L.A. Care

Delegation *Oversight*

Checking the Pulse of Delegate Performance

Delegated Entities Performance Reporting and Validation Protocols

Minimum Standards for Delegated Entities Supporting Documentation and Validation Process

Version 1.1

Table of Contents

Introduction

Background

L.A. Care Healthplan ("LAC") contracts with certain healthcare providers ("Delegates/PPGs") to perform certain administrative services and functions as part of their agreements with LAC ("Agreement"), and performs regular oversight of the Delegates' performance to ensure adherence to regulatory, contractual, and operational requirements. Each year, on a regular and periodic basis, LAC requires Delegates to submit reports to substantiate its performance for each administrative service and function delegated. LAC's oversight activities include, but are not limited to, annual audits of the Delegate, as well review of monthly and quarterly reports submitted by the Delegate. The oversight is intended to assess the Delegate's performance against benchmarks and thresholds, and validate regulatory and contractual compliance.

The purpose of this Delegated Entity Manual ("Manual") is to provide the Delegates guidelines and information on performance requirements, and establish minimum standards, and activities, required to meet the regulatory, contractual, and operational requirements. In addition, the Manual articulates the methodology LAC employs to validate the information submitted as evidence of successful adherence to applicable performance requirements.

To standardize Delegate's submissions, templates have been created, as necessary, and such templates will be mentioned in the guidelines below, as applicable. LAC requires each Delegate to adhere to the format outlined in the template, as well as the forum specified, e.g. electronic upload to sFTP site, for submission of reports, data and information. Deviations from the format or forum required by LAC could result in the report/file not being included in the review, which could, in turn, adversely impact the review and performance scores. If a Delegate is not able to comply with the template format, or submission forum, e.g. via sFTP site, it should immediately contact LAC.

Sampling Methodology

With respect to audits conducted by LAC, a random sampling methodology will be implemented to determine a statistically valid subset of data that LAC will use to validate successful adherence to milestones and metrics. The size of the sample used for validation may vary depending on the total number of files, data, and/or information submitted by the Delegate.

Documents to be Submitted and Updates to Milestones

The documents/files to be submitted with respect to each Delegated function and activity are specified below.

Disclaimer

This Manual is intended for general guidance purposes only. Submitting the documents and information mentioned herein alone does not constitute full compliance with all terms and conditions of the Delegate's Agreement, or LAC's policies and procedures, or applicable regulations. Additionally, this Manual provides guidance on the minimum level of information and documentation the Delegate must submit for LAC to evaluate the Delegate's adherence to the performance standards. As applicable, to comply with the request of a state or federal agency, or accreditation organization, additional information and documents may be requested. This Manual, in whole or in part, is subject to change, and LAC reserves the right to update, modify, and amend it per applicable rules, regulations, guidance, accreditation standards, alignment with operational requirements, and LAC's oversight program requirements, including to address issues and/or concerns raised by relevant stakeholders.

PART I
DELEGATED ACTIVITIES

PART I: DELEGATED ACTIVITIES

DESCRIPTION OF DELEGATED SERVICES AND ACTIVITIES

APPLIES TO ALL HEALTHPLAN MANAGED CARE PROGRAMS SPECIFIED IN THE AGREEMENT FOR WHICH ADMINISTRATIVE SERVICES AND ACTIVITIES (COLLECTIVELY "DELEGATED ACTIVITIES") HAVE BEEN DELEGATED TO PPG

This section specifies the specific functions which the Delegate must perform for each Delegated Activity delegated to the Delegate pursuant to the terms and conditions of the Agreement. All Delegated Activities for all Healthplan Managed Care Programs are to be performed in accordance with applicable Federal and State regulations, guidelines as well as accreditation standards. Delegate agrees to be accountable for all administrative services, activities and functions delegated by Healthplan and oversight of any sub-delegated activities, as well as subcontractors performing services on its behalf, including any management service organization, except as outlined in the Delegation Agreement. Delegate will provide periodic reports to LAC as described in the Agreement and in this Manual. LAC will oversee and monitor the Delegates performance as specified in the Agreement and this Manual. In the event deficiencies are identified through this oversight and monitoring, Delegate will provide a specific corrective action plan acceptable to LAC as specified in the Agreement and this Manual. If Delegate does not comply with the corrective action plan within the specified time frame, then LAC will take necessary steps up to and including revocation of delegation in whole or in part.

LAC will provide Delegate with the data necessary to determine member experience and clinical performance, when requested, per LAC's policies and procedures. Delegate shall submit its request to the LAC business unit which maintains the data and/or the Delegate's assigned Provider Account Manager. The request must be specific, and contain sufficient details so LAC can understand and fulfill the request. The applicable LAC business unit shall respond timely and make the data available in compliance with applicable LAC policies and procedures and State and Federal laws, including patient privacy laws.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Credentialing					

Credentialing Policies	X			The Delegate has a well-defined credentialing and re-credentialing process for evaluating licensed independent practitioners to provide care to assigned members:
				• By developing and implementing credentialing policies and procedures which specify:
				  • The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions.
				  • The verification sources used
				  • The criteria for credentialing and re-credentialing
				  • The process for making credentialing and re-credentialing decisions
				  • The process for managing credentialing files that meet PPG's established criteria. Policies must describe the process it uses to determine and approve clean files. The PPG may present all files, including clean files, to the Credentialing Committee, or it may designate approval authority to the medical director or to an equally qualified practitioner.
				  • The processes for requiring that credentialing and re-credentialing are conducted in a nondiscriminatory manner. Policies must specify that the PPG does not base credentialing and re-credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and re-credentialing process for discriminatory practices at least annually. Must maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions.
				  • The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to the PPG by the practitioner.
				  • The process to ensure that practitioners are notified of credentialing and re-credentialing decisions within 60 calendar days of the committee's decision
				  • The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program
					Healthplan retains the process for ensuring those listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty
					
					Healthplan retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers and sites
					
					Licentiate is not entitled to a hearing under LS-005: When L.A. Care has determined, based on L. A. Care's reasonable assessment of its provider network that L.A. Care already has adequate access to the types of services provided by the Licentiate.

1 Activities and Functions under each Standard relate to the most current regulatory guidelines and NCQA accreditation standards. Delegate is responsible for maintaining compliance with state and federal standards and NCQA accreditation guidelines, as updated from time to time. An NCQA activity or function not specified in the Agreement and/or in this grid are retained by Healthplan.
2 All functions delegated to PPG are listed under "Activities" and indicated by an "X" in the "Delegated" column.
3 All functions retained by Healthplan are listed under "Retained by Healthplan" and indicated by an "X" in the "Non-Delegated" column.
4 Shared functions are indicated by an "X" in the "Shared" column; Functions delegated to PPG are listed under "Activities" and functions "Retained by Healthplan" are listed under "Retained by Healthplan.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Credentialing Policies *(Continues)*	X			• The process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law • The process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. • Notification of practitioner rights in policies and procedures: ◦ The right of practitioners to review information submitted to support their credentialing application ◦ The right of practitioners to correct erroneous information, including: ◦ The timeframe for changes ◦ The format for submitting the corrections ◦ The person to whom the corrections must be submitted • The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request • Medi-Cal Fee For Service (FFS) Screening and Enrollment (Medi-Cal only): ◦ That all practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. ◦ The process for verifying Medi-Cal enrollment. ◦ The process for practitioners whose enrollment application is in process. ◦ The process for monthly monitoring to validate continued enrollment. ◦ Process for practitioners not currently enrolled in the Medi-Cal program. ◦ Process for practitioners deactivated or suspended from the Medi-Cal program. Credentialing System Controls Delegate's credentialing process describes: • How primary source verification information is received, dated and stored. • How modified information is tracked and dated from its initial verification. • Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. • The security controls in place to protect the information from unauthorized modification. How the organization audits the processes and procedures based on NCQA factors	Healthplan retains accountability for oversight of the Delegate's adherence to these procedural components through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Credentialing Committee	X			Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and re-credentialing decisions such that: The committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Any action taken upon the vote of a majority of committee members present at a duly held meeting with a quorum present in an act of the committee. A quorum consists of 3 practitioner committee members. • Reviews the credentials of practitioners who do not meet the PPG's established thresholds • Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician. • Ensures that all license accusations, sanctions or restrictions are reviewed by the credentialing committee for action.	
Credentialing Verification	X			Primary source verification and credentialing and re-credentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care within the NCQA prescribed time limits, through primary or other NCQA-approved sources prior to credentialing and re-credentialing by: Verifying that the following are within the prescribed time limits: • Current, valid license to practice (must develop a process to ensure provider licenses are kept current at all times). • A valid DEA or CDS certificate, with schedules 2 thru 5, if applicable; or the PPG has a documented process for practitioners ◦ Allowing practitioners with a valid DEA certificate to write all prescriptions for a practitioner who has a pending DEA certificate.	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Credentialing Verification *(Continues)*	X			• Require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications • The PPG verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate: ◦ Board certification if practitioner states on the application that he or she is board certified, as well as expiration date of certification ◦ Completion of a residency program ◦ Graduation from medical or professional school • Work history • Hospital and clinical privileges in good standing. • Current malpractice insurance coverage ($1 million/$3 million). • A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner • Current, valid FSR/MRR of primary care physician (PCP) offices conducted within 3 years of credentialing and re-credentialing decision. • CLIA Certifications, if applicable • NPI number • Medicare number, if applicable • Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current. Delegate shall maintain credentialing and/or other monitoring processes to assure that licensure and professional status of each Participating Provider is verified on an ongoing basis. Pursuant to the performance of its credentialing, re-credentialing, auditing, monitoring and/or other processes, which include confirmation relating to the following:	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Credentialing Verification *(Continues)*	X			• Each Participating Provider/Practitioner is and shall remain duly licensed or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the ability of Participating provider/practitioner to provide Health Care Services to LAC members as required under the Agreement. Any provider/practitioner with restrictions or limitations is not allowed to provide services for the Covered California Line of Business. • Each Delegate shall maintain professional liability insurance, either independently or through Contractor or some other entity, in a dollar amount that is sufficient for his/her/its practice and as may be required by law or accrediting entities. The Delegate's participating providers must also have general liability insurance in a dollar amount appropriate for their business practice. The PPG must notify the Healthplan immediately when a practitioner's license has expired for removal from the network.	
Sanction Information	X			Primary source verification and credentialing and re-credentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources prior to credentialing and re-credentialing: • State sanctions, restrictions on licensure, or limitations on scope of practice – review of information must cover the most recent 5 year period available. If a practitioner is licensed in more than one state, in the most recent 5 year period, the query must include all states in which they worked. • Medicare and Medicaid sanctions. • Medicare Opt-Out. • CMS Preclusion. • SAM. The PPG must notify the Healthplan immediately when practitioners are identified on any sanctions or reports for removal from the network.	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Application and Attestation	X			Applications for credentialing and re-credentialing include the following: • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary action. • Current malpractice insurance coverage ($1million/$3 million). • Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length	X			Re-credentialing all practitioners at least every 36 months.	
Ongoing Monitoring & Interventions	X			• Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between re-credentialing cycles including: • Collecting and reviewing Medicare and Medicaid sanctions within 30 calendar days of its release. In areas where reporting entities do not publish sanction information on a set schedule, the PPG must query for this information at least every 6 months. • Collecting and reviewing accusations, sanctions, restrictions or limitations on licensure and report actions taken against any identified practitioners to the health plan. • Collecting and reviewing complaints – the PPG must set a threshold to evaluate the specific complaint and the practitioner's history of issues. • Collecting and reviewing information from identified adverse events • Implementing appropriate interventions when PPG identifies instances of poor quality • The PPG's Credentialing committee may vote to flag a practitioner for ongoing monitoring • The PPG's must make clear, the types of monitoring they impose, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the PPG's credentialing committee minutes	Upon notification of any Adverse Event, Healthplan will notify the PPG of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notice will include, but is not limited to: • Requesting what actions will be taken by the PPG • What type of monitoring is being preformed • What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Ongoing Monitoring & Interventions. *(Continues)*	X			• The PPG's credentialing committee can: ◦ Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored ◦ Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion ◦ Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable PPG shall maintain credentialing and/or other monitoring processes to ensure that licensure and professional status of each Participating Provider is verified on an ongoing basis pursuant to the performance of its credentialing, recredentialing, auditing, monitoring and/or other processes, which include confirmation relating to the following: • Each Participating Provider/Practitioner is and shall remain duly licensed or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the ability of participating provider/practitioner to provide Health Care Services to our members as required under this Agreement. Any provider/practitioner with restrictions or limitations is not allowed to provide services for the Covered California line of Business.	• The notification will include a timeframe for responding to Healthplan to ensure Healthplan's members receive the highest level of quality care Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in Healthplan's policies and procedures In the event that the PPG fails to respond as required, the Healthplan will perform the oversight functions of the Adverse Event and the PPG will be subject to Healthplan's credentialing committee's outcome of the adverse events L.A. Care retains the right to ensure our delegated entities are performing the required monitoring of Adverse Events and will monitor and collaborate along with delegated entities as necessary to ensure our members receive the highest level of quality care.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
					L.A. Care reserves the right to remove, suspend, or terminate a practitioner from its network with or without cause for any reason if it believes its members are in imminent danger or if the safety and welfare of the members are compromised.
Notification to Authorities and Practitioner Appeal Rights	X			The PPG uses objective evidence and patient care considerations to decide on a course of action for dealing with practitioner who does not meet PPG's quality standards, including: • Developing and implementing policies and procedures that specify: ◦ That the PPG reviews participation of practitioners whose conduct could adversely affect members' health or welfare. ◦ The range of actions that may be taken to improve practitioner performance before termination. ◦ That the PPG reports its action to the appropriate authorities ◦ Making the appeal process known to practitioners. PPG must notify L.A. Care in writing if any contracted practitioner has any adverse or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network as referenced in the California Participating Physician Application Information Release Acknowledgments.	Healthplan retains accountability for procedural components and will oversee PPG's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Facility Site Review and Quality of Practitioner Offices		X		PPG must cooperate with Health Plan in the performance of Facility Site Reviews. In addition, practitioners must meet standards to assess the quality, safety and accessibility of office sites where care is delivered. The Plan sets site performance standards and thresholds for: • Physical accessibility • Physical appearance • Adequacy of waiting and examining room space • Adequacy of medical/treatment record keeping For primary care physicians the Plan through the DHCS collaborative will conduct facility site reviews and medical record reviews prior to credentialing committee decision date and every 36 months thereafter.	In addition to requirements for participation in the DHCS Facility Site Review Collaborative, Healthplan will develop a process to ensure that the offices of all practitioners meet its office-site standards for office site criteria and medical/treatment record-keeping criteria and implementing appropriate interventions, as needed.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Assessment of Organizational Providers	X			The PPG's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 3 years thereafter, it: • Developing and implementing policies and procedures that confirm: ◦ Confirm the provider is in good standing with state and federal regulatory bodies ◦ Confirm the provider has been reviewed and approved by an accrediting body acceptable to PPG, including which accrediting bodies are acceptable ◦ An onsite quality assessment, including a process for ensuring that the provider organization credentials its practitioners, is conducted if the provider organization is not accredited by an accrediting body acceptable to PPG. The PPG must develop a selection process and assessment criteria for each type of non-accredited provider organization with which it contracts • Including in the assessment and approval process the following medical provider organizations: ◦ Hospitals ◦ Home health agencies ◦ Skilled nursing facilities ◦ Freestanding surgical centers ◦ *Hospices ◦ *Clinical laboratories (a CMS – issued CLIA certificate or a hospital – based exemption from CLIA) ◦ *Comprehensive Outpatient Rehabilitation Facilities (CORFs) ◦ *Outpatient Physical Therapy and Speech Pathology Providers ◦ *Providers of end-stage renal disease services ◦ *Providers of outpatient diabetes self-management training ◦ *Portable x-ray Suppliers ◦ * Rural Health Clinic (RHCs) and Federally Qualified Health center (FQHCs) ◦ Completing and documenting assessments of all contracted medical health care provider organizations * Only applicable for Cal-MediConnect line of business The Delegate assesses contracted health care delivery providers against the requirements and within the time frame specified in the 2019 NCQA Standards, Standard CR 7.	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-Delegation of CR	X			If PPG sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including: • A written sub-delegation agreement between PPG and Sub-delegate that: ◦ Is mutually agreed upon ◦ Describes the activities and responsibilities of PPG and Sub-delegate ◦ Requires at least semiannual reporting to PPG ◦ Describes the process by which PPG evaluates Sub-delegate's performance ◦ Specifies that the PPG retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization sub-delegates decision making. ◦ Describes the remedies available to PPG if Sub-delegate does not fulfill its obligations, including revocation of the sub-delegation • Retention of the right by PPG and Healthplan, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites • Evaluating the capacity to meet NCQA requirements of any new Sub-delegates before the sub-delegation begins • For sub-delegation arrangements in effect for 12 months or longer, PPG: ◦ Annually reviews its sub-delegate's credentialing policies and procedures. ◦ Annually Audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect and report findings to Healthplan upon request. ◦ Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities and report findings to Healthplan upon request. ◦ Evaluates regular reports from Sub-delegate at least semi-annually or more frequently based on the reporting schedule described in the sub-delegation document ◦ Identifies and follows up on opportunities for improvement at least once in each of the past 2 years for delegation arrangements that have been in effect for more than 12 months. PPG shall cooperate with Healthplan in the performance of a pre-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, PPG shall provide Healthplan with reasonable prior notice of PPGs intent to sub-delegate. **If PPG sub-delegates any NCQA required credentialing activities, the PPG must notify Healthplan of the sub-delegated arrangement and provide a copy of the agreement upon request.**	Healthplan retains the right to perform a pre-delegation audit of any entity to which PPG sub-delegates Delegated Activities and approve any such sub-delegation. The Healthplan retains the right to approve, suspend and terminate individual practitioners, providers and sites even if the organization delegates decision making.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Provider Network					
Standardized Provider File (SPF)	X			Delegates must use the The Standardized Provider Profile (SPF) is used to submit: : • Initial data for new providers or new contracted entities • Monthly full network data submission for regulatory reporting and provider directory purposes • Add, Change, Terminate (A/C/T) data submissions The data in the SPF is intended to collect comprehensive provider data for the full network of the Healthplan to meet its contractual and regulatory requirements. The data is required to meet regulatory reporting requirements, network adequacy and timely access to care reporting requirements, provider directory requirements and internal operations requirements. The SPF format and validation processes increase data accuracy and reduce the administrative burden on providers by consolidating provider data ingestion to a single submission process. SPF files that represent Add, Change, or Termination transactions, referred to as A/C/T transactions, must be submitted in accordance with applicable statutory, regulatory, and contractual requirements. Specifically, California Health & Safety Code (HSC) §1367.27, requires providers to notify the Healthplan within five (5) business days of changes for data elements addressed in the statute. Healthplan applies the same standard for A/C/T transactions.	Standardized Provider File (SPF)
Health Education					
Health Education Services		X			Healthplan retains the provision of health education services in required health topics
Health Education Materials		X			Healthplan retains the provision of health education materials in required health topics and threshold languages

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
IHEBA		X			Healthplan retains the responsibility for providing Individual Health Education Behavioral Assessment (IHEBA) forms in required age categories and languages
IHEBA	X			Provider offices are responsible for administering IHEBA forms at appropriate age intervals.	Healthplan retains the responsibility for providing Individual Health Education Behavioral Assessment (IHEBA) forms in required age categories and languages
Health Education Staff		X			Healthplan retains the responsibility for employing a Master's level health educator specializing in public or community health education or its equivalent
Group Needs Assessment		X			Healthplan retains the responsibility for conducting a health education, cultural and linguistic group needs assessment according to required timelines
Provider Education			X	Inform provider network of health education requirements and available resources.	Healthplan shares the responsibility for educating the provider network of health education requirements and available resources

