibility of certain learning and training courses to our contracted Providers and their staff, with the help of the online Learning Management System (LMS), L.A. Care has established the L.A. Care University. Inside of the L.A. Care University, Providers and their staff will find many of the required trainings and continuing education in a self-serve virtual environment.

In order to enter L.A. Care University and to complete training, learners must do the following:

- 20.1.B.2 Steps to Complete Training:
  1. Use the registration code provided by L.A. Care to gain access to the website
     o To request a new or lost registration code, email: lacareuniversity@lacare.org
  2. After obtaining a registration code, the Provider and its staff can access L.A. Care University at:
     https://lacarehea.plateau.com/learning/user/portal.do?siteID=LACareUniversity&landingPage=login
  3. Register as a New User on the L.A. Care University website
     o If already registered with L.A. Care University, DO NOT register again, simply log into the system for access to the L.A. Care learning catalog.
  4. Once inside L.A. Care University, to locate the curriculum or course needed, enter the course name in the Find Learning tile, and click Go.
     o For Providers who need to submit an attestation, enter “Attestation” in the Find Learning tile, and continue with the steps below.
  5. Select the course(s) or attestation to self-assign the session.
  6. The course content or attestation will open a new window to begin the session.
  7. Follow all instructions on the screen for completing the course(s) or submitting the electronic attestation.
8. Complete the course(s) and receive an electronic certificate of completion with the option to print a certificate. Please keep a copy of the certificate.
9. To view a list of completed courses or to retake a course, select the Learning History tile on the homepage and click View All.
10. A Quick Reference Guide can be accessed via the My Learning Assignments tile on the homepage.
11. The Provider is responsible for the code, as well as the user credentials and passwords and not share or disclose to anyone else. The Provider must ensure that only authorized staff use L.A. Care University. The Provider and its staff must comply with the terms and conditions of use for L.A. Care University, and L.A. Care’s security requirements. If the Provider does not comply with L.A. Care’s requirements, and/or its staff misuse or disclose the code to individuals who are not authorized, then L.A. Care may remove the Provider’s access to L.A. Care University.

For questions regarding the L.A. Care University or the required courses, please email: lacareuniversity@lacare.org

20.2 Provider Programs
L.A. Care offers Providers a wide range of Provider training opportunities and continuing medical education (CME) for some courses. These include:

20.2.A Provider Continuing Education (PCE) Program
The Provider Continuing Education (PCE) Program is an accredited educational program that consists of Continuing Education (CE) activities for physicians and CE activities for other healthcare professionals. PCE Program’s ultimate goals are to share best practices to improve quality of Member care and patient outcomes, as well as partnerships and collaborations with other healthcare organizations.

For more information on the PCE Program, please visit: https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/provider-continuing-education-program

20.2.B Cultural and Linguistic Provider Training Series
The Cultural Competency and Disability Sensitivity trainings are designed to assist network Providers and office staff in delivering Member-centered care to diverse populations. The Communicating through Health Care Interpreters training offers CME credits.

For more information on Cultural and Linguistic Provider Training, please visit: https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/cultural-and-linguistic-training

For further information on the Cultural and Linguistic Department, please refer to Chapter 10 – Cultural and Linguistics (C&L).

20.2.C Quality Improvement Provider Training Series
An ongoing series of webinars, which cover a wide range of topics, related to quality improvement, including Healthcare Effectiveness Data and Information Set (HEDIS), Member satisfaction, data, and improving clinical outcomes. Some sessions provide the opportunity to earn CME or CE credits.
For more information on Quality Improvement Provider Trainings, please visit:
https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/webinars-for-ipas-and-providers

For further information on the Quality Improvement Department, please refer to Chapter 6 – Quality Improvement.

**20.2.D In-Home Supportive Services (IHSS+) Home Care Training Program**

*The following section/sentence is only applicable to (as denoted between the asterisks):
Cal MediConnect (CMC)*

This program is run by the California Long-Term Care Education Center (CLTCEC) and is offered to IHSS workers who provide care for L.A. Care Members covered by the CMC program. The 10-week course runs throughout the year by CLTCEC, and teaches caregivers:

- Cardiopulmonary Resuscitation (CPR)
- First aid
- Medication administration
- Nutrition
- Personal care

Due to COVID-19, the training program has moved to an online virtual setting until further notice from the State. Prospective applicants can apply for the IHSS+ Home Care Training program by calling the Center for Caregiver Advancement (CCA) at (844) 725-8232 or online here: https://advancecaregivers.org/.

**20.3 For More Information**

For questions regarding the information provided in this chapter, please contact the Learning and Development Department via email at PNMTraining@lacare.org.

For information tailored to our Direct Network Providers, please reference the Direct Network Contracted Provider Reference Guide.