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Cultural & Linguistic					
Interpreting Services		X			Healthplan retains the provision of 24-hour, 7 day a week, qualified face-to-face and telephonic interpreting services, including ASL
Translation of Member Informing Materials		X			Healthplan retains the provision of translation of member informing materials, including NOA templates, in Los Angeles County threshold languages in accordance with MMCD Policy Letter 99-04. Large print and alternative formats available upon request
Provider Education & Training			X	PPG/IPA is responsible for annually informing its network providers of: • Healthplan's C&L trainings • C&L requirements • Cultural competency • Disability sensitivity • How to access C&L trainings, language assistance services and resources made available to network providers by Healthplan	Healthplan retains the responsibility for making trainings (C&L requirements, Cultural Competency and Disability Sensitivity) available to PPG/IPA's network providers and evaluating effectiveness of training program and keeping training records (i.e., sign in sheets) on file.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Staff Training			X	PPG/IPA is responsible for annually informing its staff of: • Healthplan's C&L trainings • C&L requirements • Cultural competency • Disability sensitivity **How to access these trainings, language assistance services and resources made available by Healthplan**	Healthplan retains the responsibility for making trainings available to PPG/IPA staff on C&L requirements, language assistance services, cultural competency and disability sensitivity, evaluating effectiveness of training program and keeping training records (i.e., sign in sheets) on file.
Quality Improvement for C&L Program		X			Healthplan retains the responsibility for evaluating the effectiveness of its C&L program that directly links with quality improvement processes for the purpose of improving service delivery and quality of care for specific racial/ethnic and language groups.
Monitoring and Oversight of Subcontractors for Delegated C&L Services		X			Healthplan retains the responsibility for monitoring and overseeing subcontractors (first tier, downstream and related entities) to ensure compliance with C&L requirements set forth by the federal and state laws and regulations with regular frequency.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Cultural and Linguistic Services Referral		X			Healthplan retains the provision of a system to refer members to culturally and linguistically appropriate community services
Language Proficiency Assessment	X			PPG/IPA is responsible for identifying, assessing, and monitoring language capability of its bilingual staff (non-clinical and clinical) who communicates with members in a language other than English. At a minimum, PPG/IPA's language proficiency assessment should include, but are not limited to, the following: • Written or oral assessment of bilingual skills • Documentation of the number of years of employment the individual has as an interpreter and/or translator • Documentation of successful completion of a specific type of interpreter training programs (i.e., medical, legal, court, semi-technical, etc.) • Other reasonable alternative documentation of interpreter capability • A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems (for clinical staff) Assessed and qualified bilingual staff list must be kept on file and provided to L.A. Care on an annual basis. If they are not assessed and qualified to meet the criteria below, use interpreting services offered by Healthplan to communicate with LEP members. Language proficiency criteria for non-clinical bilingual staff shall include: • Have conversational fluency in both the target language and English including: ◦ Speak in a grammatically correct manner for statements and questions ◦ Comprehend spoken language related to both health care settings and customer services ◦ Have adequate vocabulary of managed care terminology, forms of address, greetings, directions, time of day, days of the week, names of the months, services process, and personnel ◦ Assessed and qualified non-clinical should be able to: • Assist limited English proficient (LEP) members to complete forms, in English, appropriate to the specific setting or circumstance • Precisely explain non-clinical consent forms (e.g. transfer of medical records, admission forms, and advance directives)	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Language Proficiency Assessment *(Continues)*	X			Language proficiency criteria for clinical bilingual staff shall include: • Have all of the language skills required of non-clinical bilingual staff listed above and must have proficiency related to clinical settings including:: ◦ Fluency in medical terminology in both languages (anatomical terms, body processes and physiology, symptoms, common disease names and processes, common etiologic terms, clinical procedures, instructions, and treatment plans) ◦ Appropriate training to take or assist with gathering information for an accurate medical history ◦ Assessed and qualified non-clinical should be able to: • Assist providers by interpreting clinically related consent forms.	
Linguistic Capabilities of Provider Network			X	PPG/IPA is responsible for maintaining a provider network reflective of member demographic. This includes maintaining the linguistic capabilities of providers and provider office staff on file and providing this information to the Healthplan.	Healthplan retains the responsibility of monitoring the provider network to ensure that it is reflective of member demographics and meets the members' needs. Healthplan will list languages spoken by providers and their staff in the provider directory.
Translation of PPG/ IPA-developed Member Informing Materials/ verbiage	X			PPG/IPA is responsible for the translation and alternative format conversion of PPG/IPA-developed materials/ verbiage (beyond materials developed and translated by Healthplan), including the non-template individualized verbiage in NOA letters, into Los Angeles	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Translation of PPG/ IPA-developed Member Informing Materials/ verbiage *(Continues)*	X			County threshold languages in accordance with state and federal regulations. Responsibilities include: • Ensuring documents undergo the three-step process (translation, editing and proofreading) by at least two separate qualified translators • Ensuring translated documents are at the six grade reading level • Keeping on file an attestation for each document and translated language from the individual, organization, or vendor conducting the translation. The attestation should affirm the qualifications of the translators and certify that the translation is true and accurate Threshold languages for Los Angeles County include: • English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog and Vietnamese PPG/IPA is responsible for providing PPG/IPA-developed written Member Informing Materials (refer to definitions of Member Informing Materials and Vital Documents by DHCS, DMHC and CMS) in the members' preferred threshold language on a routine basis and alternative formats upon request in accordance with state and federal regulations. Responsibilities include: • Enabling members to make a standing request for written member informing materials in their preferred threshold language and alternative format upon request • Distributing fully translated Member Informing Materials to members on a routine basis. This includes member specific information on a form letters including, but not limited, deferral, denial, modification, and termination letters ◦ PPG/IPA should use the translated notice of action letter templates provided by L.A. Care ◦ Non-template verbiage, including member-specific information or denial reason, should be fully translated upon request ◦ Letters should include a language block (i.e., a disclaimer or notice of the availability of translation services) which reflects PPG/IPA's phone number ◦ Providing all Cal MediConnect materials (English and translated) with "Disclaimer on Availability of Non-English Translations" or the "Multi-Language Insert" to members, as needed	

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Quality Management and Improvement (QI)					
Program Structure (NCQA QI 1)		X			**Element A: QI Program Structure** **Element B: Annual Work Plan** **Element C: Annual Evaluation** **Element D: QI Committee Responsibilities**
Program Operations (NCQA QI 2)		X			**Element A: Practitioner Contracts** **Element B: Provider Contracts** **Affirmative Statement**
Continuity and Coordination of Medical Care (NCQA QI 3)			X	**Element D: Transition to Other Care** The PPG/IPA helps with a members transition to other care, if necessary: • When their benefits end If covered benefits are exhausted while a member needs care, the PPG/IPA notifies the member about alternatives and resources for continuing care and how to obtain it, as appropriate. The organization is not required to develop alternative resources. The PPG/IPA is not required to manage the transition from pediatric care to adult care for every member. The PPG/IPA will utilize Healthplan criteria (e.g., diagnosis, age) for notification to individuals or their caretakers of the transition and assist them with identifying an adult primary care provider in the network.	Healthplan retains accountability for policy components and will oversee PPG/IPA's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards **Element A: Identifying Opportunities** **Element B: Acting on Opportunities** **Element C: Measuring Effectiveness** Healthplan distributes criteria for the identification and interventions with notification process for pediatric/adolescent care to adult primary care.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
					Healthplan will oversee PPG/IPA's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards
Continuity and Coordination Between Medical Care and Behavioral Healthcare (NCQA QI 4)			X	The organization is responsible for coordination of other covered benefits including those delegated to or carved out to other entities.	**Element A: Data Collection** **Element B: Collaborative Activities** **Element C: Measuring Effectiveness**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of QI (NCQA QI 5)		X			Healthplan retains the right to perform a pre-delegation audit of any entity to which PPG/IPA sub-delegates Delegated Activities and approve any such sub-delegation for purposes of this Delegation Agreement. PPG/IPA shall cooperate with Healthplan in the performance of a pre-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, PPG/IPA shall provide Healthplan with reasonable prior notice of PPG/IPAs intent to sub-delegate.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of QI (NCQA QI 5) *(Continues)*		X			**Element A: Sub-delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the organization. 4. Describes the process by which the organization evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested. 6. Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of QI (NCQA QI5) *(Continues)*		X			**Element B:** **Pre Sub-delegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation began. **Element C:** **Review of QI Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in Element A.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of QI (NCQA QI5) *(Continues)*		X			**Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.
Population Health Management (PHM)					
PHM Strategy (NCQA PHM 1)		X			**Element A: Data Integration** **Element B: Population Assessment**
Population Identification (NCQA PHM 2)		X			**Element A: Strategy Description** **Element B: Informing Members** **Element C: Activities and Resources** **Element D: Segmentation**
Delivery System Supports (NCQA PHM 3)		X			**Element A: Practitioner or Provider Support** **Element B: Value-Based Payment Arrangements**
Wellness and Prevention (NCQA PHM 4)		X			**Element F: Frequency of Health Appraisal Completion** **Element H: Topics of Self-Management Tools**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Complex Case Management (NCQA PHM 5)		X		Identifying Members for Case Management Identifies members for case management using the following data sources to analyze the health status of members: • Claims or encounters data, • Hospital discharge data, • Pharmacy data and • Data collected through the UM process • Data supplied by members or caregivers • Data supplied by practitioners Participation in the Interdisciplinary Care Team in accordance with DHCS All Plan Letter 17-012	**Element A: Access to Case Management** **Element B: Case Management Systems** **Element C: Case Management Process** **Element D: Initial Assessment** **Element E: Case Management: Ongoing Management**
Population Health Management Impact (NCQA PHM 6)		X			**Element A: Measuring Effectiveness** **Element B: Improvement and Action**
Delegation of PHM (NCQA PHM 7)		X			**Element A: Delegation Agreement** **Element B: Predelegation Evaluation** **Element C: Review of PHM Program** **Element D: Opportunities for Improvement**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Network Management (NET)					
Availability of Practitioners (NCQA NET 1)		X			**Element A: Cultural Needs and Preferences** **Element B: Practitioners Providing Primary Care** **Element C: Practitioners Providing Specialty Care** **Element D: Practitioners Providing Behavioral Healthcare**
Accessibility of Services (NCQA NET 2)		X			**Element A: Access to Primary Care** **Element B: Access to Behavioral Healthcare** **Element C: Access to Specialty Care**
Assessment of Network Adequacy (NCQA NET 3)		X			**Element A: Assessment of Member Experience Accessing the Network** **Element B: Opportunities to Improve Access to Nonbehavioral Healthcare Services** **Element C: Opportunities to Improve Access to Behavioral Healthcare Services**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Marketplace Network Transparency and Experience (NCQA NET 3/ME 7)		X			**NET 3A, ME 7C, ME 7E: Marketplace Member Experience** **NET 3B, NET 3C, ME 7D, ME 7F): Marketplace Member Experience Opportunities for Improvement**
Continued Access to Care (NCQA NET 4)			X	**Element A: Notification of Termination** The organization notifies members affected by the termination of a specialty care practitioner or specialty practice group at least 90 calendar days prior to the effective termination date, and helps them select a new practitioner. **Element B: Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	Healthplan will oversee PPG/IPA's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards **Element A: Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Physician and Hospital Directories (NCQA NET 5)		X			**Element A: Physician Directory Data** **Element B: Physician Directory Updates** **Element C: Assessment of Physician Directory Accuracy** **Element D: Identifying and Acting on Opportunities** **Element E: Searchable Physician Web-Based Directory** **Element F: Hospital Directory Data** **Element G: Hospital Directory Updates** **Element H: Searchable Hospital Web-Based Directory** **Element I: Usability Testing** **Element J: Availability of Directories**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of NET (NCQA NET 6)		X			Healthplan retains the right to perform a pre-delegation audit of any entity to which PPG/ IPA sub-delegates Delegated Activities and approve any such sub-delegation for purposes of this Delegation Agreement. PPG/IPA shall cooperate with Healthplan in the performance of a pre-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, PPG/IPA shall provide Healthplan with reasonable prior notice of PPG/IPAs intent to sub-delegate. **Element A: Sub-delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of NET (NCQA NET 6) *(Continues)*		X			3. Requires at least semiannual reporting by the sub-delegated entity to the organization. 4. Describes the process by which the organization evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested. 6. Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Element B: Pre Sub-delegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation began.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of NET (NCQA NET 6) *(Continues)*		X			**Element C: Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's network management procedures. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in Element A. **Element D: Opportunities for Improvement** FFor sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Utilization Management (UM)					
Utilization Management Structure (NCQA UM 1)			X	The organization has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. **Element A: Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior-level physician in UM program implementation. 4. The program scope and process used to determine benefit coverage and medical necessity **5. Information sources used to determine benefit coverage and medical necessity. A written description of the program structure.** **Element B: Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary. PPG is responsible for UM process and activities in pursuant to its individual contract with Healthplan and following regulatory requirements by line of business. DHCS Technical Assistance Guide Utilization Management DMHC Technical Assistance Guide Utilization Management Medicare Managed Care Manual Chapter 13; 42 CFR Subpart M; 42 CFR § 422.152	Healthplan retains accountability for policy components and will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. **Element A: Written Program Description** Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Clinical Criteria for UM Decisions (NCQA UM 2)			X	**Element A: UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs. 3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. In addition, the organization will abide by any additional criteria or criteria hierarchy provided by the Healthplan, including but not limited to those specified by regulatory bodies (e.g DHCS All Plan Letters). **Element B: Availability of Criteria** The organization: 1. States in writing how practitioners can obtain UM criteria. 2. Makes the criteria available to its practitioners upon request. **Element C: Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable.	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. Provide criteria hierarchy prior to delegation and when updated.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Communication Services (NCQA UM 3)			X	**Element A: Access to Staff** The organization provides the following communication services for members and practitioners 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. Note: Includes maintaining hospitalist program to facilitate appropriate admissions, transfers, length of stay and discharge from acute care settings. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues.	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation.
Communication Services		X			Healthplan retains accountability for maintaining a documented process for and sends communication of services to members and providers at least annually and upon enrollment

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Appropriate Professionals (NCQA UM 4)			X	**Element A: Licensed Health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision making. **Element B: Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice. 2. A current clinical license to practice or an administrative license to review UM cases. Note: "Denials" refers to any type of adverse decision. **Element C: Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity. **Affirmative Statement About Incentives** The organization distributes a statement to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. **Element D: Practitioner Review of Behavioral Healthcare Denials** **Element E: Practitioner Review of Pharmacy Denials** **Element F: Use of Board-Certified Consultants**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Timeliness of Utilization Management Decisions (NCQA UM 5)			X	The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. Delegate will comply with the timeliness standards for decisions and notification as required by the State of California, CMS, and NCQA. **Element A: Notification of Nonbehavioral Decisions** **Element D: UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Non-behavioral UM decision making. 2. Notification of non-behavioral UM decisions.	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. **Element B: Notification of Behavioral Healthcare Decisions** **Element C: Notification of Pharmacy Decisions** **ELement D: UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Behavioral UM decision making. 2. Notification of behavioral UM decisions. 3. Pharmacy UM decision making. 4. Notification of pharmacy UM decisions.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Clinical Information (NCQA UM 6)			X	**Element A: Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. **Element B: Relevant Information for Behavioral Healthcare Decisions** **Element C: Relevant Information for Pharmacy Decisions**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Denial Notices (NCQA UM 7)			X	**Element A: Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss non-behavioral healthcare UM denial decisions with a physician or other appropriate reviewer. **Element B: Written Notification of Nonbehavioral Healthcare Denials** The organization's written notification of non-behavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language. Note: Readability standards for Medi-Cal specify the 6th grade level. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request. **Element C: Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal. 2. An explanation of the appeal process, including members' rights to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. Healthplan will provide the template written communications for UM decision making; PPG must implement and utilize the most recent version of the Healthplan approved templates **Element D: Discussing a Behavioral Healthcare Denial With a Reviewer** **Element E: Written Notification of Behavioral Healthcare Denials** **Element F: Behavioral Healthcare Notice of Appeal Rights/Process** **Element G: Discussing a Pharmacy Denial With a Reviewer** **Element H: Written Notification of Pharmacy Denials** **Element I: Pharmacy Notice of Appeals Rights/Process**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Policies for Appeals (NCQA UM 8)		X			**Element A: Internal Appeals**
Appropriate Handling of Clinical Appeals (NCQA UM 9)				PPG to immediately forward any requests for appeal to Healthplan and to provide any needed clinical or other information needed in Healthplan appeal process.	**Element A: Preservice and Postservice Appeals** **Element B: Timeliness of the Appeal Process** **Element C: Appeal Reviewers** **Element D: Notification of Appeal Decision/Rights** **Element E: Final Internal and External Appeal Files** **Element F: Appeals Overturned by the IRO**
Grievance and Appeals		X		Ensure members receive the member grievance and appeals process in compliance with the regulatory and contractual requirements PPG to immediately forward any grievances and/or requests for appeal to Healthplan and to provide any needed clinical or other information needed in Healthplan grievance and appeal process.	Healthplan retains the function of grievance and appeals/reconsiderations/ redetermination, including the member communications
Reconsideration/ Redetermination (CMC Only)		X		Ensure members receive the Medicare required reconsideration/redetermination in compliance with the Medicare requirements PPG to immediately forward any requests for reconsideration/redetermination to Healthplan and to provide any needed clinical or other information needed in Healthplan review process.	Healthplan retains the function of grievance and appeals/reconsiderations/ redetermination, including the member communications

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Evaluation of New Technology (NCQA UM 10		X			**Element A: Written Process** **Element B: Description of the Evaluation Process**
Provider and Member Satisfaction with UM			X	The organization's annual assessment of satisfaction with the UM process includes: 1. Collecting and analyzing data on member satisfaction for the identification of improvement opportunities (DMHC & DHCS requirement) The organization has gathered and used information that specifically addresses member satisfaction with the UM program. The evaluation process must address satisfaction with the process of getting a service approved and obtaining a referral. The gathering of information does not have to be a questionnaire methodology. 2. Collecting and analyzing data on practitioner satisfaction for the identification of improvement opportunities. (DMHC & DHCS requirement) The organization has gathered and used information that specifically addresses practitioner satisfaction with the UM program. The evaluation process must address satisfaction with the process of getting a service approved and obtaining a referral. The gathering of information does not have to be a questionnaire methodology.	At least annually, evaluates member and practitioner satisfaction with Healthplan and PPG's UM processes, addresses opportunities for improvement and develops appropriate interventions, if necessary.
Emergency Services			X	Evaluating emergency department visits or claims, including: • Written policies and procedures that require: ◦ Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed and ◦ Coverage of emergency services if an authorized representative, acting for PPG, has authorized the provision of emergency services • A review of presenting symptoms and discharge diagnoses by a physician or other appropriate doctoral level practitioner prior to denying or down-coding emergency department claims. • Coverage of emergency services when approved by an authorized representative	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Pharmaceutical Management (NCQA UM 11)		X			**Element A: Pharmaceutical Management Procedures** **Element B: Pharmaceutical Restrictions/Preferences** **Element C: Pharmaceutical Patient Safety Issues** **Element D: Reviewing and Updating Procedures** **Element E: Considering Exceptions** Healthplan retains accountability for developing and maintaining policies and procedures for pharmaceutical management. The organization's policies and procedures for pharmaceutical management include the following: • The reference used to adopt pharmaceutical management procedures • A process that uses clinical evidence from appropriate external organizations • A process to include pharmacists and appropriate practitioners in the development of procedures • A process to provide procedures to practitioners annually and when it makes changes

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Pharmaceutical Management (NCQA UM 11) *(Continues)*		X			Annually and after updates, the organization communicates the following to members and prescribing practitioners: • A list of pharmaceuticals (i.e., formulary), including restrictions and preferences • How to use the pharmaceutical management procedures • An explanation of limits • How prescribing practitioners must provide information to support an exception request • The organization's process for generic substitution, therapeutic interchange and step-therapy protocols

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Pharmaceutical Management (NCQA UM 11) *(Continues)*		X			The organization's pharmaceutical procedures include: • Identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification • An expedited process for prompt identification and notification of members and prescribing practitioner affected by a Class I recall With the participation of physicians and pharmacists, the organization annually: • Reviews the procedures • Reviews its list of pharmaceuticals • Updates the procedures as appropriate • Updates the list of pharmaceuticals as appropriate

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Pharmaceutical Management (NCQA UM 11) *(Continues)*		X			The organization has exceptions policies and procedures that describe the process for: • Making an exception request based on medical necessity • Obtaining medical necessity information from prescribing practitioners • Using appropriate pharmacists and practitioners to consider exception requests • Timely handling of requests Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.
UM System Controls (NCQA UM 12)				**Element A: UM Denial System Controls** Delegate has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6.	**Element B: UM Appeal System Controls** Healthplan has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
UM System Controls (NCQA UM 12) *Continues)*					3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Delegation of UM (NCQA UM 13)		X			Healthplan retains the responsibility for and has appropriate structures and mechanisms to oversee delegated UM activities. The Healthplan maintains written delegation documents that are mutually agreed upon, describe delegated activities, describe the reporting of the delegated entity to the Healthplan and describes the remedies available if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. Healthplan provides the member experience and clinical performance data upon request from the PPG/IPA. Healthplan's delegation document includes the use of protected health information by the delegation. Healthplan annually revises delegates UM program and performance against the NCQA standards for delegated activities; evaluates regular reports and identifies and followed up on opportunities for improvement.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of Utilization Management (NCQA UM 13)		X			Healthplan retains the right to perform a pre-delegation audit of any entity to which PPG sub-delegates Delegated Activities and approve any such sub-delegation for purposes of this Delegation Agreement. PPG shall cooperate with Healthplan in the performance of a pre-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, PPG shall provide Healthplan with reasonable prior notice of PPGs intent to sub-delegate. PPG must also maintain a copy of its sub-delegation agreement and provide to Healthplan upon request.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of Utilization Management (NCQA UM 13) (*Continues*)					**Element A: Sub-Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the organization. 4. Describes the process by which the organization evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested. 6. Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of Utilization Management (NCQA UM 13) *(Continues)*		X			**Element B: Pre Sub-delegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation began.. **Element C: Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that sub-delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for sub-delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of Utilization Management (NCQA UM 13) *(Continues)*		X			**Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.
Continued Access to Care			X	The PPG/IPA monitors and takes action, as necessary, to provide continuity and coordination of care. The PPG/IPA notifies Healthplan of the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 90 calendar days prior to the effective termination date. Provide Continuity of Care for new and existing eligible members per: • California Health & Safety Code 1373.96 • DHCS All Plan Letter 18-008 • DHCS Dual Plan Letter 16-002 • 42 C.F.R. § 422.112(b)(3) • Medicare Managed Care Manual Chapter 4	Healthplan notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner Healthplan will oversee PPG/IPA's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Assessing Provider and Member Experience with the UM process		X			Healthplan retains accountability for, at least annually, evaluating member and practitioner experience with Healthplan and PPG/IPA's UM processes, addresses opportunities for improvement and develops appropriate interventions, if necessary.
Care Management and Care Coordination Services			X	The PPG maintains an appropriate program to coordinate services and help all members access needed resources through care coordination and case management activities (excluding complex case management) in accordance with regulatory requirements. The PPG ensures care coordination and care management services including: • Process and criteria for identifying level of members' needs for care coordination, low and moderate risk case management (e.g. medical, psycho-social risk factors) • Staffing with ratios to support care coordination and non-complex case management • Information systems to support compliance with regulatory requirements and reporting • Coordination across the full continuum of service providers, including benefits provided by other entities (e.g. Medi-Cal Dental, IHSS, DMH) and access to community resources • Person-centered, outcome-based approaches with a focus on providing services in the least restrictive setting The PPG maintains policies and procedures for the following: • Receipt and processing of assessments from Healthplan, including communication of results with PCP • Development of individualized care planning (ICP) using person-centered planning to address issues from assessments • Coordinating and facilitating the interdisciplinary care team (ICT) • Coordinating care with Healthplan Long Term Services and Supports (LTSS) programs (i.e. CBAS, LTC, IHSS, MSSP, Care Plan Options)	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Care Management and Care Coordination Services *(Continues)*			X	• Coordinating with Healthplan Behavioral Health and or Beacon • Evaluation of available benefits from the Healthplan and from community resources, including carved out and linked services • Assisting members with transitions across care settings including timely follow-up with PCP or specialist post-discharge • Training programs for care coordinators, providers and members of the Interdisciplinary Care Team on the above **For CMC only** Staffing • PPG will assign a care coordinator or case manager to each member with the appropriate experience and qualifications based member's risk level • Care Coordinators will be clinicians or other trained individuals employed or contracted by the PPG. Care coordinators are accountable for: providing care coordination services, assuring appropriate referral and timely two way transmission of useful member information, and obtaining reliable and timely information about services other than those provided by the PCP. • PPG will ensure an adequate ratio of care coordinators/case managers to members • PPG will ensure member have at least one care team contact per quarter Individualized Care Plan • ICT will develop and implement an Individualized Care Plan (ICP) for each member using information from various sources, including but not limited to: ◦ Information from the HRA ◦ Member, caregiver and provider input ◦ Internal (e.g. utilization data) and external sources (e.g. LTSS records) • ICPs shall be completed ◦ Within 90 calendar days of effective date of enrollment ◦ Within the last 365 calendar days of the last ICP with our without HRA ◦ Updated/created within 30 calendar days from a transition of care	Formalized assessment and risk stratification of members via Health Information Form/Member Evaluation Tool (HIF/MET, all new Medi-Cal members) and Medi-Cal Seniors & Persons with Disabilities (SPD) initial and annual Health Risk Assessments (HRA). Healthplan will share HRA and HIF/MET information with PPG. Health plan to provide annual training and training materials.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Care Management and Care Coordination Services *(Continues)*			X	• ICPs content must include ◦ At least one care goal documented discussion of care goals (initial and revised ICPs) ◦ Goals that address issues identified by the HRA (when available) ◦ Coordination of CMC benefits including carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate • ICP Communication ◦ ICP shall be communicated members and PCP within 30 calendar days from date of ICP creation (new members) ◦ ICP shall be communicated to member and PCP with 30 days of ICP update following care transition, PPG transfer, change in condition, annual update (continuing members) ◦ Members must have the opportunity to review and sign the ICP and any of its amendments. PPG must provide members with copies of the ICP and any of its amendments. The ICP must be made available in alternative formats and in member's preferred written or spoken language. Interdisciplinary Care Team • PPG shall offer Interdisciplinary Care Team (ICT) for each member • ICT documentation must describe the integration of medical, LTSS, behavioral health and other health needs through assessment, care planning, authorization of services and transitions of care issues. • ICTs must be comprised of professionals appropriate for the needs, preferences and abilities of the member • ICTs shall be convened no later than 150 days from effective date and as needed afterwards. ICTs must be completed at least once every 365 calendar days. • ICT participants must receive training during onboarding process and annually thereafter PPG Transfer Process • The PPG that loses assigned member will submit ICP, ICT and other care coordination documents to the Healthplan sFTP site • The PPG that has a newly assigned transfer member will ◦ Collect ICP, ICT and care coordinations documents from sFTP site ◦ Assign member to care coordinator ◦ Review and revise ICP and ICT	Healthplan will faciliatate the collection of members' case files from prior PPG and will transfer PPG info with HRA to new receiving PPG. Healthplan will conduct oversight activities to ensure appropriate documentation is submitted by the prior PPG and that the receiving PPG has updated the ICP and ICT.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Care Management and Care Coordination Services *(Continues)*			X	Delegate to reference the following: DHCS All Plan Letters 17-013, 14-010 DHCS Case Management and Coordination of Care Technical Assistant Guide Dual Plan Letter 15-001 Care Coordination is also detailed in WIC Sections 14182.17(d)(4) and 14186(b)	
Care Transitions			X	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible, prevents unplanned transitions. The PPG facilitates safe transitions by the following tasks and monitoring system performance: • For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process within two business days • For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the changes to the member's health status and plan of care within two business days • For planned and unplanned transitions from any setting to another setting. Providing each member who experiences a transition with a consistent person or unit within the organization who is responsible for supporting the member through transitions between any points in the system within two business days	Healthplan will oversee PPG's adherence to these standards through pre-delegation, routine monitoring and annual review. Oversight can occur more frequently, as required, per changes in contract, Federal and State regulatory guidelines, accreditation standards and/or as part of any corrective actions and remediation. Healthplan to notify PPG of emergent admissions and all hospital and SNF discharges.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Care Transitions (*Continues*)			X	The PPG facilitates safe transitions by the following tasks and monitoring system performance: • For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process within two business days • For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the changes to the member's health status and plan of care within two business days • For planned and unplanned transitions from any setting to another setting. Providing each member who experiences a transition with a consistent person or unit within the organization who is responsible for supporting the member through transitions between any points in the system within two business days The organization identifies transitions by reviewing the following for facilities in its network: • Reports of hospital admissions within one business day of admission • Reports of admissions to skilled and long-term care facilities within one business day of admission The organization minimizes unplanned transitions and works to maintain members in the least restrictive setting possible by: • Analyzing data at least monthly, to identify individual members at risk of transition • Coordinating services for member at high risk of having a transition • Educating members or responsible parties about transitions and how to prevent unplanned transitions • Analyzing rates of all member admission to facilities and ED visits at least annually to identify areas for improvement	
Organization Determinations (CMC Only)		X			Termination of Provider Services: Notice of Termination of SNF, HHA, or CORF Services (Notice Content) 42 C.F.R. § 422.624 Termination of Provider Services: Notice of Medicare Non-Coverage of SNF, HHA, or CORF Services (Timeliness) 42 C.F.R. § 422.624

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Members Experience (ME)					
Statement of Members' Rights and Responsibilities (NCQA ME 1)				**Element B: Distribution of Rights Statement** The organization distributes L.A. Care's member rights and responsibilities statement to the following groups: New practitioners, when they join the network.	**Element A: Rights and Responsibilities Statement** **Element B: Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, annually. 4. Existing practitioners, annually.
Subscriber Information (NCQA ME 2)		X			**Element A: Subscriber Information** **Element B: Interpreter Services**
Marketing Information (NCQA ME 3)		X			**Element A: Materials and Presentations** **Element B: Communicating With Prospective Members** **Element C: Assessing Member Understanding**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Functionality of Claims Processing (NCQA ME 4)		X			**Element A: Functionality: Website** **Element A: Pharmacy Benefit Information: Website**
Pharmacy Benefit Information (NCQA ME 5)		X			**Element A: Pharmacy Benefit Information: Website** **Element B: Pharmacy Benefit Information: Telephone** **Element C: QI Process on Accuracy of Information** **Element D: Pharmacy Benefit Updates**
Personalized Information on Health Plan Services (NCQA ME 6)					**Element A: Functionality: Website** **Element B: Functionality: Telephone** **Element C: Quality and Accuracy of Information** **Element D: Email Response Evaluation**

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Policies and Procedures for Complaints and Appeals (NCQA ME 7)		X			**Element A: Policies and Procedures for Complaints** **Element B: Policies and Procedures for Appeals** **Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** **Element D: Nonbehavioral Opportunities for Improvement** **Element E: Annual Assessment of Behavioral Healthcare and Services** **Element F: Behavioral Healthcare Opportunities for Improvement**
Sub-delegation of Members' Rights and Responsibilities (NCQA ME 8)		X			Healthplan retains the right to perform a pre-delegation audit of any entity to which PPG sub-delegates Delegated Activities and approve any such sub-delegation for purposes of this Delegation Agreement. PPG shall cooperate with Healthplan in the performance of a pre-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, PPG shall provide Healthplan with reasonable prior notice of PPGs intent to sub-delegate. PPG must maintain a copy of the sub-delegation agreement to provide to Healthplan upon request.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of Members' Rights and Responsibilities (NCQA ME 8) (*Continues*)		X			**Element A: Sub-Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the organization. 4. Describes the process by which the organization evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested. 6. Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement.

Standard[1]/ Admin. Service	Delegated[2]	Non-Delegated[3]	Shared[4]	Activities/Functions To Be Performed By Delegate	Activities/Functions Retained by Healthplan
Sub-delegation of Members' Rights and Responsibilities (NCQA ME 8) *(Continues)*		X			**Element B: Pre Sub-delegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation began. **Element C: Review of Performance** For arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports, as specified in Element A. 2. Annually evaluates delegate performance against NCQA standards for sub-delegated activities. **Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

PPG REPORTING REQUIREMENTS

UTILIZATION MANAGEMENT, NETWORK MANAGEMENT, QUALITY MANAGEMENT AND IMPROVEMENT, AND MEMBERS' RIGHTS AND RESPONSIBLITIES, CREDENTIALING, CULTURAL & LINGUISTIC SERVICES, AND QUALITY IMPROVEMENT – STANDARD DELEGATION

PPG shall provide Healthplan with the below specified reports, as applicable, in the form and format as specified by Healthplan, electronically. As applicable, PPG shall use the template formats specified by Healthplan. If the reports are incomplete or not submitted in the appropriate form and/or format, Healthplan shall notify the PPG and PPG shall promptly correct the errors and resubmit the applicable report(s)

Report	Due Date	Submit To	Required Format
APPLICABLE TO ALL LOB **UM Program Description** The UM Program describes UM, CM, Care Coordination Programs and Processes, and the medical health aspects of the Program.	Annually Feb 15th Report Current Year	Submit to L.A. Care Delegation Oversight via SFTP Site	Narrative
APPLICABLE TO ALL LOB **UM Workplan** Work Plan goals and planned activities.	Annually Feb 15th Report Current Year	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Quarterly ICE Reporting Format provided by L.A. Care**
APPLICABLE TO ALL LOB **UM Program Evaluation** Report that provides a detailed description of utilization activities, delegated activities, and strategic initiatives accomplished during the past year. This report is incorporated into the Q4 UM ICE Report, no need to submit a separate report.	Annually Feb 15th Report Previous Year	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Quarterly ICE Reporting Format provided by L.A. Care**
APPLICABLE TO ALL LOB **UM ICE Quarterly Report** • Report that provides a detailed description of utilization activities, delegated activities, and strategic initiatives accomplished during the quarter	Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Quarterly ICE Reporting Format provided by L.A. Care**

Report	Due Date	Submit To	Required Format
APPLICABLE TO ALL LOB 1. SAR Report 2. MediCal Provider Preventable Conditions Report. Welfare and Institutions Code 14131.11, as well Title 42 of the Code of Federal Regulations, sections 447, 434 and 438, require all Medi-Cal providers to report provider-preventable conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment prescribed to a Medi-Cal patient for which payment would otherwise be available. Providers do not need to report PPCs that existed prior to the initiation of treatment of the beneficiary by the provider. See APL 17-009 • Visit site below to report PPRCs: • **https://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx** • Provide copy of form to Clinical Assurance Department via the CA SFTP Site • If none to report, please attest by providing report stating none to report	Previous month report due by 15th of the following month Immediately after issuing letter to member and provider	1. Submit to L.A. Care Delegation Oversight via SFTP Site 2. Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	Reporting templates provided by L.A Care L.A. Care Format
APPLICABLE TO ALL LOB **Dental General Anesthesia Services Report (DGAS)** Dental general anesthesia services provided by a physician in conjunction with dental services for managed care beneficiaries in hospitals, ambulatory medical surgical settings, or dental offices.	Quarterly • 1st Q -April 15 • 2nd Q - July 15 • 3rd Q - Oct 15 • 4th Q - Jan 15	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**
APPLICABLE TO ALL LOB **Continued Access to Care (COC) and Transition to Other Care (TOC) Report** **(NCQA NET Element A & B(NCQA QI 3 Element D)**	Quarterly 1st Qtr. – April 15 2nd Qtr. – July 15 3rd Qtr. – Oct 15 4th Qtr. – Jan 15	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**
APPLICABLE TO CMC LOB ONLY **CMC ICE TOC Log** Members with a Transition Record within 24 Hours of Discharge	Weekly Every Friday	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**

Report	Due Date	Submit To	Required Format
APPLICABLE TO CMC LOB ONLY **Core 5.1 Care Coordinator to Member Ratio** A. Total # of Full Time Employee per member involved in the demonstration B. Total FTE care coordinators assigned to care management and conducting assessments C. Total number of newly hired FTE care coordinators (or those newly assigned to the MMP) D. Total number of FTE care coordinators that left the MMP **CA 3.2 Care coordinator training for supporting self-direction under the demonstration.** A. Total number of care coordinators who have been employed by the MMP for at least 30 days. B. Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.	Annually Jan 15 Previous year's data	Submit to L.A. Care Clinical Assurance (CA) via MOC SFTP Site	**Reporting template provided by L.A. Care**
APPLICABLE TO CMC LOB ONLY **Case Management/Care Coordination Log** ICP completion status within 30 working days of the HRA- Member completed, ICP, Refused ICP, or was Unable to Contact to complete ICP.	Monthly Every 15th of the month Previous month's data	Submit to L.A. Care Clinical Assurance (CA) via MOC SFTP Site	**Reporting template provided by L.A. Care**
APPLICABLE TO CMC LOB ONLY **CA1.6 Members with documented discussions of care goals.** A. Total number of members with an initial Individualized Care Plan (ICP) developed B. Total number of members sampled that met the inclusion criteria. C. Total number of members with at least one documented discussion of care goals in the initial ICP D. Total number of existing ICPs revised E. Total number of revised ICPs sampled that met inclusion criteria F. Total number of revised ICPs with at least one documented discussion of new or existing care goals	Quarterly • 1st Q -April 15 • 2nd Q - July 15 • 3rd Q - Oct 15 • 4th Q - Jan 15	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**

Report	Due Date	Submit To	Required Format
APPLICABLE TO CMC LOB ONLY **CA1.12 Members who have a care coordinator and have at least one care team contact during the reporting period:** A. Total number of members who have/had a case coordinator. B. Total number of members who had at least one case coordinator or other care team contact.	Quarterly • 1st Q -April 15 • 2nd Q - July 15 • 3rd Q - Oct 15 • 4th Q - Jan 15	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**
APPLICABLE TO CMC LOB ONLY **Core 3.2 Members with a care plan completed within 3 mos. of enrollment** A. Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. B. Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment. C. Total number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan within 90 days of enrollment. D. Total number of members with a care plan completed within 90 days of enrollment.	Monthly Every 4th of the month	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**
APPLICABLE TO CMC LOB ONLY **CA1.11 Members with first follow-up visit within 30 days after hospital discharge:** Reports members with first follow-up visit received within 30 days after hospital discharge.	Quarterly L.A. Care CA Dept. staff will provide due date	Submit to L.A. Care Clinical Assurance (CA) via SFTP Site	**Reporting template provided by L.A. Care**
ME 1B Factor 3: Tracking Log Distribution of Member Rights & Responsibilities Statement to New Practitioners	Semi-Annually Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 & Q2)	Submit to L.A. Care Quality Improvement Department (QI) via SFTP Site	L.A. Care reporting format
New Provider Onboarding Training Log	Monthly- first business day of the month	Email to PNMTraining@lacare.org	L.A. Care reporting format

Report	Due Date	Submit To	Required Format
Standardized Provider File Format (SPF)	1. Monthly full file due within the first five (5) calendar days of each month 2. Data Quality Error Reports - within three (3) business days of submission. 3. SPF File rejections are resubmitted within three (3) business days of notification of rejection. 4. SPF files rejected for data errors are resubmitted within three (3) business days of notification. 5. A/C/T transactions are submitted within five (5) business days of changes for data elements as required under California Health & Safety Code §1367.27.	L.A. Care SFTP site	L.A. Care format
For Shared Risk/Extended Delegate Activities Only **UM Daily Electronic Load of Delegated Authorizations (ELDA)** • See UM Technical Bulletin for report specifications • Delegated Authorizations shall be submitted within two (2) days of referral decision • ELDA Error Reports must be worked and authorizations resubmitted within five (5) business days of receipt of the error report	Daily	L.A. Care's FTP site	L.A. Care Format

Report	Due Date	Submit To	Required Format
Credentialing			
Network Management Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May 15 2nd Qtr – August 15 3rd Qtr – Nov 15 4th Qtr – Feb15	Credentialing Department credinfo@lacare.org	L.A. Care Quarterly ICE Reporting Format
Cultural and Linguistics			
Cultural and Linguistic Services – Applicable to PPG agreements for any Healthplan program **Annual Bilingual Staff List** A list of assessed and qualified bilingual staff, including the following information: • Name • Title • Department • Language spoken/written • Level of proficiency (using the ICE Employee Language Skills Assessment Tool or any other assessment tool) • Assessment date • Documentation of successful completion of an interpreter training program (name of training program and completion date), if any	January 31 Quarterly Translation Report 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	CL_Reports_Mailbox@lacare.org Health Education, Cultural and Linguistic Services Department	L.A. Care Format

Report	Due Date	Submit To	Required Format
Cultural and Linguistic *(Continues)* **Quarterly Translation Report** If PPG translates member materials, a tracking log of all documents translated, including document title, language(s) translated into, type of document, product line, and date of request and sent to the member			
Quality Improvement			
Quarterly Critical Incidents Tracking Report Log (CMC LOB ONLY): PPGs serving CMC members shall have processes to identify, prevent and report critical incidents in the following categories listed below to promote health, safety, and welfare of L.A. Care members related to: - Abuse - Exploitation - Neglect - Disappearance/Missing Member - Unexpected Death - A Serious Life Threatening Medical Event that requires immediate emergency evaluation by a Medical Professional - Restraints or seclusion - Suicidal attempt • PPGs shall keep track of all Critical Incidents and ensure appropriate reporting and resolution of the incident in a timely fashion.	Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 1 5	Submit to L.A. Care Quality Improvement (qi) via FTP Site with department tag	Mutually agreed upon format: The Critical Incident Tracking Log should be in the Healthplan Report Format, which includes but not limited to member information, specific information about the incident (date, time, location, entity/person involved in the incident. . . etc.)

PART II
ANNUAL AUDIT ACTIVITIES

PART II: ANNUAL AUDIT ACTIVITIES

Overview

In connection with all of its managed care programs, LAC will conduct annual audits of Delegates to ensure compliance with all federal, state statutory, regulatory, contractual, and National Committee for Quality Assurance (NCQA) accreditation requirements.

LAC Delegation Oversight department is the centralized business unit that includes the Delegation Oversight Audit team whose purpose is to coordinate, facilitate, and execute annual and other audits of LAC's Delegates.

LAC will audit Delegates' compliance with state and federal laws, regulations, guidance and contractual requirements; regulatory requirements; LAC's policies, procedures and contractual requirements; and NCQA accreditation requirements related to Delegated Activities including but not limited to credentialing, cultural and linguistic services, health education, provider network operations and contracting, quality improvement, and utilization management.

LAC will perform annual, ad hoc, and risk based audits of contract responsibilities, functions and services delegated by LAC. Procedures on audits of different Delegated Activities are outlined in the "References" section below.

Delegates will allow LAC, DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ, and the DMHC, or their designees, to audit, inspect, and evaluate information related to LAC Members. Delegates must make available for the purposes of any audit, evaluation or inspection of its premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems related to the services rendered to LAC Members and/or Delegated Activities performed. Unless a longer time is specified by a law, rule or regulation, the right to audit will exist through 10 years from the final date of the contract period, or from the date of completion of any audit, whichever is later as required by State and Federal laws, regulations and guidance.

ORGANIZATIONAL COMPONENTS
Compliance Program Effectiveness

Performance Standard #1: Written Policies, Procedures and Standards of Conduct

Standard:	**1.0 Compliance Officer, Compliance Committee and High Level Oversight**
Authorities:	**Standard:** PPG must designate a compliance officer and a compliance committee who report directly and are accountable to the PPG's chief executive or other senior management. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(A) Medicare Managed Care Manual, Chapter 21, Section 50.1 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements Federal Guidelines: OMH CLAS Standards, Standards 1-4, 9

Frequency: Annual Audit

Performance Standard #2: Compliance Officer and Committee

Standard:	**2.0 Compliance Officer, Compliance Committee and High Level Oversight**
Authorities:	**Standard:** PPG must designate a compliance officer and a compliance committee who report directly and are accountable to the PPG's chief executive or other senior management. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(B) Medicare Managed Care Manual, Chapter 21, Section 50.2 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #3: Effective Training and Education

Standard:	**3.0 Effective Training and Education**
Authorities:	**Standard:** PPG must establish, implement and provide effective training and education for its employees, including the CEO, senior administrators or managers, and for the governing body members, and downstream and related entities. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(C) Medicare Managed Care Manual, Chapter 21, Section 50.3 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #4: Effective Lines of Communication

Standard:	**4.0 Effective Lines of Communication**
Authorities:	**Standard:** PPG must establish and implement effective lines of communication, ensuring confidentiality between the compliance officer, members of the compliance committee, the PPG's employees, managers and governing body, and the PPG's downstream and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(D) Medicare Managed Care Manual, Chapter 21, Section 50.4 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #5: Well Publicized Disciplinary Standards

Standard:	**5.0 Well Publicized Disciplinary Standards**
Authorities:	**Standard:** PPG must have well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(E) Medicare Managed Care Manual, Chapter 21, Section 50.5 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.1: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Routine Monitoring and Auditing

Standard:	**6.1 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Routine Monitoring and Auditing**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.2: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Development of a System to Identify Compliance Risks

Standard:	**6.2 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Development of a System to Identify Compliance Risks**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.3: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks- Development of the Monitoring and Auditing Work Plan

Standard:	**6.3 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks- Development of the Monitoring and Auditing Work Plan**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42C.F.R.§§422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.4: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Audit Schedule and Methodology

Standard:	**6.4 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Audit Schedule and Methodology**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42C.F.R.§§422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.5: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Audit of the PPG's Operations and Compliance Program

Standard:	**6.5 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Audit of the PPG's Operations and Compliance Program**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42C.F.R.§§422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.6: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Monitoring and Auditing Downstream and Related Entities

Standard:	**6.6 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Monitoring and Auditing Downstream and Related Entities**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42C.F.R.§§422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.7: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Monitoring and Auditing Downstream and Related Entities

Standard:	**6.7 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Monitoring and Auditing Downstream and Related Entities**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** • 42C.F.R.§§422.503(b)(4)(vi)(F) • Medicare Managed Care Manual, Chapter 21, Section 50.6 • Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.8: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks -OIG/GSA Exclusion

Standard:	**6.8 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks -OIG/GSA Exclusion**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements Medicare Managed Care Manual, Chapter 21, Section 50.6 42C.F.R.§§422.503(b)(4)(vi)(F)

Frequency: Annual Audit

Performance Standard #6.9: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Use of Data Analysis for Fraud, Waste and Abuse Prevention and Detection

Standard:	**6.9 Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Use of Data Analysis for Fraud, Waste and Abuse Prevention and Detection**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42C.F.R.§§422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #6.10: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Special Investigation Units (SIUs)

Standard:	**6.10:Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks - Special Investigation Units (SIUs)**
Authorities:	**Standard:** PPG must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the PPG's, including downstream and related entities', compliance with CMS requirements and the overall effectiveness of the compliance program. **Authorities:** 42C.F.R.§§422.503(b)(4)(vi)(F) Medicare Managed Care Manual, Chapter 21, Section 50.6 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #7: Procedures and Systems for Prompt Response to Compliance Issues

Standard:	**7.0 Procedures and Systems for Prompt Response to Compliance Issues**
Authorities:	**Standard:** PPG must establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements. **Authorities:** 42 C.F.R. §§ 422.503(b)(4)(vi)(G) Medicare Managed Care Manual, Chapter 21, Section 50.7 Participating Physician Group Services Agreement, Exhibit S, Cal MediConnect Program Requirements

Frequency: Annual Audit

Performance Standard #8: Federal False Claims Act (FCA)

Standard:	**8.0 Federal False Claims Act (FCA)**
Authorities:	**Standard:** PG must evidence compliance with the Federal False Claims Act. **Authorities:** 31 USC §§3729-3733 42 USC §1396a(a) Public Law 109-171, §6032 California Government Code, §§12650-12655 DHCS, Agreement 04-36069 A02, Exhibit E, Attachment 2, Provision 32 PPGSA, §2.12 "Compliance Program and Anti-Fraud Initiatives" L.A. Care Health Plan Provider Manual, latest posted version, §15.0, "The Federal False Claims Act"

Frequency: Annual Audit

Privacy

Performance Standard #1: PPG policies and procedures

Standard:	**1.0 PPG Policies and Procedures**
Authorities:	PPG must establish and implement effective lines of communication, ensuring confidentiality between the compliance officer, members of the compliance committee, the PPG's employees, managers and governing body, and the PPG's downstream and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified. **Authorities:** 45 CFR §164.502(a) 45 CFR §164.502(e) 45 CFR §164.514(d) 45 CFR §164.530(c) 45 CFR §164.530(i) 45 CFR §164.530(j) California Civil Code §56.101 Medi-Cal Managed Care Division (MMCD) All PPG Letter 06001

Frequency: Annual Audit for selected PPGs

Performance Standard #2: Access to PHI

Standard:	**2.0 Access to PHI**
Authorities:	PPG evidences a process, P&Ps, or similar evidence for: • Identifying persons or classes of persons within the PPG that need access to PHI to carry out their job duties • Identifying the categories or types of PHI needed and any conditions appropriate to such access • Removing access upon separation of employment or once access is no longer needed to carry out job duties **Authorities:** 45 CFR §164.502(b) 45 CFR §164.514(d) 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #3: Personal Representative Process

Standard:	**3.0 Personal Representative Process**
Authorities:	PPG's evidences a written process or similar which addresses, at a minimum, the following circumstances in which the parent is not the personal representative of a minor child: • When state or other law does not require parental consent, the minor consents and has not requested a parent or guardian to be treated as a personal representative • When a court or another person authorized by law consents • When a parent or guardian agrees to confidentiality between the minor and provider PPG evidences a process, P&P, or similar evidence addressing personal representatives of deceased individuals PPG evidences a process, P&P, or similar evidence addressing personal representatives and abuse, neglect, and endangerment situations **Authorities:** 45 CFR §164.502(g) 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #4: Personal Representative Process

Standard:	**4.0 Designation of a Privacy Official**
Authorities:	PPG evidences designation of a privacy official who is responsible for the development and implementation of the policies and procedures of the PPG. PPG evidences designation of a contact person or office who is responsible for receiving complaints and who provides further information about matters covered by the Notice of Privacy Practices **Authorities:** 45 CFR §164.530(a) 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #5: Sanctions

Standard:	**5.0 Sanctions**
Authorities:	PPG evidences a policy and procedure applying appropriate sanctions against workforce members who fail to comply with its privacy policies and procedures of the PPG. PPG does not apply its sanction policies to actions related to disclosures by whistleblowers, workforce members that are crime victims, or use sanctions as a form of intimidation or retaliation as outlined in 45 CFR §160.316 **Authorities:** 45 CFR §160.316 45 CFR §164.502(j) 45 CFR §164.530(e)(1) 45 CFR §164.530(g)(2) 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #6: Facsimile Communications Containing PHI

Standard:	**6.0 Facsimile Communications Containing PHI**
Authorities:	PPG evidences a policy and procedure applying appropriate safeguards to facsimile communications containing PHI **Authorities:** 5 CFR §164.514(d) 45 CFR §164.530(c) 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #7: Incident Notification

Standard:	**7.0 Incident Notification**
Authorities:	PPG evidences a policy and procedure, plan, or other documentation outlining an incident notification and mitigation process that is compliant with the Breach Notification Rule and its Business Associate Agreement with L.A. Care. PPG performs risk assessments of suspected impermissible acquisitions, uses, or disclosures of PHI that determine the probability that the PHI has been compromised PPG investigates a breach, or unauthorized use or disclosure of PHI, and provides a written report of the investigation to the Office for Civil Rights and L.A. Care within the timeframe noted in its Business Associate Agreement **Authorities:** 45 CFR §164.400 - §164.414 45 CFR §164.530(f) 45 CFR §164.530(i) 45 CFR §164.530(j) Business Associate Agreement

Frequency: Annual Audit for selected PPGs

Performance Standard #8: Member's Right to Access PHI

Standard:	**8.0 Member's Right to Access PHI**
Authorities:	PPG evidences a policy and procedure addressing a Member's right to access, to inspect, and obtain a copy of their PHI. PPG's policies and procedures requires action on the request for access within 30 days of receipt. PPG's policies and procedures address situations where a Member's right of access is denied. PPG provides the Member with access to PHI in the form and format requested by the individual or in another form as agreed to by the PPG and the Member, including provision of information via an electronic copy when information is maintained in one or more electronic designated record sets and the individual asks for an electronic copy. **Authorities:** 45 CFR §164.524 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #9: Complaints Related to PHI

Standard:	**9.0 Complaints Related to PHI**
Authorities:	PPG evidences a policy and procedure on processing complaints related to PHI. PPG evidences a policy and procedure, process, or similar evidence requiring cooperation with regulatory agency complaint investigations and compliance reviews, including permitting access to facilities, records, and other sources of information **Authorities:** 45 CFR §160.306 45 CFR §160.310(b) 45 CFR §160.312 45 CFR §160.530 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #10: Processing Member PHI Amendment Requests

Standard:	**10.0 Processing Member PHI Amendment Requests**
Authorities:	PPG evidences a policy and procedure on processing member PHI amendment requests. PPG's policies and procedures on processing member PHI amendment requests require action within 60 days after receipt. PPG's policies and procedures are compliant with 45 CFR §164.526 requirements for granting and denying amendment requests. PPG has a process, policy and procedure, or similar evidence in place for amending the PHI in a designated record set if informed by another covered entity of an amendment to a member's PHI. PPG's policies and procedures, processes, or similar evidence requires documentation of the titles or persons or offices responsible for receiving and processing requests for amendments by members and retain the documentation. **Authorities:** 45 CFR §164.526 45 CFR §164.530(i) 45 CFR §164.530(j) Health & Safety Code §123111

Frequency: Annual Audit for selected PPGs

Performance Standard #11: Restrictions on use and Disclosure of PHI

Standard:	**11.0 Restrictions on use and Disclosure of PHI**
Authorities:	PPG evidences a policy and procedure on processing member requests to restrict the use and disclosure of PHI **Authorities:** 45 CFR §164.522 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Performance Standard #12: Workforce Training

Standard:	**12.0 Workforce Training**
Authorities:	PPG evidences a policy and procedure on privacy workforce training for members of the workforce to carry out their functions within the PPG PPG's training program evidences new workforce member training within a reasonable time period PPG's training program evidences a process for training the PPG's workforce within a reasonable time period when there is a material change to its Policies and Procedures PPG's training program evidences a process for documenting that training has been provided **Authorities:** 45 CFR §164.530(b) 45 CFR §164.530(i) 45 CFR §164.530(j)

Frequency: Annual Audit for selected PPGs

Security

Performance Standard #1: Security Management Process

Standard:	**1.0: Security Management Process**
Authorities:	**Standard:** PPG evidences policies and procedures to prevent, detect, contain, and correct security violations. **Authorities:** 45 CFR §164.308(a)(1)(i) 45 CFR §164.308(a)(1)(ii)(A) - (D)

Frequency: Annual Audit for selected PPGs

Performance Standard #2: Assigned Security Responsibility

Standard:	**2.0: Assigned Security Responsibility**
Authorities:	**Standard:** PPG evidences policies and procedures that identify a security official who is responsible for the development and implementation of the Plan's information security policies and procedures. **Authorities:** 45 CFR §164.308(a)(2)

Frequency: Annual Audit for selected PPGs

Performance Standard #3: Security Awareness and Training

Standard:	**3.0: Security Awareness and Training**
Authorities:	**Standard:** PPG evidences implementation of a security awareness and training program for all members of its workforce. **Authorities:** 45 CFR §164.308(a)(5)

Frequency: Annual Audit for selected PPGs

Performance Standard #4: Security Incident Procedures

Standard:	**4.0: Security Incident Procedures**
Authorities:	**Standard:** PPG evidences policies and procedures to address security incidents. PPG's security incident response and reporting processes includes a process for the following: (1) Identification and responses to suspected or known security incidents (2) Mitigation, to the extent practicable, of the harmful effects of the security incidents that are known to the Plan (3) Documentation of security incidents and their outcomes **Authorities:** 45 CFR §164.308(a)(6)

Frequency: Annual Audit for selected PPGs

Performance Standard #5: Contingency Plans

Standard:	**5.0: Contingency Plans**
Authorities:	**Standard:** PPG evidences policies and procedures for responding to an emergency or other occurrence (e.g., fire, vandalism, system failure, natural disaster) that damages systems that contain ePHI, established and implemented procedures to create and maintain retrievable exact copies of ePHI, and evidences procedures to restore any loss of data. PPG evidences procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in emergency mode. **Authorities:** 45 CFR §164.308(a)(7)(i) 45 CFR §164.308(a)(7)(ii)(A) - (C)

Frequency: Annual Audit for selected PPGs

Performance Standard #6: Facility Access Controls

Standard:	**6.0: Facility Access Controls**
Authorities:	**Standard:** PPG evidences policies and procedures that limit the physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed. PPG evidences approved policies and procedures to: • safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft • control and validate a person's access to facility based on their role or function • document repairs and modifications to the physical components of the health plan **Authorities:** 45 CFR §164.308(a)(7)(i) 45 CFR §164.308(a)(7)(ii)(A) - (C)

Frequency: Annual Audit for selected PPGs

Performance Standard #7: Workstation Use

Standard:	**7.0: Workstation Use**
Authorities:	**Standard:** Approved policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surrounding of a specific workstation or class of workstation that can access ePHI **Authorities:** 45 CFR §164.310(b)

Frequency: Annual Audit for selected PPGs

Performance Standard #8: Workstation Security

Standard:	**8.0: Workstation Security**
Authorities:	**Standard:** Approved policies and procedures that implement physical safeguards for all workstations that access ePHI, to restrict access to authorized users. **Authorities:** 45 CFR §164.310(b)

Frequency: Annual Audit for selected PPGs

Performance Standard #9: Device and Media Controls

Standard:	**9.0: Device and Media Controls**
Authorities:	**Standard:** Approved policies and procedures that govern receipt and removal of hardware and electronic media that contain ePHI into and out of a facility, and the movement of these items within the facility. Implemented policies and procedures that address the final disposition of ePHI, and/or the hardware or electronic media on which it is stored. Approved policies and procedures for the removal of ePHI from electronic media before the media are made available for re-use. Approved policies and procedures for tracking the movements of hardware and electronic media and any person responsible therefore. Approved policies and procedures for the creation of retrievable, exact copies of ePHI, when needed, before movement of equipment. **Authorities:** 45 CFR §164.310(d)(1) 45 CFR §164.310(d)(2)(i) - (iv)

Frequency: Annual Audit for selected PPGs

Special Investigations Unit (SIU)

Authorities for SIU Standards #1-11:

California Welfare and Institutions Code, §§s 14043.1 (a) and (i)

DHCS Medi-Cal Agreement, Exhibit E, Attachment 2, §26.

42 C.F.R. §438.608 Program integrity requirements under the contract

42 C.F.R. §455.2, Definitions of FWA

42 C.F.R. §423.504(B)(4)(vi)(D), General Provisions

42 C.F.R. §423.504(B)(4)(vi)(G), General Provisions

42 C.F.R. §455.17, Reporting Requirements

28 C.C.R. § 1300.71, Claim Settlement Practices

Prescription Drug Benefits Manual, Chapter 9, "Part D Program to Control Fraud, Waste and Abuse."

The Deficit Reduction Act of 2002 § 6032

The Federal False Claims Act 31 U.S.C §§ 3729-3733

The Medicare Managed Care Manual, Chapter 21, "Compliance Program Guidelines" and Chapter 9, Prescription Drug Benefit Manual

The Program Fraud Civil Remedies Act of 1986 31 U.S.C §§ 3801-3812

The California False Claims Act: California Government Code §§ 12650-12655

California Welfare & Institutions Code §§ 14107 & 14123.2

DHCS Medi-Cal Agreement, Exhibit E, Attachment 2, Section 26

Medicare Program Integrity Manual, Chapter 4, "Benefits Integrity."

California Health & Safety Code, § 1348(a).

California Welfare and Institutions Code, § 14043.2

California Labor Code §1102.5, whistleblower provisions

C.A. DHCS All Plan Letter 15-026- Actions Required Following Notice of a Credible Allegation of Fraud

Performance Standard #1: Coordination of Benefits

Standard:	**1.1: Coordination of Benefits**
Authorities:	**Standard:** Approved written policies and procedures and/or processes addressing contractual and regulatory requirements surrounding the coordination of benefits to determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan.

Frequency: Annual Audit for selected PPGs

Performance Standard #2: Overpayments

Standard:	**1.2: Overpayments**
Authorities:	**Standard:** Approved written policies and procedures and/or processes addressing contractual and regulatory requirements surrounding any payment(s) that a provider receives in excess of the amount payable for a service rendered.

Frequency: Annual Audit for selected PPGs

Performance Standard #3: Third Party Liability/ Subrogation

Standard:	**1.3: Third Party Liability/ Subrogation**
Authorities:	**Standard:** Approved written policies and procedures and/or processes addressing contractual and regulatory requirements surrounding the recovery, from a third party, of medical costs that were originally paid by a healthcare benefits plan.

Frequency: Annual Audit for selected PPGs

Performance Standard #4: FWA Regulations and Trainings

Standard:	**1.4: FWA Regulations and Trainings**
Authorities:	**Standard:** (1) Approved written policies and procedures and/or processes addressing policies and procedures for enforcing Fraud, Waste and Abuse (FWA) regulations. (2) Approved written policies and procedures and/or processes addressing all staff and contractors completing new hire or annual FWA training in the last (12) twelve months. (3) Approved written policies and procedures and/or processes addressing downstream providers receive FWA training within (90) days of hire and annually thereafter. (4) Approved written policies and procedures and/or processes addressing Medicare Advantage and Medicare Part D FWA. (5) Approved written policies and procedures and/or processes addressing examples of FWA applicable to job functions. This specifically includes ensuring that employees are appropriately trained that falsifying documents and inappropriate alteration of records is unacceptable. (6) Approved written policies and procedures and/or processes addressing False Claims Act, Deficit Reduction Act, Stark and Anti-kickback statute.

Frequency: Annual Audit for selected PPGs

Performance Standard #5: Reporting FWA Concerns

Standard:	**1.5: Reporting FWA Concerns**
Authorities:	**Standard:** (1) Approved written policies and procedures and/or processes addressing requiring staff, contractor(s) AND Board members to report all compliance concerns and potential FWA. (2) Approved written policies and procedures and/or processes addressing on how to report FWA 24/7 anonymously. (3) Approved written policies and procedures and/or processes addressing non-retaliation/whistle-blower protection for reporting FWA. (4) Approved written policies and procedures and/or processes addressing for taking measures or action to address FWA problems. (5) Approved written policies and procedures and/or processes addressing evidence of a widely publicized and enforced "no-tolerance policy for retaliation or retribution" for anyone who reports FWA. (6) Approved written policies and procedures and/or processes addressing having a system to receive record, respond to and track compliance issues or potential FWA. (7) Approved written policies and procedures and/or processes addressing evidencing widely publicized disciplinary standards for staff, contractors, and sub-delegates if FWA is not reported in a timely manner.

Frequency: Annual Audit for selected PPGs

Performance Standard #6: Inquiries into FWA Concerns

Standard:	**1.6: Inquiries into FWA Concerns**
Authorities:	**Standard:** (1) Approved written policies and procedures and/or processes addressing evidence of a reasonable inquiry into all potential FWA concerns. (2) Approved written policies and procedures and/or processes addressing evidence that inquiries are initiated as quickly as possible and no later than two (2) weeks after the date that the potential FWA is identified. (3) Approved written policies and procedures and/or processes addressing evidence for the FWA investigation conclusion within a reasonable time after the activity is discovered. (4) Approved written policies and procedures and/or processes addressing evidence evidencing that noncompliance or FWA committed by your employees is documented and includes ramifications should the employee fail to make the corrective actions.

Frequency: Annual Audit for selected PPGs

Performance Standard #7: FWA Reporting

Standard:	**1.7: FWA Reporting**
Authorities:	**Standard:** (1) Approved written policies and procedures and/or processes addressing referring cases of FWA to the MEDIC and DHCS. (2) Approved written policies and procedures and/or processes addressing reporting of suspected FWA violations to L.A. Care immediately, but no later than (48) hours upon identification.

Frequency: Annual Audit for selected PPGs

Performance Standard #8: FWA Monitoring and Analysis

Standard:	**1.8: FWA Monitoring and Analysis**
Authorities:	**Standard:** Approved written policies and procedures and/or processes addressing conducting data analysis for monitoring FWA

Frequency: Annual Audit for selected PPGs

Performance Standard #9: FWA Internal Investigations

Standard:	**1.9: FWA Internal Investigations**
Authorities:	**Standard:** Approved written policies and procedures and/or processes addressing conducting FWA investigations within your organization. • If your organization does not conduct FWA investigations, who conducts these investigations on your behalf? 1. Approved written policies and procedures and/or processes addressing conducting FWA investigations within your organization: ◦ Does your organization have a documented Anti-Fraud Plan? If yes, please provide the document source. ◦ If your organization does not conduct FWA investigations, who conducts these investigations on your behalf? ◦ What is the procedure for managing incidents of suspected fraud? ◦ What are the internal procedures for referring suspected fraud to the appropriate government agencies? 2. Provide the designation or the contract for individuals conducting fraud investigations for your organization (i.e. what are these individuals' investigative expertise/experience).

Frequency: Annual Audit for selected PPGs

Performance Standard #10: FWA Internal Investigations

Standard:	**1.10: FWA Payment Integrity**
Authorities:	**Standard:** (1) Approved written policies and procedures and/or processes addressing your end-to-end process (including internal or vendors) to deny (cost avoid) claims for member's with other known active coverage and Medicaid is the payer of last resort? (2) Approved written policies and procedures and/or processes addressing your end-to-end process (including internal or vendors) to identify and recover claim payments (previously made to providers) for members with other known active coverage at the time of service? (3) Approved written policies and procedures and/or processes addressing your end-to-end process (including internal or vendors) to deny (cost avoid) claims that are submitted with correct coding exceptions (i.e. Medicaid Correct Coding Initiative, CPT coding, etc.)? (4) Approved written policies and procedures and/or processes addressing your end-to-end process (including internal or vendors) to identify and recover claims that are submitted and paid with correct coding exceptions (i.e. Medicaid Correct Coding Initiative, CPT coding, etc.)?

Frequency: Annual Audit for selected PPGs

Performance Standard #11: FWA 24 Hour Hotline Referral

Standard:	**1.11: FWA Payment Integrity**
Authorities:	**Standard:** (1) Approved written policies and procedures and/or processes addressing maintaining a (24) hours a day, (7) days a week compliance hotline • List how many hotline referrals were received? • How many FWA allegations were investigated by your organization? • Please provide a list of targets under investigation? • How many targets were referred to L.A. Care? • How many resulted in a CAP? OP? Termination? Or Law Enforcement (LE) referral? (2) Describe the process for your investigation workflow, step by step from allegation to resolution. (3) Describe your DS technology, how it works, what it produces, and how many FWA referrals it produced. (4) Does your organization send representatives to the CA DOJ and CMS quarterly trainings? • If yes, name the individuals who have attended these trainings.

Frequency: Annual Audit for selected PPGs

PROVIDER MANAGEMENT
Credentialing

Performance Standard #1: Credentialing Policies, Practitioner Credentialing Guidelines and protection of Practitioner Rights

Standard:	**1.0: Credentialing Policies, Practitioner Credentialing Guidelines and protection of Practitioner Rights**
Authorities:	**Standard:** The PPG has a well-defined credentialing and re-credentialing process for evaluating and selecting licensed independent practitioners to provide care to Members. Intent: The PPG has a rigorous process to select and evaluate practitioners. The PPG must have written policies and procedures for notifying practitioners of their right to review information it has obtained to evaluate their credentialing application. Evaluation includes information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), with the exception of references, recommendations or other peer-review protected information. The PPG is not required to notify practitioners of their rights during re-credentialing. **Authorities:** State Contract 6.5.4.2 L.A. Care Policies & Procedures Provider Manual Service Agreement NCQA CR 1 DHCS Policy Letter 02-03 MMCD 02-03 Medicare Advantage Deeming Module: Standard 8, Element A, Element B Managed Care Manual, Chapter 6, 60.2, 60.3

Frequency: Annual Audit for selected PPGs

Performance Standard #2: Credentialing Committee

Standard:	**2.0: Credentialing Committee**
Authorities:	**Standard:** The organization designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions. Intent: The organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions. **Authorities:** State Contract 6.5.4.1, 6.5.4.2 L.A. Care Policies & Procedures Service Agreement NCQA CR 2

Frequency: Annual Audit for selected PPGs

Performance Standard #3: Credentialing Verification

Standard:	**3.0: Credentialing Verification - Credentialing File Review**
Authorities:	**Standard:** The organization verifies credentialing information through primary sources, unless otherwise indicated. Intent: The organization conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. **Authorities:** State Contract 6.5.4.2 L.A. Care Policies & Procedures Provider Manual Service Agreement NCQA CR 3

Frequency: Annual Audit for selected PPGs

Performance Standard #4: Re-credentialing Cycle Length

Standard:	**4.0: Re-credentialing Cycle Length**
Authorities:	**Standard:** The PPG formally re-credentials its practitioners at least every 36 months. Intent: The PPG conducts timely re-credentialing. **Authorities:** State Contract 6.5.4.3 L.A. Care Policies & Procedures Provider Manual Service Agreement NCQA CR 4

Frequency: Annual Audit for selected PPGs

Performance Standard #5: Ongoing Monitoring Requirements

Standard:	**5.0: Ongoing Monitoring Requirements**
Authorities:	**Standard:** The PPG develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. Intent: The PPG identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing. **Authorities:** State Contract 6.5.4.2, 6.5.4.3 L.A. Care Policies & Procedures L.A. Care QM Policies & Procedures Provider Manual Service Agreement NCQA CR 3, 5

Frequency: Annual Audit for selected PPGs

Performance Standard #6: Notification to Authorities and Practitioner Appeal Rights

Standard:	**6.0: Notification to Authorities and Practitioner Appeal Rights**
Authorities:	**Standard:** A PPG that has taken action against a practitioner for quality reasons, reports the action to the appropriate authorities, and offers the practitioner a formal appeal process. Intent: The PPG uses objective evidence and patient-care considerations to decide on the means of altering its relationship with a practitioner who does not meet its quality standard. **Authorities:** L.A. Care Policies & Procedures Provider Manual Service Agreement NCQA CR 6 Medicare Advantage Deeming Module – Standard 8, Elements A, Factor 3 Medicare Managed Care Manual – Chapter 6, 60.4

Frequency: Annual Audit for selected PPGs

Performance Standard #7: Assessment of Organizational Practitioners (Applicable primarily to Plan Partners)

Standard:	**7.0: Assessment of Organizational Practitioners (Applicable primarily to Plan Partners)**
Authorities:	**Standard:** The PPG has written policies and procedures for the initial and ongoing assessment of providers with which it contracts. Intent: The PPG evaluates the quality of providers with which it contracts. This element is not applicable if there were no instances of suspension or termination to report. **Authorities:** State Contract 6.5.4.2 L.A. Care Policies & Procedures Provider Manual Service Agreement NCQA CR 7

Frequency: Annual Audit for selected PPGs

Performance Standard #8: Delegation of Credentialing

Standard:	**8.0: Delegation of Credentialing**
Authorities:	**Standard:** If the PPG delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. Intent: The PPG remains accountable for credentialing and re-credentialing its practitioners, even if it delegates all or part of these activities. LAC reserves the right to conduct oversight audits on NCQA accredited PPGs or may accept the NCQA accreditation in lieu of an oversight audit except when contracted for Medicare Line of Business. **Authorities:** State Contract 6.5.4.4 L.A. Care Policies & Procedures Provider Manual NCQA CR 8

Frequency: Annual Audit for selected PPGs

Performance Standard #9: Identification of HIV/AIDS Specialists

Standard:	**9.0: Identification of HIV/AIDS Specialists**
Authorities:	**Standard:** The PPG documents and implements a method for identifying HIV/AIDS specialists. Intent: The PPG is accountable for identifying practitioners who qualify as HIV/AIDS specialists to whom appropriate Members may be given a standing or extended referral when the Member's condition requires specialized medical care, over a prolonged period of time or is life-threatening, degenerative or disabling, from a specialist or specialty care center that has expertise in treating HIV/AIDS, in accordance with California Health and Safety Codes. **Authorities:** California AB 2168 State Contract 6.5.4.4 L.A. Care Policies & Procedures Provider Manual

Frequency: Annual Audit for selected PPGs

Cultural and Linguistic

Performance Standard #1: Bilingual Employees

Standard:	**1.0: Bilingual Employees**
Authorities:	**Standard:** PPG identifies, assesses, and reports the linguistic capabilities of bilingual employees. Qualified bilingual employee means a PPG employee who is designated by the PPG to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the PPG that he or she: (1) Is proficient in speaking and understanding both spoken English and least one other spoken language, including a fundamental knowledge in both languages of any necessary specialized vocabulary, terminology and phraseology, and concepts relevant to health care delivery systems, and (2) is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages. **Authorities:** Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) & (d)(9) Code of Federal Regulations (CFR), Title 45 §92.4 & 92.201(e)(4) Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with California Department of Health Care Services and Local Initiative Health Authority for LA County, §2.9.7.3 DHCS Agreement No. 04-36069, Exhibit A, Attachment 9(13) (B) DHCS Policy Letter 99-03 Participating Physicians Group Services Agreement, Exhibit P.1 Policy and Procedure, CL-003, Language Proficiency of Bilingual Staff Policy and Procedure, CL-006, Delegation and Monitoring of Cultural and Linguistic Services for Delegated Subcontractors Federal Guidelines: OMH CLAS Standards, Standard 7

Frequency: Annual Audit for selected PPGs

Performance Standard #2: Member Informing Materials

Standard:	**2.0: Member Informing Materials**
Authorities:	**Standard:** PPG provides written Member Informing Materials in the Member's identified preferred language on a routine basis and alternative formats upon request (applicable only to PPG generated written materials including member-specific information in NOA letters.) Qualified translator means a translator who: (1) adheres to generally accepted translator ethics principles, including client confidentiality; (2) has formal education in the other written non-English target language; (3) has demonstrated proficiency reading, writing, and understanding both English and the other written non-English target language; (4) is able to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology; and (5) has knowledge and experience with culture(s) of the intended audience. **Authorities:** California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI CMS Medicare Marketing Guidelines, Section §30.5.1, 50.4 Code of California Regulations (CCR), Title 22, §53876 (a)(2) &(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) &(e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4, 92.8 Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services and Local Initiative Health Authority for LA County, §1.89, §2.11.1.2.3, §2.11.4.5, §2.12.1.13.3, §2.17.2, §2.15.1.5, §2.15.2, §2.17.5.9 & Appendix B, Provision (H)(c) & (P) DHCS Agreement No. 04-36069, Exhibit A, Attachment 9(14) (B)(2), (14) (C), Attachment 13(4)(C)(1)-(3) DHCS All Plan Letter 05-005 DHCS All Plan Letter 17-011 DHCS Policy Letter 99-04 Participating Physicians Group Services Agreement, Exhibit P.1 Policy and Procedure, CL-006, Delegation and Monitoring of Cultural and Linguistic Services for Delegated Subcontractors Policy and Procedure, CL-007, Language Assistance Services and Reasonable Accommodations for Limited English Proficient Members Policy and Procedure, CL-012, Translation, Alternative Format Conversion and Distribution of Written Member Informing Materials Federal Guidelines: OMH CLAS Standards, Standard 8

Frequency: Annual Audit for selected PPGs

Performance Standard #3: Knowledge about C&L requirements

Standard:	**3.0: Knowledge about C&L requirements**
Authorities:	**Standard:** PPG ensures its employees and network providers are knowledgeable about C&L requirements, language assistance resources, cultural competency including disability sensitivity. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3); Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services and Local Initiative Health Authority for LA County, §2.5.1.8.6.2, §2.9.7.4, §2.9.7.5, §2.9.7.7, §2.9.10.2.1, §2.9.10.4 &§2.10.10.1.1.2 DHCS Agreement No. 04-36069 A08, Exhibit A, Attachment 7(5)(B), Attachment 9(13)(E) Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 DHCS Policy Letter 99-03 Participating Physicians Group Services Agreement, Exhibit P.1 Policy and Procedure, CL-004, Cultural and Linguistic Education and Training Policy and Procedure, CL-007, Language Assistance Services and Reasonable Accommodations for Limited English Proficient Members Federal Guidelines: OMH CLAS Standards, Standard 4 Federal Guidelines: OMH CLAS Standards, Standard 7

Frequency: Annual Audit for selected PPGs

Provider Network Operations

Performance Standard #1: Service Requirements

Standard:	**1.0: Service Requirements**
Authorities:	**Standard:** Service Requirements for providers contracted with PPGs **Authorities:** L.A. Care Participating Physician Group Services Agreement, section 1.34 L.A. Care Medi-Cal Provider Manual, 2017

Frequency: Annual Audit

Performance Standard #2: NCQA Requirements

Standard:	**2.0 NCQA Requirements**
Authorities:	**Standard:** Compliance with applicable requirements according to the National Committee for Quality Assurance **Authorities:** NCQA Standard QI 3: Health Services Contracting, Elements A, B, and C L.A. Care Medi-Cal Provider Manual, 2017

Frequency: Annual Audit

Performance Standard #3: Cal Medi-Connect Program

Standard:	**3.0 Cal Medi-Connect Program**
Authorities:	**Standard:** Compliance with applicable requirements according to the Centers for Medicare and Medicaid Services Medicare Advantage Statute and Regulations for services rendered to Members enrolled in L.A. Care's Cal MediConnect Managed Care Program. **Authorities:** Cal MediConnect Requirements Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with California Department of Health Care Services and L.A. Care Health Plan LAC Medi-Cal Provider Manual, 2017 CFR, 42, 438.230(b)(3), (4) CCR, Title 22, section 53867 CMS Requirements Centers for Medicare and Medicaid Services Medicare Advantage Statute and Regulations (Chapter 42 of the Code of Federal Regulations, Part 422) Medicare Part C & Part D Universal Audit Guide.

Frequency: Annual Audit

HEALTH SERVICE PAYMENT
Claims Processing

Performance Standard #1: Claims Timeliness

Standard:	**1.0: Service Requirements**
Authorities:	**Standard:** The Participating Provider Group (PPG) shall provide timely claims processing services for the Provider Services for which PPG is financially responsible under the applicable DOFR in the PPG's Agreement with LAC, and process claims according to the applicable State, Federal and contractual requirements. **Authorities:** California Welfare and Institutions Code, Section 14104.3(3) Code of California Regulations (CCR), Title 28, - §1300.71(g) & (h) Code of Federal Regulations (CFR), Title 42, §422.100(b); §422.500 Medicare Managed Care Manual Chapter 13, §40 Medicare Part C & Part D Universal Audit Guide – Chapter 8 - Version 1 Participating Physician Group Services Agreement (PPGSA), §1.32, Exhibit N Policy and Procedures, FC-006, as amended Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #2: Claims Appropriateness

Standard:	**2.0 Claims Appropriateness**
Authorities:	**Standard:** The PPG shall appropriately provide claims processing services for the Provider Services for which PPG is financially responsible for under the applicable DOFR in the PPG's Agreement with LAC and process claims according to the applicable State, Federal and contractual requirements. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(3) & (a)(8)(K) Medicare Claims Procedure Manual, Chapter 12, §20 Code of Federal Regulations (CFR), Title 42, §422.100(b)Medicare Part C & Part D Universal Audit Guide – Chapter 8 – Version 1 MCM Chapter 4, §10.2 Participating Physician Group Services Agreement (PPGSA), §1.32 (a) & (b) Policy and Procedures, FC-006, as amended Policy and Procedures, FC-008, as amended Social Security Act (SSA), §1816 [42 U.S.C. 1395h] (c)(2)(B) & §1842 [42 U.S.C. 1395u] (c)(2)(B)

Frequency: Annual Audit

Performance Standard #3: Notice of Denial of Payment

Standard:	**3.0 Notice of Denial of Payment**
Authorities:	**Standard:** The PPG shall, at all times, issue a written notice to CMC members for any denial of request for payment and/or services. **Authorities:** Code of Federal Regulations (CFR), Title 42, §422.568(d) and (e) Medicare Managed Care Manual, Chapter 13, §40.2.1 Medicare Part C & Part D Universal Audit Guide – Chapter 8 – Version 1 Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #4: Accurate and Clear Explanations

Standard:	**4.0 Accurate and Clear Explanations**
Authorities:	**Standard:** The PPG shall provide accurate and clear written explanation of specific reason(s) for denied, adjusted or contested claims. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(8)(F) & (d)(1) Code of Federal Regulations (CFR), Title 42, §422.568(d) and (e) Medicare Managed Care Manual, Chapter 13, §40.2.3 Medicare Part C & Part D Universal Audit Guide – Chapter 8 – Version 1 Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #5: Acknowledgement of Claims

Standard:	**5.0 Acknowledgement of Claims**
Authorities:	**Standard:** The PPG shall acknowledge the receipt of claims within the applicable specified claims processing time limits for the applicable Managed Care Program, or, if applicable, a shorter time frame per PPG's policies and procedures. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(8)(E) & (c) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #6: Provider Dispute Resolution (PDR)

Standard:	**6.0 Provider Dispute Resolution (PDR)**
Authorities:	**Standard:** The PPG shall ensure that Provider Dispute Resolution (PDR) claims processing is in accordance with established provider claims practices as well as dispute resolution requirements. **Authorities:** California Health and Safety Code (CHSC), Division 2, Chapter 2.2, Article 5, §1371, §1371.1, §1371.2, §1371.22, §1371.35, §1371.37, §1371.4 & §1371.8 Code of California Regulations (CCR), Title 28, §1300.71, §1300.71(a)(8)(K), (P), (R), (S), §1300.71(i), §1300.71.38, §1300.71.38(b), (e), (f), (g), §1300.71.4 & §1300.77.4 Code of Federal Regulations (CFR), Title 42, §422. 582 Medicare Claims Procedure Manual, Chapter 12, §20 Medicare Managed Care Manual, Chapter 13, §40.2.3 CMS memo dated January 4 , 2010 – Provider Payment Dispute Resolution for Non-Contracted Providers Medicare Part C & Part D Universal Audit Guide – Chapter 8 – Version 1, RC01 Policy and Procedures, FC-008, as amended Social Security Act (SSA), §1816 [42 U.S.C. 1395h] (c)(2)(B) & §1842 [42 U.S.C. 1395u] (c)(2)(B), §§1852(a)(2)(A)

Frequency: Annual Audit

Performance Standard #7: Provider Dispute Resolution (PDR) Mechanism

Standard:	**7.0 Provider Dispute Resolution (PDR) Mechanism**
Authorities:	**Standard:** The PPG shall ensure that the provider dispute resolution mechanisms is in accordance with established provider claims practices as well as dispute resolution requirements. **Authorities:** California Health and Safety Code (CHSC), Division 2, Chapter 2.2, Article 5, §1371, §1371.1, §1371.2, §1371.22, §1371.35, §1371.37, §1371.4 & §1371.8 Code of California Regulations (CCR), Title 28, §1300.71, §1300.71(a)(8)(K), (P), ©, (S), §1300.71(i), §1300.71.38, §1300.71.38(b), ©, (f), (g), §1300.71.4 & §1300.77.4 Code of Federal Regulations (CFR), Title 42, §422. 582 Medicare Claims Procedure Manual, Chapter 12, §20 Medicare Managed Care Manual, Chapter 13, §40.2.3 CMS memo dated January 4 , 2010 – Provider Payment Dispute Resolution for Non-Contracted Providers Medicare Part C & Part D Universal Audit Guide – Chapter 8 – Version 1, RC01 Social Security Act (SSA), §1816 [42 U.S.C. 1395h] ©(2)(B) & §1842 [42 U.S.C. 1395u] (c)(2)(B), §§1852(a)(2)(A) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #8: Acceptance of Late Claims

Standard:	**8.0 Acceptance of Late Claims**
Authorities:	**Standard:** The PPG shall review and adjudicate late claims subject to submission of a provider dispute and good cause pursuant to applicable policies and procedures. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(b)(4) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #9: Forwarding of Misdirected Claims

Standard:	**9.0 Forwarding of Misdirected Claims**
Authorities:	**Standard:** The PPG shall forward the receipt of misdirected claims to the appropriate payor within the specified claims processing time limits for each Managed Care Program. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(8)(B), (b)(2)(A) & (B) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #10: Request for Reimbursement of Overpaid Claims

Standard:	**10.0 Request for Reimbursement of Overpaid Claims**
Authorities:	**Standard:** The PPG shall ensure that written request for reimbursement for overpayment be processed within the specified claims processing time limits. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(b)(5) and (d)(3), (4), (5) & (6) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #11: Authorization of Services

Standard:	**11.0 Authorization of Services**
Authorities:	**Standard:** The PPG shall not rescind or modify an authorization for services subsequently rendered in good faith and pursuant to the authorization. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(8)(T) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #12: Claim Filing Deadline

Standard:	**12.0 Claim Filing Deadline**
Authorities:	**Standard:** The PPG shall not impose a deadline for the receipt of claims that are less than the specified claims processing time limits for each Managed Care Program. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(8)(A) & (b)(1) Code of Federal Regulations (CFR), Title 42, §424.44 Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #13: Requests for Medical Records

Standard:	**13.0 Requests for Medical Records**
Authorities:	**Standard:** The PPG shall ensure that requests for medical records from providers to process claims submitted only be utilized when deemed reasonably necessary to determine payor liability. This provision does not apply to the PPG's ability to request such medical records to review claims for fraud, waste, and abuse. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.71(a)(8)(H) & (I) Policy and Procedures, FC-008, as amended

Frequency: Annual Audit

Performance Standard #14: Payment Issuance

Standard:	**14.0 Payment Issuance**
Authorities:	**Standard:** The PPG must facilitate access to records necessary to complete audit without limitation. **Authorities:** Participating Physicians Group Services Agreement (PPGSA) Section 1.6.(b)

Frequency: Annual Audit

Financial Solvency

Performance Standard #1: Financial Solvency

Standard:	**1.0 Financial Solvency**
Authorities:	**Standard:** The PPG is financially solvent and meets the six (6) minimum financial solvency requirements. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.75.4.2 Participating Physician Group Services Agreement (PPGSA), §1.6(a) LAC Policy and Procedures, FC-002 §4.1, as amended

Frequency: Annual Audit

Performance Standard #2: Risk Management

Standard:	**2.0 Risk Management**
Authorities:	**Standard:** The PPG has adequate insurance coverage. **Authorities:** Code of California Regulations (CCR), Title 28, §1300.75.4.2(c)(8) Participating Physician Group Services Agreement (PPGSA), §1.13 L.A. Care Health Plan Policy and Procedures, FC-002, §4.2, as amended

Frequency: Annual Audit

HEALTH SERVICE DELIVERY

Utilization and Care Management Project Components

Authorities for UM Performance Standards #1-31 specified below:

- Cal Medi-Connect (CMC) 3 Way Contract 2014 three year Duals Demonstration Project
- Contract between United State Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with California Department of Health Care Services and LAC issued: January 7, 2014.
- Compliance with applicable requirements according to LAC's CMS and DHCS Contract Agreement No 04-36069
- Compliance with applicable requirements according to LAC's DHCS Agreement DHCS Duals All Plan Letters
- Compliance with applicable requirements according to DHCS All Plan and Dual Letters
- Welfare and Institution Code - WIC Section 14182.17(d) (2) – 14132.275 (1) (2) (A), 14185(b)
- DMHC Requirements - Compliance with applicable requirements according to Title 28
- NCQA Standards and Guidelines - Compliance with applicable requirements.
- Covered California Qualified Health Plan Contract for 2014, as amended from time to time.

Other Referenced Requirements:

- Compliance with other applicable requirements pertinent to the specific UM Section will be scored. This includes, but is not limited to: Knox-Keene Act of 1975 Health & Safety Codes 1340 et seq; Welfare and Institutions Codes 14200 et seq, Title 22 CCR Section 1300 et seq, Title 22 CCR Section 53800; Title 28

Other Contract and/or Regulatory Requirements:

- LAC UM audit utilizes a subcategory reserved for contract or other regulatory requirements which are not routinely included in the annual compliance audit, supplemental file reviews, quarterly reviews, or any other UM delegation monitoring activity, but which will be reported if found to be out of compliance during an audit.

Note:

- In cases where regulatory body standards or requirements differ, the strictest standard, as determined by L.A. Care, will prevail.
- MOON: The MOON notice (Medicare Outpatient Observation Notice) (CMS-10611) is mandated by the Federal Notice of Observation and Implication for Care Eligibility Act (NOTICE Act) passed on August 6, 2015.

Performance Standard #1: UM Program and Standards

Standard:	**1.1 Utilization Management (UM) Program and Standards**
Authorities:	**Standard:** Delegate has developed, implemented, and continuously updated and improved a UM Program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services: The UM Program Description (UMP) describes UM Structure, Scope of Services, the Qualified staff responsible for the UM program. It also requires a separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management, Second Opinion. The UM Program requires tracking and monitoring referrals requiring prior Authorization, the Policies/Procedures lists services exempt from prior authorization, Over/Under Utilization, Description of Utilization Management's interface with Quality Management, Utilization Management Committees (UMC), and that UM Program has requirements for Confidentially.

Frequency: Annual Audit

Performance Standard #2: UM Administrative Capacity, Staffing Capacity, Task Experience, and Budgetary Resources

Standard:	**1.2 UM Administrative Capacity, Staffing Capacity, Task Experience, and Budgetary Resources**
Authorities:	**Standard:** The Delegate ensures that a system is in place to provide Physician coverage to be available 24 hours a day 7 days per week for timely authorization of medically necessary care, and Staff Education is including Annual Compliance Training Code of Conduct, FWA & HIPAA. The Organizational Charts are provided for the Organization and the UM Department Comparison of the Plan's budgeted and filled UM/CM positions, Job descriptions (and competency files, if applicable) review and that all Licensed staff licenses are current.

Frequency: Annual Audit

Performance Standard #3: Under and Over Utilization Policies/Procedures/Mechanisms

Standard:	**1.3 Under and Over Utilization Policies/Procedures/Mechanisms**
Authorities:	**Standard:** Delegate shall include within the UM Program Description/policies/procedures the mechanisms used to detect both under- and over-utilization of health care services. Delegate's internal reporting mechanisms used to detect Member utilization patterns shall be reported to L.A. Care and/or DHCS upon request: Quarterly Reports, Monthly Reports, and Provider Preventable Conditions (PPCs) (DPL17-002 / APL17-009),

Frequency: Annual Audit

Performance Standard #4: Policy/Procedure Review and File Review for UM Referral Management

Standard:	**2.1 Policy/Procedure Review and File Review for UM Referral Management**
Authorities:	**Standard:** Policy and Procedures will be reviewed and File Review will be conducted for items marked with *: • UM Review Procedures • After Hours Calls • Post Stabilization Care • UM Timeliness of Decision Making – Inpatient Concurrent Review • UM Review of Admissions and Concurrent Review • Discharge Planning • Post Hospital Discharge Outreach • Medicare Outpatient Observation Notice (MOON)- (CMC only) • Home Health • Hospice and End of Life (EOL) Services • Palliative Care (APL17-015) • Long Term Care Admissions: (Medi-Cal and Duals) • UM timeframes and Notification Requirements* • Standing Referrals* • Transition to Other Care When Benefits End • Continuity of Covered Services • Approval File Review* • Specialty Referral Tracking File Review* • Standing Referral Tracking System File Review* • Other Self- Referral Management Processes (Exceptions from Prior Authorization) • Sterilization & Informed Consent P&P (PM 330 Medi-Cal Only) • Sterilization & Informed Consent P&P (PM 284 LACC) (Non-Federally Funded) • Sexually Transmitted Diseases (STDs) • Abortion is covered by the Medi-Cal Program as a physician service • HIV Testing and Counseling • Minor Consent Services • Delegate shall ensure that Members and Practitioners have Access to Communication with UM Staff.

Frequency: Annual Audit

Performance Standard #5: UM Review Criteria, Disclosure of UM Processes Upon Request, and Consistency in the Application of UM Criteria (Inter-rater Reliability Evaluation)

Standard:	**2.2 UM Review Criteria, Disclosure of UM Processes Upon Request, and Consistency in the Application of UM Criteria (Inter-rater Reliability Evaluation)**
Authorities:	**Standard:** The Delegate's UM Program should: • Have established and current criteria for approving, modifying, deferring, or denying requested services • Be able to provide the Current Criteria in use • Be able to Disclosure Criteria Used if requested by a provider, member or public, • Demonstrate consistency in the Application of UM Criteria

Frequency: Annual Audit

Performance Standard #6: Emergency Services and After Hours Care

Standard:	**2.3 Emergency Services and After Hours Care**
Authorities:	**Standard:** Emergency Department Policies/Procedures must meet the following requirements: The Delegate ER Policies/Procedures do not require members to receive prior authorization of emergency services that meet the "prudent layperson" rule". Emergency services are provided (medical screening and stabilization) where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed in compliance with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Health and Safety Code Section 1317 and The Delegate has policies/procedures to assure availability of and accessibility to emergency health care services 24 hours a day and 7 days a week.

Frequency: Annual Audit

Performance Standard #7: Sub Delegation Agreement

Standard:	**2.4 Sub Delegation Agreement**
Authorities:	**Standard:** Emergency Department Policies/Procedures must meet the following requirements: The Sub Delegation Agreements: • Are Written Delegation Agreement • Have Provisions for PHI- If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions: Covered entity • Have Approval of UM Program • Have Annual Evaluation • Require Reports that are evaluated • Include Opportunities for improvement.

Frequency: Annual Audit

Performance Standard #8: PPG Care Coordination

Standard:	**3.1 Care Coordination**
Authorities:	**Standard:** • Preventive Services for Initial Health Assessment and Periodic Health Assessments; • IHA clinical documentation, • New member checkup • Children's Preventive Services and Immunizations; Screening for Blood Lead and Chlamydia; • EPSDT (Early and Periodic Screening, Diagnosis and Treatment; • Adult Preventive Services and Immunizations; • Pregnancy Care Guidelines; • Provisions of Certified Nurse Midwife Services; • Cervical Cancer Screening and HPV (Human Papillomavirus Vaccine) policies and procedures.

Frequency: Annual Audit

Performance Standard #9: Policy/Procedure Review In and Out of Network Base Case Management

Standard:	**3.2 In and Out of Network Base Case Management**
Authorities:	**Standard:** PPG to ensure that Basic Comprehensive Medical Case Management is provided to each Member by their PCP. PPG has policies and procedures describing system/mechanisms for identifying individuals requiring comprehensive/ complex case management for notifying L.A. Care Health Plan UM Department.

Frequency: Annual Audit

Performance Standard #10: Policy/Procedure Review Out-of-Plan Case Management and Coordination of Care with Linked and Carved Out Services

Standard:	**3.3 Out-of-Plan Case Management and Coordination of Care with Linked and Carved Out Services**
Authorities:	**Standard:** PPG shall implement procedures to identify individuals who may need or who are receiving services from out of network providers and/or linked and carved out programs in order to ensure coordinated service delivery, and efficient and effective joint case management for services delivery, and efficient and effective joint case management for services presented in linked and carved out services listed below: • Specialty Mental Health Services: (Medi-Cal only) • Non-Specialty Mental Health Services; • Arrange for referral to Alcohol and Substance Abuse Treatment Services; • Services for Children with Special Health Care Needs (CSHCN); • California Children Services; • Services for Persons with Developmental Disabilities; • Early Intervention Services; • Local Education Agency Services; • School Linked CHDP Services; • Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome; • Dental Services for Members; • Vision Care for Members; • Tuberculosis (within Scope of PCP); • Direct Observed Therapy (DOT); • Women, Infant, and Children (WIC) Supplemental Nutrition Program.

Frequency: Annual Audit

Performance Standard #11: Long Term Care/Major Organ Transplant/Community Based Waiver Programs

Standard:	**3.4 Long Term Care; Major Organ Transplant; Waiver Programs**
Authorities:	**Standard:** Policies/Procedures shall meet standard which describe that members receive all necessary care coordination of all medically necessary services within network including continuity of care through: • Notification of L.A. Care Member Services & UM Departments for disenrollment to Major Organ Transplant Services. • To notify and coordinate with L.A. Care UM & Case Management for: ◦ Long Term Care (Medi-Cal and L.A. Care Covered) ◦ Major Organ Transplants Services (Medi-Cal and L.A. Care Covered) ◦ Medi-Cal Waiver Programs (Medi-Cal) **Authorities:** Title 22, CCR: Sections 51118, 51120, 51120.5, 51121, 51124.5, 51124.6 51335, 51335.5, 51335.6, 51334, 51003(e).

Frequency: Annual Audit

Performance Standard #12: California Children's Services

Standard:	**3.5 California Children's Services (CCS) File Review**
Authorities:	**Standard:** To ensure there is documentation in the medical record noting that the PCP is aware of members CCS status, or that the PCP was the referring MD to CCS. Indication that child is receiving complete physical examinations/periodic care and preventive health services (i.e. Immunizations, screenings) When services are not covered by CCS, there is documentation in the medical record of appropriate specialty provider referral. When covered by CCS, there is a summary and/or documentation from a CCS paneled physician with a documented discussion from CCS provider. There is evidence of transition planning from CCS to other programs for children who have reached age 19 and will continue to need services by the time they reach age 21.

Frequency: Annual Audit

Performance Standard #13: Initial Health Assessment

Standard:	**3.6 File Review Initial and Periodic Health Assessments (IHA)**
Authorities:	**Standard:** PPG must be compliant with IHA criteria. Files review will be conducted to assess IHA requirements related to new members, members aged 0-21 years, adult, all Medi-Cal SPD, and female members. • Ensure the provision of an IHA within 120 days following the date of enrollment. • Medical Record reflects a SHA/IHEBA assessment has been conducted. • The medical record reflects diagnostic, treatment and follow-up services for risk factors identified in the IHA within 60 days of discovery. • The medical records reflect TB screening for all applicable members. • Ensure initial and annual assessment of tobacco use for each adolescent and adult member. • The medical record reflects the HPV immunization was offered to age appropriate member. • The medical record reflects attempts to schedule IHA if not completed and documentation of missed appointments and two (2) follow-up attempts. • For Asymptomatic Adults, the medical record reflects completion of an age appropriate IHA according to the most current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) as documented by a history & physical & review of organ systems. • Medical record includes colon and rectal cancer screening for adults 50-70 years. • The medical record includes immunization for adults as required.

Frequency: Annual Audit

Performance Standard #14: Utilization Management Program for Cal Medi-Connect (CMC)

Standard:	**4.1 Utilization Management Program**
Authorities:	**Standard:** PPG shall have appropriate Utilization Management (UM) Program, Significant problems corrected, Delegate does not prohibit a health care professional from advising or advocating on behalf of a patient and Delegate ensures reasonable reimbursement for covered services **Authorities:** 42 C.F.R. §422.101(b)(1) -(5); 42 C.F.R. §422.152(b)(1), (2), and (4); 42 C.F.R. §422.152(f)(3); 42 C.F.R. §422.100(a) and (b)(1) -(2) CMS Manual Ch.5 – Section 20 CMS Manual Ch.5 – Section 30.1.1 CMS Manual Ch.4 – Section 10.2

Frequency: Annual Audit

Performance Standard #15: UM Administrative Capacity, Staffing Capacity, Task Experience, and Budgetary Resources for Cal Medi-Connect (CMC)

Standard:	**4.2 UM Administrative Capacity, Staffing Capacity, Task Experience, and Budgetary Resources**
Authorities:	**Standard:** PPG shall have Sufficient Staffing and Staff Training Delegate staff should be adequately trained to submit Critical Incident and abuse reports to L.A. Care Health Plan. Training includes but is not limited to: ways to detect and report instances of abuse, neglect, and exploitation of members by service providers and/or natural support providers (Critical Incident Log). The training program for case managers & care coordinators includes, but is not limited to: a. Roles and responsibilities b. Timeframes for all initial contact and continued outreach c. Needs assessment and care planning d. Service monitoring e. MLTSS and social services, including eligibility requirements, services covered, assessment criteria, timeframes for initial and yearly assessments, maximum services available, the appeals process and roles and responsibilities of county social services offices and Public Authorities in in-home supportive services (IHSS) f. Self-direction of services g. Behavioral health h. Care transitions i. Skilled nursing needs j. Abuse and neglect reporting k. Community resources l. Member rights and responsibilities m. Most integrated/least restrictive setting; n. How to identify behavioral health and MLTSS needs o. How to obtain services to meet behavioral and MLTSS needs p. Dementia care management for specially-designated care coordination staff q. Independent living philosophy The Delegate's staff training should include compliance with confidentiality guidelines and HIPAA compliance obligations.

Frequency: Annual Audit

Performance Standard #16: Care Coordination/Continuity of Care for Cal Medi-Connect (CMC)

Standard:	**4.3 Care Coordination/Continuity of Care (CMC)**
Authorities:	**Standard:** • The delegate has written Policies/Procedures in place that describes the processes/mechanisms by which the medical necessity and benefits coverage decisions are determined by physicians for availability of services that meet or exceed standards established by CMS. • The delegate ensures that the hours of operation of its providers are convenient to and do not discriminate against members. • The Delegate provides or arranges for initial assessment of risk status along with providing or arranging for necessary specialty care • The Delegate provides or arranges for necessary specialty care • The Delegate shall ensure that Comprehensive Medical Case Management is provided to each Member by their PCP and/or care coordinator in collaboration with the Plan. • Delegate has a process to assure that it offers an interdisciplinary care team (ICT) to coordinate the delivery of services and benefits to every member • The Delegate maintains policies to ensure staff has collaboration with the Member to develop the Individualized Care Plan (ICP) and will use the information gathered from the assessments of the member in developing the ICP. • The Delegate has a process to monitor and audit care coordination • Delegate maintains processes for Transition Between Care Settings. • Person-Centered Planning: Delegate must allow the member to be engaged in his or her treatment. • Systems- Delegate has Care Coordination and Care Quality Improvement systems in place. • Medical Home- Delegate must ensure that a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. • Timely Communication of Clinical Information- Delegate must ensure continuity and coordination of care through procedures for timely communication of clinical information among contracted network providers, with the member, and with his/her designees (if applicable). • Standards for Member Input into Treatment Plan/Advance Directives- Delegate should provide documents such as P&P, Provider Manual, Newsletter, Audit results and other member education materials to demonstrate compliance. • There should be No Member Discrimination in Delivery of Health Care **Authorities:** 42 C.F.R. § 422.112(a) (6) (i) and (a) (7) 42 C.F.R. § 422.112(a) (3) 42 C.F.R. § 422.112(a)(6)(iii); § 422.128 42 C.F.R. §422.110; CMS Manual Chapter 4-Section 100.1 and 100.3 CMS Manual Chapter 4-Section 120.2 CMS Manual Chapter 4-Section 160

Frequency: Annual Audit

Performance Standard #17: Under and Over Utilization Policies/Procedures/Mechanisms for Cal Medi-Connect (CMC)

Standard:	**4.4 Under and Over Utilization Policies/Procedures/Mechanisms**
Authorities:	**Standard:** Delegate shall include within the UM Program Description/policies/procedures the mechanisms used to detect both under- and over-utilization of health care services. Delegate's internal reporting mechanisms used to detect Member utilization patterns shall be reported to L.A. Care and/or DHCS upon request. Medicare Advantage Part C - Organization UM Determinations reported timely on a quarterly basis using the Standardized ICE Reporting

Frequency: Annual Audit

Performance Standard #18: Organization Determinations for Cal Medi-Connect (CMC)

Standard:	**4.5 Organization Determinations**
Authorities:	**Standard:** The Delegate correctly distinguishes between Organization Determination and Reconsiderations: The Delegate has Organization Determination Policies/Procedures & uses correct notification templates The Delegate has process in place for: • Processing Expedited Organization Determination Requests, • Communicating Adverse Standard Pre-Service Organization Determinations • Providing Detailed Explanation of Non-Coverage **Authorities:** 42 C.F.R. § 422.564(b); § 42 C.F.R. § 422.566(b); 42 C.F.R. § 422.580 42 C.F.R. § 422.570(c)(2) and (d); § 422.572(a)-(c) 42 C.F.R. § 422.568(a) 42 C.F.R. § 422.626(e)

Frequency: Annual Audit

Performance Standard #19: UM Annual PPG Denial File Review

Standard:	**5.0 Denial/Modification/Delay/Terminate File Review**
Authorities:	**Standard:** For files reviews the PPG must: • Meet the standard decision time; • Have the case be reviewed by MD or Appropriate Practitioner • Document Date of request for extension • Document if Member voluntarily agreed to extension or extension due to matters beyond control; • Document Verbal Notification Date to Practitioner • Have record of Notifications sent by electronic transmission, or by fax within 24 hours of decision; • Meet Practitioner and Member Decision Notification standard time • Demonstrate that Denial files contain appropriate Clinical Information; • Provide the Opportunity to discuss the decision with MD reviewer • Demonstrate that the Written Notification of denial contains specific reasons for denial and it contains reference to the Criterion on which Denial was based; • Provide Appeal Rights • Utilize Correct Template & Language

Frequency: Annual Audit

Performance Standard #20: Informed Consent - Sterilization

Standard:	**5.1 PM 330 Informed Consent – Sterilization File Review (MCLA)**
Authorities:	**Standard:** • Delegate must use the correct PM 330 Consent Form for Medi-Cal members. • Provide evidence that the patient to be sterilized was at least 21 years of age at the time the consent for sterilization is obtained, is not mentally incompetent, is able to understand the consent and nature of the informed consent process, and is not institutionalized and has signed and dated the consent form; • An interpreter was provided if there is evidence that the patient did not understand the language of the informed consent process • Provide evidence of appropriate person completing the consent section; • Physician completed section information as applicable and signed and dated the consent form; • Sterilization was performed at least 30 days but not more than 180 days after the consent form was obtained, except in cases involving emergency abdominal surgery or premature delivery where specific requirements are documented to have been met; • There is documentation in the case that before obtaining consent, the person must provide the individual to be sterilized with a copy of the DHCS booklet on sterilization prior to the patient signing the informed consent form and in enough time for the member to fully consider the information prior to signing the PM 330 consent form.

Frequency: Annual Audit

Performance Standard #21: Informed Consent - Sterilization

Standard:	**5.1A PM 284 Informed Consent – Sterilization File Review (LACC, PASC, CMC)**
Authorities:	**Standard:** • Delegate must use the correct PM 284 Consent Form for LACC, PASC and CMC members. • Evidence that the patient to be sterilized was at least 21 years of age at the time the consent for sterilization is obtained, is not mentally incompetent, is able to understand the content and nature of the informed consent process, and is not institutionalized and has signed and dated the consent form; • An interpreter was provided if there is evidence that the patient did not understand the language of the informed consent process; Evidence of appropriate person completing the consent section; • Physician completed section information as applicable and signed and dated the PM 284 consent form; • There is documentation in the case that before obtaining consent, the person who obtains consent must provide the individual to be sterilized with a copy of the DHCS booklet on sterilization prior to the patient signing the informed Consent form and in enough time for the member to fully consider the information prior to signing the PM 284 consent form • Sterilization was performed at least 30 days after the consent form is signed EXCEPT in specific instances fully explained to the member: ◦ Thirty (30) day waiting period is waived but not less than 72 hours, ◦ Member is at least 18 years of age ◦ OR under age of 18 AND entered into a valid marriage, ◦ OR on active duty with the U.S. armed forces, ◦ OR have received a declaration or emancipation pursuant to Section 64 of the Civil Code, ◦ OR over 15 years of age, live apart from parents or guardians, and manage own financial affairs.

Frequency: Annual Audit

Performance Standard #22: Concurrent Denial File Audit

Standard:	**5.2 Concurrent Denial File Review**
Authorities:	**Standard:** File Reviews will be conducted for concurrent Denied cases to ensure: • Decision time standard was met; • Appropriate practitioner reviewed the case; • If extension was requested, the date of request for extension is documented; • Member voluntarily agreed to extension or extension due to matters beyond control; • Notification date of practitioner decision verbally, • Notification date of electronic transmission, or by fax was within 24 hours of the decision; • Date of verbal notification to member; • Decision notification standard met for both practitioner and member; • Written Notification of Denial standard met for both practitioner and member within two (2) working days; • Denial file contains appropriate clinical information; • Practitioner provided opportunity to discuss decision with MD reviewer; • Written notification of denial contains specific reasons for denial; • Written notification contains reference to the criterion on which denial is based; • Written notification of denial contains notification that member can obtain a copy of the criterion; • The appropriate "State Citation" is noted within the letter; • Written notification of denial contains description of appeal rights; • Written notification of denial contains description of Expedited Appeal Process; • Written notification of denial contains description of Expedited Appeal; • Availability of concurrent external review for urgent/ongoing treatment; • The letter template used is the correct template for the line of business; • The letter was also sent to the member in their Threshold Language. **Authorities:** L.A. Care's DHCS Agreement No 04-36069 Title 28. Knox-Keene Act of 1975 Health & Safety Codes 1340 et seq. Welfare and Institutions Codes 14200 et seq. Title 22 CCR Section 1300 et seq. Title 22 CCR Section 53800; Title 28, etc.

Frequency: Annual Audit

Performance Standard #23: CMC Denial File Audit

Standard:	**5.3 CMC Denial Filer Review**
Authorities:	**Standard:** File Reviews will be conducted for Cal Medi-Connect Denied cases to ensure: • Decision time standard was met; • Appropriate practitioner reviewed the case; • Date of request for extension is documented; • Member voluntarily agreed to extension or extension due to matters beyond control; • Notification date/time to provider • Notification date/time to member • Decision notification standard met for both practitioner and member; • Written Notification of Denial standard met for both practitioner and member • Denial file contains appropriate clinical information; • Practitioner provided opportunity to discuss decision with MD reviewer; • Written notification of denial contains specific reasons for denial; • Written notification contains reference to the criterion on which denial is based; • Written notification of denial contains notification that member can obtain a copy of the criterion; • The appropriate "State Citation" is noted within the letter; • Written notification of denial contains description of appeal rights; • Written notification of denial contains description of Expedited Appeal Process; • Written notification of denial contains description of Expedited Appeal; • Availability of concurrent external review for urgent/ongoing treatment; • The letter template used is the correct template for the line of business; • The letter was also sent to the member in their Threshold Language. **Authorities:** L.A. Care's DHCS Agreement No 04-36069 LA Care's Cal Medi-Connect contract CMS manual Knox-Keene Act of 1975 Health & Safety Codes 1340 et seq; Welfare and Institutions Codes 14200 et seq , Title 22 CCR Section 1300 et seq, Title 22 CCR Section 53800; Title 28

Frequency: Annual Audit

Performance Standard #24: Exempt from Prior Authorization

Standard:	**6.3 Services Exempt from Prior Authorization**
Authorities:	**Standard:** L.A. Care will request that Delegated entities submit claims data covering the audit period (not encounter data). The Delegated entity's claims department will perform a data report. For audit purposes, this data is sorted by L.A. Care to identify non-contracted provider claims for compliance with DHCS contractual requirements as Exempt from Prior Authorization. Prior Authorization shall not be applied to: • emergency services, • family planning services, • preventive services, • basic prenatal care, • sexually transmitted disease services, • HIV testing, • tobacco cessation, • drug and alcohol abuse treatment. • Out of Network dialysis (for CMC only) Non-contracted provider claims are sorted to identify denied services that are exempt from prior authorization. Claims reported are sorted further for: • untimely filing, • ineligibility at the time of service, • secondary payer, etc., and then eliminated. The PPG should do this same sorting. After all sorting is completed, L.A. Care verifies if the denied claim(s) for services are in fact, exempt from prior authorization. If any claim(s) remain, proof of payment is requested from the delegated entity (by a designed date) for each identified claim. If claim(s) were denied for errors and/or omission, an EOB with explanation and/or letter to the requesting provider of facility must be provided to the auditor. **Authorities:** L.A. Care DHCS Agreement No 04-36069, Exhibit A, Attachment 5, 2.G L.A. Care 3-way Contract Section 2.8.4.1.9

Frequency: Annual Audit

Performance Standard #25: Early Intervention/Early Start/Developmental Disabilities (EI/ES/DDS)

Standard:	**6.4 EI/ES/DDS File Review**
Authorities:	**Standard:** 1. The medical record should reflect collaboration between the Regional Center/Early Start/Early Intervention program and the PCP (i.e., MD notes [DDS or ES/EI provider]; referral from or to the Regional Center and/or Early Start program for ages 0-3) 2. The medical record reflects coordination of specialist services with the Health Plan network. 3. The medical record reflects documentation of members with developmental disabilities who are eligible and /or been referred to Home and Community-Based Services (HCBS) Waiver program. 4. For Children 18 Months to 2 Years old, Medical record should reflect Autism Spectrum Disorder Screening as recommended per AAP and Bright Futures. • *Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F)* • *Translations Survey of Well-being of Young Children (SWYC) (Parent's Observations of Social Interactions)* 5. The medical record reflects the member is receiving all medically necessary covered diagnostic, preventive, and treatment services through their PCP.

Frequency: Annual Audit

Performance Standard #26: Comprehensive Perinatal Service Program (CPSP)

Standard:	**6.5 CPSP File Review**
Authorities:	**Standard:** 1. Evidence that risk assessment tool and corresponding risk intervention protocols comply with CPSP requirements. 2. A comprehensive obstetrical record and initial risk assessment tool is completed at the initiation of pregnancy related services. 3. Evidence that risk assessment covers medical/obstetrical issues, nutritional advice, psychosocial counseling, and health education. 4. Evidence that an evaluation of the patient's risk status was done at each trimester. 5. Evidence that a risk assessment was conducted at the postpartum visit (within sixty (60) day of delivery). 7. Evidence that identified risk conditions were followed up with interventions appropriate to remedy the condition/ problem in a prioritized manner. 8. The medical record reflects documented missed appointments and attempts for follow-up, if applicable.

Frequency: Annual Audit

Performance Standard #27: Specialty Referral File Review

Standard:	**2.1.18 Specialty Referral File Review**
Authorities:	**Standard:** The delegate maintains a specialty referral tracking system to track and monitor all specialty referrals with: • Date it was approved, • Date of Members appointment • Date consultant report received or documentation of consultation results on the medical record. The Delegate must ensure that there is evidence that the member was scheduled for requested services along with evidence that the consulting physician sent a written report (on the member record) or discussed member's results with the referring physician. If applicable, there is evidence that there was a follow-up conducted on a missed appointment and there is evidence that there was a follow-up conducted on the referral if it remains open or unused. **Authorities:** Health & Safety Code 1367.01, DHCS State Contract, Amendment 14, Exhibit A, Attachment 5, 1-F

Frequency: Annual Audit

Performance Standard #28: Standing Referral File Review

Standard:	**2.1.19 Standing Referral Tracking System File Review**
Authorities:	**Standard:** The delegate maintains a specialty referral tracking system to track and monitor standing referrals requiring prior authorization. The system shall include authorized, denied, deferred, or modified referrals. This specialty referral for standing referrals system should include non-contracting providers. There is evidence that the treatment plan was developed in collaboration with the PCP and specialist or specialty center and approved according to the PPG Referral Management Process. There is evidence that the standing referral determination was made within three business days of the date of the request and all appropriate medical records and other items of information necessary to make the determination were provided. There is evidence that the referral was made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his/her designee. The medical record reflects the member receiving all medically necessary covered diagnostic, preventive and treatment service through their PCP. **Authorities:** CA Health & Safety Code 1374.16

Frequency: Annual Audit

Performance Standard #29: Critical Incidents Annual Audit (CMC)

Standard:	**2.1.19 Standing Referral Tracking System File Review**
Authorities:	**Standard:** DELEGATE/ PROVIDER must have written policies and/or procedures that are detailed and specific, and describe the mechanisms in place for identifying, reporting, collecting, and tracking critical incidents by member within the Cal MediConnect (CMC) program. DELEGATE/PROVIDER has approved policies and/or procedures that articulate the mechanism by which critical incidents will be identified and reported by member within the CMC program. DELEGATE/PROVIDER has approved policies and/or procedures that articulate the mechanism by which critical incidents will be collected and tracked by member **Authorities:** 42 C.F.R. §§ 422.152(1)(3) Medicare Managed Care Manual (MMCM), Chapter 5, Section 30.1.1 Delegate/ Services Agreement, Section 2.22.3.9.a L.A. Care Health Plan Policy QI-027 Critical Incident Reporting and Tracking

Frequency: Annual Audit

Performance Standard #30: Critical Incidents Annual Audit (CMC)

Standard:	**2.0 Effective Training and Education**
Authorities:	**Standard:** DELEGATE/ PROVIDER must establish, implement, and provide effective training and education for its providers and staff on the identification, reporting to appropriate agencies and L.A. Care Health Plan, collection, and tracking of critical incidents. DELEGATE/PROVIDER provides effective training and education for providers and staff on critical incident identification, reporting, collection, and tracking. Provider and staff training materials include the requirement to report critical incidents to the appropriate agencies and to L.A. Care. DELEGATE/PROVIDER has approved policies and/or procedures that outline the system by which providers and staff will be trained to identify, report, collect, and track critical incidents by member. Policies and Procedures include the requirement to report critical incidents to the appropriate agencies and to L.A. Care. **Authorities:** 42 C.F.R. §§ 422.152(1)(3) Medicare Managed Care Manual (MMCM), Chapter 5, Section 30.1.1 Delegate/ Services Agreement, Section 2.22.3.9.a L.A. Care Health Plan Policy QI-027 Critical Incident Reporting and Tracking

Frequency: Annual Audit

Performance Standard #31: Critical Incidents Annual Audit (CMC)

Standard:	**3.0 Timely Response to Critical Incidents**
Authorities:	**Standard:** DELEGATE/PROVIDER must ensure timely response to critical incidents. DELEGATE/PROVIDER must evidence timely response to critical incidents. DELEGATE/PROVIDER must evidence submission of quarterly Critical Incident Log to L.A. Care. **Authorities:** 42 C.F.R. §§ 422.152(1)(3) Medicare Managed Care Manual (MMCM), Chapter 5, Section 30.1.1 Delegate/ Services Agreement, Section 2.22.3.9.a L.A. Care Health Plan Policy QI-027 Critical Incident Reporting and Tracking

Frequency: Annual Audit

PART III
L.A. CARE MONITORING PROGRAM

PART III: L.A. CARE MONITORING PROGRAM PROCEDURES

This section of PART III: Monitoring Activities describes the LAC Monitoring Program. In includes a background, overview of the performance measures, and description of the monitoring activity processes.

Background

The Regulatory Audits and Monitoring unit within the Compliance Department is responsible for creating and directing the audit readiness strategy. The Delegation Oversight department centralizes all communications and oversight activities of delegated entities. Other business units or 'Monitor Business Units' serve as subject matter expert reviewers and conduct case file reviews. The purpose of the monitoring program is to oversee LAC's functional areas and its delegated entities on an ongoing basis. The monitoring program utilizes data to score quantitative measures and case reviews to score qualitative measures.

Performance Measures

Measures are categorized as "**Critical**" and "**Non-Critical**":

- **Critical measures:** Measures in which noncompliance may result in an enrollee's lack of access to medications and/or services, or posed an immediate threat to an enrollee's health and safety and the following:
  - Regulatory audit element
  - A new and/or repeat regulatory audit finding;
  - An identified delegation oversight audit trend;
  - A referral from Risk Management and/or CCO; and/or
  - A trend in Notices of Non-Compliance from regulatory agencies.
- **Non-critical measures:** Measures in which non-compliance may affect members, but are not of such a severe nature that enrollees' immediate health and safety is affected. Generally, this involves non-compliance with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations, or staffing.

Summary of Monitoring Process and Timeline

Phase I: Report Submission and Automated Data Assessment

- **Frequency:** Monthly
- Delegated entities submit requested reports
- Automated data assessment of reports submitted

Phase II: Live Data Validation Testing

- **Frequency:** Quarterly
- Live reviews to validate the data in reports against Delegates' systems
- 5 samples per report
- 80% threshold

Phase III: Performance Evaluation

- **Frequency:** Monthly and Quarterly
- Monthly, all records/cases are reviewed for compliance using automated calculations for each Quantitative measure.
- Quarterly, targeted samples are selected from reports submitted to test qualitative measures (i.e. clinical decision making) during monitoring field work.

Phase IV: Monitoring Reports

- **Frequency:** Quantitative reviews (i.e. timeliness) reported monthly, qualitative reviews (i.e. clinical decision making) reported quarterly
- Scorecards/reports submitted to Delegates

Phase V: Monitoring Close Out

- **Frequency:** As required
- Notice of Non-Compliance or "Non-Reportable"
- CAP Monitoring

Summary of Monitoring Phases

The monitoring process consists of five phases:

I. Report Submission and Automated Data Assessment
II. Live Data Validation Testing
III. Case File Reviews
IV. Monitoring Reports
V. Monitoring Close Out

The following sections describe important milestones in each phase of the monitoring process.

Phase I: Report Submission and Automated Data Assessment

The report submission and automated data assessment is the first phase of monitoring. During this phase, the functional areas and delegated entities are required to submit reports, which is outlined in **Section 2, Monitoring Protocol: Reporting Specification, below**. Key milestones within Phase I are summarized below in detail.

Report Submission – On the 15th of every month (or the next business day after if the 15th lands on a weekend/holiday), each delegated entity is required to submit all requested reports as outlined in **Section 3, Monitoring Protocol: Reporting Specifications, below,** following all instructions.

Automated Data Assessment – In preparation for live data validation reviews, reports undergo an automated data assessment, which is an automated review of the functional areas' and delegated entities' submitted reports for completeness, data formatting, and logic.

If the Automated Data Assessment identifies errors in 20% or more records/cases within the report submission, this will be documented as an "NR" or "Non-Reportable" for all applicable measures. The report will not be included in Live Data Validation Testing (Phase II) as it has already been deemed inaccurate through the automated data assessment.

Phase II: Live Data Validation Testing

Data Validation Testing – Quarterly and prior to case file reviews (as applicable), a separate webinar will be held to verify that the data provided in the reports are accurate. The delegated entities should have available the information and documents necessary to demonstrate that the data provided in the reports are accurate. Specific documents in live systems will be reviewed during the webinar.

5 samples are randomly selected for each report subject to the data validation reviews. All fields within one sample must match the systems in order for one case to pass. The report is deemed "accurate" if 4 out of 5 samples (80%) passes. If there are less than 5 cases in the report, all cases must be reviewed for data validation.

If the delegated entity fails to provide accurate and timely report submissions, this will be documented as an "NR" or "Non-Reportable".

> *NOTE: Worst-Case Scenario Mailing Policy – In instances where systems are programmed to capture the date letters are generated (as opposed to the "mailing date"), the worst-case scenario mailing policy can apply. The functional areas and delegates can apply its mailing policy to populate the "Notification Date" fields.*

Phase III: Performance Evaluation

(A) Quantitative (Automated Scoring)

Monthly, all records/cases are reviewed for compliance using automated calculations for each measure. The score for each measure is calculated by dividing the total number of records/cases in the selection by the number of compliant records/cases. The automated score will be populated in the performance dashboard monthly. Quarterly scores, however, may result in an "NR" or "non-reportable" if the applicable report is deemed inaccurate during the live data validation and/or automated data assessment.

(B) Qualitative (Case File Reviews)

Sample Selection – Quarterly, targeted samples are selected from reports submitted to test qualitative measures (i.e. clinical decision making) during monitoring field work. Specific sample sizes vary by functional area and element and are listed within the respective functional area monitoring process and data request documents. If an "NR" or "Non-Reportable" is cited for any measure/report, samples will still be selected for this portion of the monitoring process.

Samples can either be reviewed via webinar through live systems while others can be reviewed through case file reviews.

Notification of Sample Selection – The notification of sample selections timing is dependent on the type of review conducted: For live reviews, notification of sample selections is sent to delegated entities on the day the case file reviews are conducted via email approximately one hour before the start of the webinar. For case file reviews, notification of sample selections is sent to the delegated entities 7 calendar days prior to reviews. Delegated entities have 7 days to complete and submit the case files.

Webinar Reviews – During the webinar reviews, the delegated entities are expected to present its supporting documentation while the auditors evaluate sample cases live in the system(s) to determine whether the case is compliant. For cases deemed pended or non-compliant, the delegated entity must take screen shots and submit the case to the reviewers.

Phase IV: Monitoring Reports – Compliance Scores

Monitoring Reports are sent to Delegates on a monthly and quarterly basis. Each month, Delegates will receive a Monthly Monitoring Report with the results of the quantitate scoring for that month. On a quarterly basis, Delegates will receive a Final Monitoring Report that contains the quantitative and qualitative scores for the full quarter.

Classifications and Scoring: Each report in the monitoring program has defined compliance calculations to determine an overall score for each performance measure. Subsequently, each performance measure is assigned levels of scoring based on the definitions below.

Classification	Definition	Actions Required	Scoring Methodology
RED: Non-Reportable (NR)		An NR is cited for each element that cannot be tested due to failure to submit an accurate or complete report. For example, if dates and times on a report are deemed inaccurate timeliness measures would receive an "NR" or 0% timeliness score. NRs will be noted in the report and immediate corrective action must be taken to stop or prevent the data errors from recurring.	Excluded from overall score
RED	If systemic deficiencies are identified are so severe that they require immediate correction, an ICAR is cited. Identified issues of this nature would be limited to **critical measures** where the deficiency resulted in an enrollee's lack of access to medications and/or services, or posed an immediate threat to an enrollee's health and safety.	**Critical Measures:** • 1 quarter RED: L.A. Care will send the delegate a Warning Letter. • 2 quarters RED: L.A. Care will issue a Notice of Non-Compliance (NONC). Delegated entities are required to submit Corrective Action Plans (CAPs) in the L.A. Care CAP Form describing the root causes and corresponding actions taken to stop the non-compliance within one week of the issuance of the report. L.A. Care will monitor the CAPs for implementation and completion. • 3 quarters RED: L.A. Care will refer the ongoing non-compliance to Delegation Oversight or Internal Audit to conduct a focused review/audit. **Non-Critical Measures:** • Delegated entities must conduct root cause analyses and complete corrective actions. Documentation will not be submitted to L.A. Care, but must be tracked and monitored by the business unit or delegated entity. L.A. Care will continue to monitor the measures to ensure improvement and conduct focused audits, as needed.	2 points
Yellow	These issues may affect members, they are not of such a severe nature that enrollees' immediate health and safety is affected. Generally, this involves non-compliance with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations, or staffing.	Delegated entities must conduct root cause analyses and complete corrective actions. Documentation will not be submitted to L.A. Care, but must be tracked and monitored by the business unit or delegated entity. L.A. Care will continue to monitor the measures to ensure improvement and conduct focused audits, as needed.	1 point
Green	Cases are found to be compliant. Cases may also be found to be non-compliant, but are non-systemic, or represent an anomaly or "one-off" issue. These would be noted as observations and would result in continued monitoring.	These would be noted as observations and would result in continued monitoring.	0 points

Once classifications are complete, the final score of all monitoring measures applicable to LAC and its delegated entities then divide that number by the number of monitoring elements tested to determine the organizational scores. Some elements and areas may not apply to certain organizations and therefore will not be considered when calculating overall monitoring scores.

Phase V: Monitoring Close Out

Issuance of the Final Monitoring Report: The Final Monitoring Report contains the final score and classification of findings noted during the monitoring review period.

Referral to Sanctions Committee: Delegated entities may be referred to the Sanctions Committee to determine if an enforcement action (money penalties, sanction, or contract termination) is warranted. If a delegated entity is referred to the Sanctions Committee, delegated entities' Compliance Officers will be notified by LAC.

Monitoring Protocol: Reporting Specifications

As referenced in the LAC Monitoring Program Procedures above, this section lists the report specifications for each report in the Monitoring Program.

Each Report Specification in this section contains the following detail:

1. **The Report Name**
2. **The Report ID**
3. **File Naming Convention**
4. **Notes** - Details to note regarding what to include or exclude from the report
5. **Data Specifications** – the **Column, Field Name, Field Length**, and **Description** for each data element in the report. These specifications will be checked during the monthly Automated Data Assessment.

Report 2A: Service Authorization Request (SAR) Log

Report ID: 2.1

File Naming Convention: 2A_PPG CODE_SARLog_Univ_YYYYMM- YYYYMM.xlsx

Notes

- Include all requests processed as expedited and standard service authorization requests for Medi-Cal, LACC, CMC, LAC-D, and PASC lines of business whether approvals or denials.
- Exclude payment and reimbursement requests, dismissals, reopenings, withdrawn requests.
- Submit cases based on the date the delegate's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).
- If a standard service authorization request addresses more than one service, include all of the request's line items in a single row and enter the multiple line items as a single service authorization request.
- All data must be submitted in Text format

Data Specifications

Column ID	Field Name	Field Length	Description
A	Member First Name	50	First name of the member.
B	Member Last Name	50	Last name of the member.
C	Cardholder ID	20	Cardholder identifier used to identify the member. For **CMC** enter MBI. (11 characters, randomly generated numbers and uppercase letters) For **Medi-Cal** enter CIN (9 characters, 8-digits followed by a letter) For **LACC** and **LACD** enter Member ID (14 characters, starts with "MEM" followed by 11 randomly generated numbers) For **PASC,** enter member's PASC member ID (9 characters, starts with "IH" followed by 7numbers)
D	Line of Business	4	Line of business the request was processed under. Options are: **MCLA** (Medi-Cal) **CMC** (Cal MediConnect) **LACC** (L.A. Care Covered) **LACD** (L.A. Care Covered Direct) **PASC** (PASC-SEIU)
E	Aid Code	20	Enter the Medi-Cal Assigned Aid Codes (For **MCLA** and **CMC** Lines of Business only)
F	Authorization or Claim Number	40	The associated authorization number assigned by the organization for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Review Type	2	Indicate the request priority. Options are: **CN** (Concurrent) **CU** (Concurrent Urgent) **PN** (Preservice Nonurgent) **PU** (Preservice Urgent) **PS** (Post Service)
H	Who made the request?	3	Indicate who made the service authorization request. Options are: **CP** (Contract Provider) **NCP** (Non-contract provider) **M** (Member) **MR** (Member's representative) **SC** (Service Coordinator/Care Coordinator) Note- the term "provider" encompasses physicians and facilities.

Data Specifications

Column ID	Field Name	Field Length	Description
I	Provider Type	3	Indicate the type of provider performing the service. Options are: **CP** (contract provider) **NCP** (non-contract provider)
J	Date the request was received	10	Provide the date the request was received by your organization. Submit in **CCYY/MM/DD** format (e.g., 2018/01/01). **Note** - This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR.
K	Time the request was received	8	Provide the time the request was received by your organization. Submit in **HH:MM:SS** military time format (e.g., 23:59:59). **Note** - This is the original receipt of the request and not the date that the request became valid via an AOR.
L	Diagnosis	100	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If there are multiple Diagnosis codes, provide them in a list separated by a comma. If the character count for a list of procedure codes exceeds 100 characters, only include the procedure codes up to the 100 character limit. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
M	Type of service	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
N	Issue description	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known).
O	Procedure Code	200	Provide the CPT code or HCPS code If there are multiple codes, provide them in a list separated by a comma. If the character count for a list of procedure codes exceeds 200 characters, only include the procedure codes up to the 200 character limit.
P	Place of Service	2	Provide the place of service code
Q	Was request made under expedited timeframe, but processed by the delegate under the standard timeframe?	2	Yes (Y)/No (N) indicator of whether the request was made under an expedited timeframe, but was processed under a standard timeframe. NA: Enter NA if the case was processed as expedited.

Data Specifications

Column ID	Field Name	Field Length	Description
R	Was a timeframe extension taken?	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the organization extended the timeframe to make the service authorization decision. **Y**= Timeframe extended. **N**= Timeframe not extended.
S	If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	2	Yes (Y)/No (N) indicator of whether the organization notified the member of the delay. Answer NA if no extension was taken. **Y**= Notified the beneficiary of the delay **N**= Did not notify the beneficiary of the delay
T	Date of Notification of Extension	10	If an extension was taken, indicate the date the member was notified **NA**= No extension taken
U	Request Disposition	8	Status of the request. Valid values are: approved, or denied. Note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
V	For CMC Line of Business only, was determination based on CMC Medicare or CMC Medi Cal?		Indicate if the determination was based on CMC Medi-Cal or CMC Medicare criteria. *For **CMC** line of business ONLY.*
W	Date of decision	10	Date of the decision. Submit in **CCYY/MM/DD** format (e.g., 2018/01/01). Answer **NA** for untimely cases that are still open
X	Time of decision	8	Time of the decision (e.g., approved, denied). Submit in **HH:MM:SS** military time format (e.g., 23:59:59). Answer NA for untimely cases that are still open. **Note** – This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.
Y	Was the request denied for lack of medical necessity?	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer **NA** if the request was approved.
Z	Date oral notification provided to member	10	Date oral notification provided to member. Submit in **CCYY/MM/DD** format (e.g., 2018/01/01).
AA	Time oral notification provided to member	8	Time oral notification provided to member. Submit in **HH:MM:SS** military time format (e.g., 23:59:59).
AB	Date written notification provided to member	10	Date written notification provided to member. The term "provided" means when the letter left the establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the organization. Submit in **CCYY/MM/DD** format (e.g., 2018/01/01).

Data Specifications

Column ID	Field Name	Field Length	Description
AC	Time written notification provided to member	8	Time written notification provided to member. Submit in **HH:MM:SS** military time format (e.g., 23:59:59).
AD	Date notification provided to provider	10	Date the provider was notified (call or fax). Submit in **CCYY/MM/DD** format (e.g., 2018/01/01).
AE	Time notification provided to provider	8	Date the provider was notified (call or fax). Submit in **HH:MM:SS** military time format (e.g., 23:59:59).
AF	Date service authorization entered/effectuated in the system	10	Date service authorization/approval was entered in the system. Submit in **CCYY/MM/DD** format (e.g., 2018/01/01). Answer **NA** for denials.
AG	Time service authorization entered/effectuated in the system	8	Time service authorization/approval entered in the system. Submit in **HH:MM:SS** military time format (e.g., 23:59:59). Answer **NA** for denials.
AH	AOR receipt date	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received. Submit in **CCYY/MM/DD** format (e.g., 2018/01/01).
AI	AOR receipt time	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received. Submit in **HH:MM:SS** military time format (e.g., 23:59:59).
AJ	First Tier, Downstream, and Related Entity	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the expedited service authorization request (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator).

Report 3B: Core 3.2 Report

Report ID: 3B

File Naming Convention: 3B_PPG CODE_Core_3.2_YYYYMM- YYYYMM.xlsx

Notes

- L.A. Care will provide a pre-populated report to Delegate. Rows in grey highlight below will be pre-populated by L.A. Care.

Data Specifications

Column ID	Field Name	Field Length	Description
A	PPG Region Code *	35	Enter PPG Region Code
B	Beneficiary Name *	100	Last Name, First Name of all members who have reached 3 months of enrollment by the quarter reporting period.
C	Beneficiary DOB *	10	Enter Beneficiary's date of birth. Please use short date format: Example 4/15/1954
D	Beneficiary CIN *	10	The CIN is a unique identifier assigned to an individual by the state. The CIN begins with a 9, followed by 7 numeric digits, then an alpha character
E	CMS Contract ID *	5	Enter H8258 for CMC
F	Effective Date of Enrollment *	10	Enter the date of Enrollment to L.A. Care Health Plan. Please use short date format: Example 5/01/2014
G	Disenrollment Date *	N/A	N/A
H	Effective PPG date *	10	Enter the date of Enrollment to PPG assigned. Please use short date format: Example 5/01/2014
I	HRA Date *	10	Enter the date of the most recent HRA completed, after enrollment date. Please use short date format: Example 5/19/2018
J	HRA Risk Level *	10	Low, Moderate, High, or Complex
K	ICP **with member involvement** completed within 3 months of enrollment	5	Enter **Y** if ICP was completed **with member involvement** within 3 months of **LA Care Enrollment.** • Enter **N** if ICP was not completed with member involvement within 3months of enrollment. • Enter **N** if ICP was not completed • Enter **N** if Beneficiary was unable to contact • Enter **N** if Beneficiary refused to complete ICP
L	ICP completion date **with member involvement** within 3 months of enrollment	10	Enter **date** ICP with member involvement was completed after enrollment. **Do not** enter Basic Care Plan date In the event the PPG revised the ICP with member involvement multiple times, please enter **closest date to initial enrollment date**.
M	Did Beneficiary refuse ICP within 3 months of enrollment?	5	Enter **Y** if Beneficiary **refused** ICP within 3 months of enrollment. Enter **N** if Beneficiary.

Column ID	Field Name	Field Length	Description
N	ICP refusal date within 3 months of enrollment	10	Enter **date** Beneficiary refused ICP (**refusal date must be within 3 months of enrollment date**). Please use short date format: Example 5/19/2014 Enter **NA** if you answered **N in column 12**
O	Did Beneficiary request delay in completion of the ICP within 3 months of enrollment?	5	Enter **Y** if Beneficiary requested delay in completion of the ICP within 3 months of enrollment. Enter Y if Beneficiary expressed **willingness** to complete the ICP, **but rescheduled, or subsequently is non-responsive** after the date requested for ICP completion within 3 months of enrollment. Example for Member request delay in completion scenario: 10/1/2017-member effective date of 10/1/17 11/5/2017 - HRA was completed 11/10/2017 - member was contacted, - member agreed to ICP but requested for it to be done on 11/12/17. 11/12/2017 - member was contacted and no response/no call from member. Enter **N** if Beneficiary **did not** request delay in completion of the ICP within 3 months of enrollment.
P	Date Beneficiary requested delay/Agreed in completion of the ICP within 3 months of enrollment		Enter the **date** the Beneficiary was contacted by PPG and requested delay in completion of the ICP within 3 months of enrollment. Please use short date format. **OR** **Enter the date Beneficiary was contacted by PPG or LA Care CM and agreed for Care Planning activities and a Follow-Up Call.** For the example, in column 14, we used the scenario 10/1/2017-member effective date of 10/1/17 11/5/2017 - HRA was completed **11/10/2017** - member was contacted, - **member agreed to ICP but requested** for it to be done on 11/12/17. **Or agreed upon schedule**. 11/12/17 - member was contacted and no response/no call from member. Based on this scenario, PPG would enter 11/10/2017 date in column 15, since that was the date the Beneficiary was contacted and requested delay in completion of the ICP within 3 months of enrollment. Enter **NA** if you answered **N in column 14** **For members with high or complex HRAs assigned to LA Care & members without HRAs** - In the event that PPG created a timely ICP with member involvement (could be due to triggering events such as transition of care), please populate columns 10 & 11, overwrite the report as needed and complete columns 12-22. Otherwise, leave as is.

Column ID	Field Name	Field Length	Description
Q	Follow-up date Beneficiary was non-responsive after requesting delay in completion of the ICP	10	Enter the **date** the PPG followed-up with Beneficiary and the Beneficiary was non-responsive after requesting **delay/agreeing** in completion of the ICP within 3 months of enrollment. **OR** **Enter the future date (date outside the first 3 months of effective date) the member requested to be called to complete the ICP.** For the example, in column 14, we used the scenario 10/1/2017-member effective date of 10/1/17 11/5/2017 - HRA was completed 11/10/2017 - member was contacted, - member agreed to ICP but requested for it to be done on 11/12/17. **11/12/2017** - member was contacted and no response/no call from member. Based on this scenario, PPG would enter 11/12/2017 date in column 16, since that was the date of the follow up to complete the ICP, the PPG reached out to the Beneficiary, and the Beneficiary was non-responsive. Please use short date format: Example 11/12/2017. Enter **NA** if you answered **N in column 14**
R	Beneficiary is UTC for ICP completion within 3 months of enrollment	5	Enter Y if Beneficiary is Unable to Contact for ICP completion within 3 months of enrollment with a minimum of 3 attempts (columns 18, 19, & 20 must have dates within 3 months in order for this to be a valid UTC) Enter N if PPG was able to contact Beneficiary for ICP completion within 3 months of enrollment or if PPG was Unable to Contact Beneficiary for ICP completion after 3 months of enrollment For members with high or complex HRAs assigned to LA Care & members without HRAs - In the event that PPG created a timely ICP with member involvement (could be due to triggering events such as transition of care), please populate columns 10 & 11, overwrite the report as needed and complete columns 12-22. Otherwise, leave as is.
S	UTC for ICP completion date #1 within 3 months of enrollment	10	Enter **1st** date Beneficiary was **Unable to Contact for ICP completion** within 3 months of enrollment Enter **NA** if you answered **N in column 17**
T	UTC for ICP completion date #2 within 3 months of enrollment	10	Enter **2nd** date Beneficiary was **Unable to Contact for ICP completion** within 3 months of enrollment Enter **NA** if you answered **N in column 17**
U	UTC for ICP completion date #3 within 3 months of enrollment	12	Enter **3rd** date Beneficiary was **Unable to Contact for ICP completion** within 3 months of enrollment Enter **NA** if you answered **N in column 17**

Column ID	Field Name	Field Length	Description
V	Basic Care Plan completion date without Member Involvement	100	Enter **date** when the basic care plan without member involvement was initially completed after HRA completion date (as per the 2018 Core Reporting Requirements, the Plan is required to have Care Plans for all CMC members within 90 days of enrollment). • **DO NOT** enter ICP date with member involvement in Column 21. Columns **11 and 21** should not have the same date. • Enter **NA** if there's no basic care plan completion date without member involvement • Please use short date format: Example 5/19/2014 • Basic Care Plan is **NOT** a substitute for an ICP. CMS intent for ICP is: Member is involved and there is a documented discussion of care goals. **Please note, if a basic care was completed and a date was entered in column 21, L.A. Care needs to know reason for completion of basic care plan without member involvement. Either complete columns 12-13 for refusal, or columns 17-20 for Unable to Contact or if other reason, please state the reason in column 22.**
W	State reason for those beneficiaries who were not categorized as either completed, refused, or UTC	100	Enter the other **reason ONLY** for those beneficiaries **who were not** categorized as either completed, refused, or UTC. For example--> applicable scenario may include but not limited to: - L.A. Care failed to post the HRA - Staffing issue - Staff Performance Issue - PPG failed to distribute the cases to case managers - Member is medically unable to respond and no authorized representative to complete ICP on their behalf - Member considered complex case and currently being managed by L.A. Care

- * These data elements (highlighted in grey) will be pre-populated by L.A. Care.
- In the event that this report is automatically generated by the Delegate, the Delegate may overwrite the pre-populated information from columns 10-22
- ***Members with High or complex HRAs are assigned to LA Care*** - In the event that PPG created a timely ICP with member involvement (could be due to triggering events such as transition of care, or member contacted PPG directly), please populate columns 10 & 11, overwrite the report as needed and complete columns 12-22. Otherwise, leave as is.

Report 3C: IHA Due Date Report

Report ID: 3C

File Naming Convention: 3C _SARLog_Univ_YYYYMM.xlsx

Notes

- This report will be generated internally by L.A. Care.

Data Specifications

- N/A. This report will be generated internally by L.A. Care.

Report 3D: Managed Care Plan (MCP) File

Report ID: 3D

File Naming Convention: 3D _MCP_File_YYYYMM-YYYYMM.xlsx

Notes

- This report will be generated internally by L.A. Care.

Data Specifications

- N/A. This report will be generated internally by L.A. Care.

Monitoring Protocol: Measures Specifications

As referenced in the L.A. Care Monitoring Program Protocol, this document lists the specifications for each measure in the Monitoring Program.

Each Measure Specification in this document contains the following detail:

1. **Line of Business**
2. **Functional Area**
3. **Data Source**
    a. **Report** – The name of the report
    b. **Applicable Data Fields** – The data elements that will be tested for each selected sample that pertain to this measure. If these elements are not accurate, the measure may be scored an "NA."
4. **Performance Evaluation**
    a. **Method** – Either Quantitative or Qualitative, depending on the type of measure
    b. **Frequency** – The frequency at which this score is calculated
    c. **Cases Evaluated** – The number and/or means of selecting cases from the report in order to calculate the score
    d. **Requirement** – A summary of the requirements that must be met by each record or sample in order to qualify as a "compliant" record or sample
    e. **Evaluation** – The specific formula or list of requirements used to calculate whether a record or sample is compliant.
5. **Monitoring Report**
    a. **Overall Compliance Score Calculation** – The formula used to calculate the overall compliance score for this measure, based on the individual records or samples scored in the Performance Evaluation.
    b. **Performance Benchmarks** – The benchmarks for how the Overall Compliance Score translates to an NR, Red, Yellow, or Green.
6. **References** – A list of relevant cross-references for the measure, including regulatory or contractual authority.

2.1 Utilization Management – Service Authorization Requests
Measure 2.1.1 - Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of Business) • Column G (Review Type) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line Of Business) for MCLA Only • Filter Column G (Review Type) for PU Only

Requirement	Evaluation:
Within 72 hours from receipt of request, with a possible extension of 14 calendar days	• 1. Column W (Date of decision) & Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W & X (Date and time of decision) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA and Preservice Urgent (PU)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(2)
DHCS Contract – Exhibit A, Attachment 5, 3H

Measure 2.1.2 – Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request

Line of Business:	**Functional Area:**
CMC	Utilization Management

1. Data Source

Report:	**Applicable Data Fields:**
2A. SAR Log	• Column D (Line of Business) • Column G (Review Type) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for PU only

Requirement	**Evaluation:**
Within 72 hours from receipt of request, with a possible extension of 14 calendar days	• 1. Column W (Date of decision) & Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W & X (Date and time of decision) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC and Preservice Urgent (PU)

Performance Benchmarks:

RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 94%	95-99.9%	100%

References

H3-way contract – 2.11.5.6.2

Measure 2.1.3 - Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request

Line of Business:	**Functional Area:**
LACC	Utilization Management

1. Data Source

Report:	**Applicable Data Fields:**
2A. SAR Log	• Column D (Line of Business) • Column G (Review Type) • Column J (Date the request was received) • Column K (Time the request was received) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for PU only

Requirement	**Evaluation:**
Within 72 hours from receipt of request	• 1. Column W (Date of decision) & Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC and Preservice Urgent (PU)

Performance Benchmarks:

RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(2)

Measure 2.1.4 - Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request

Line of Business:	**Functional Area:**
PASC	Utilization Management

1. Data Source

Report:	**Applicable Data Fields:**
2A. SAR Log	• Column D (Line of Business) • Column G (Review Type) • Column J (Date the request was received) • Column K (Time the request was received) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for PU only

Requirement	**Evaluation:**
Within 72 hours from receipt of request	• 1. Column W (Date of decision) & Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC and Preservice Urgent (PU)

Performance Benchmarks:

RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(2)

Measure 2.1.5 - Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision

Line of Business:	**Functional Area:**
MCLA	Utilization Management

1. Data Source

Report:	**Applicable Data Fields:**
2A. SAR Log	• Column D (Line of Business) • Column G (Review Type) • Column U (Request Disposition) • Column W (Date of decision) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	• Filter column D (line of business) for Medi-Cal only • Filter column G (review type) for PU only • Filter column U (request disposition) for denied only

Requirement	**Evaluation:**
Notify the member within 2 business days of the decision (denials only)	• 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 2 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records when filtered for MCLA & preservice urgent (PU) & Denials

Performance Benchmarks:

RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(3)

Measure 2.1.6 - Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 hours from Receipt of the Request

Line of Business:	**Functional Area:**
MCLA	Utilization Management

1. Data Source

Report:	**Applicable Data Fields:**
2A. SAR Log	• Column D (Line of Business) • Column G (Review type) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column U (Request Disposition) • Column AB (Date written notification provided to member) • Column AC (Time written notification provided to member)

2. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	• Filter column D (line of business) for Medi-Cal only • Filter column G (review type) for PU only • Filter column U (request disposition) for denied only

Requirement	**Evaluation:**
Within 72 hours from receipt of request, with a possible extension of 14 calendar days (denials only)	• 1. Column AB (Date of written notification provided to member) and Column AC (Time written notification provided to member) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column AB & AC (Date and time of written notification) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days. • If any of the calculations above are met, case is considered compliant

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/ Total number of records when filtered for MCLA & preservice urgent (PU) & Denials

Performance Benchmarks:

RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 94%	95-99.9%	100%

References

DHCS Contract – Exhibit A, Attachment 5, 3H & 2F

Measure 2.1.7 - Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 hours from Receipt of the Request

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of Business) • Column G (Review type) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column U (Request Disposition) • Column Z (Date oral notification provided to member) • Column AA (Time oral notification provided to member) • Column AB (Date written notification provided to member) • Column AC (Time written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for PU only

Requirement	Evaluation:
Within 72 hours from receipt of request, with a possible extension of 14 calendar days (denials only)	• 1. Column AB (Date of written notification provided to member) and Column AC (Time written notification provided to member) – Column J(Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column U (Request Disposition) = Approved, then calculate: Column Z (Date oral notification provided to member) and Column AA (Time oral notification provided to member) - Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 3. If Column U (Request Disposition) = Denied, then calculate: If Column Z (Date oral notification provided to member) and Column AA (Time oral notification provided to member) is before the date in Columns AB & AC (Date and time of written notification), AND Column Z (Date oral notification provided to member) and Column AA (Time oral notification provided to member) - Column J (Date the request was received) and Column K (Time the request was received) is less than or equal to 72 hours, then Column AB & AC – Column Z & AA must be equal to or less than 3 calendar days • 4. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column AB & AC (Date and time of written notification) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report			
Overall Compliance Score Calculation:			
# of compliant records/ Total number of records when filtered for CMC & preservice urgent (PU)			
Performance Benchmarks:			
RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 94%	95-99.9%	100%
References			
3-way contract – 2.11.5.6.2 42 CFR 422.572 (a)(1) 42 CFR 422.572(c) Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance – 10.5.3, 40.12.1			

Measure 2.1.8 - Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column U (Request Disposition) • Column W (Date of decision) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for PU only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify the member within 2 business days of the decision (denials only)	• In order for a case to be considered compliant, the first calculation and either the second or third calculation must be met. • 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 2 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/ Total number of records when filtered for MCLA & preservice urgent (PU) & Denials

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(3)

Measure 2.1.9 - Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column U (Request Disposition) • Column W (Date of decision) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for PU only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify the member within 2 business days of the decision (denials only)	• In order for a case to be considered compliant, the first calculation and either the second or third calculation must be met. • 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 2 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records when filtered for PASC & preservice urgent (PU) & Denials

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(3)

Measure 2.1.10 - Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to member) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for PU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Preservice Urgent (PU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(3)

Measure 2.1.11 - Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 Hours of Receipt of the Request

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken) • Column S (If an extension was taken did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for PU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Within 72 hours from receipt of request, with a possible extension of 14 calendar days	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column J (Date the request was received) & Column K (Time request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column AD (Date notification provided to provider) – Column J (Date the request was received) must equal be equal to or less than 17 calendar days.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Preservice Urgent (PU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

DHCS contract – Exhibit A, Attachment 5, 2J & 3H

Measure 2.1.12 - Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 Hours of Receipt of the Request

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken) • Column S (If an extension was taken did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column AB (Date written notification provided to member) • Column AC (Time written notification provided to member) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for PU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Within 72 hours from receipt of request, with a possible extension of 14 calendar days	• 1. Column AD (Date notification provided to provider) and Column AE (Time notification provided to provider) – Column J(Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column AB & AC (Date and time of written notification) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for CMC, Preservice Urgent (PU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

3-way contract – 2.11.5.6.2
42 CFR 422.572 (a)(1)
3-way contract – 2.11.6.3.9

Measure 2.1.13 - Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for PU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for LACC, Preservice Urgent (PU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01(h)(3)

Measure 2.1.14 - Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for PU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for PASC, Preservice Urgent (PU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01(h)(3)

Measure 2.1.15 - Standard/Routine Preservice Service Authorization Request Decisions Made within 5 Business Days of Receipt of Information

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for PN only

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W (Date of decision) – Column J (Date the request was received) must be less than or equal to 28 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for MCLA and Preservice Non-urgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HHSC 1367.01 (h)(1)
DHCS Contract – Exhibit A, Attachment 5, 3G

Measure 2.1.16 - Standard/Routine Preservice Service Authorization Request Decisions Made within 14 Calendar Days of Receipt of the Request

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for PN only

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 14 calendar days • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W (Date of decision) – Column J (Date the request was received) must be less than or equal to 28 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for CMC and Preservice Non-urgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.5.6.1

Measure 2.1.17 - Standard/Routine Preservice Service Authorization Request Decisions Made within 5 Business Days of Receipt of the Information

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for PN only

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W (Date of decision) – Column J (Date the request was received) must be less than or equal to 28 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for LACC and Preservice Non-urgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.18 - Standard/Routine Preservice Service Authorization Request Decisions Made within 5 Business Days of Receipt of the Information

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for PN only

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W (Date of decision) – Column J (Date the request was received) must be less than or equal to 28 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for PASC and Preservice Non-urgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.19 - Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within Two Business Days of the Decision

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column U (Request Disposition) • Column W (Date of decision) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for PN only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify the member within 2 business days of the decision (denials only)	• 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 2 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for MCLA, Preservice Non urgent (PN), and denied cases

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)
Enforcement Matter 16-227

Measure 2.1.20 - Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column U (Request disposition) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for PN only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify the member within 14 calendar days of the request, with a possible extension of 14 calendar days (denials only)	• 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 3 business days • 2. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be less than or equal to 14 calendar days • 3. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column AB (Date of written notification) – Column J (Date the request was received) must equal be equal to or less than 28 calendar days. • (In order for a case to be compliant, both #1 & 2 must be met, or just #3)

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for MCLA, Preservice Non-urgent (PN), and denied cases

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

DHCS contract – Exhibit A, Attachment 5, 2F & 3G
DHCS contract – Exhibit A, Attachment 13, 8E
42 CFR 438.210(d)

Measure 2.1.21 - Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column U (Request disposition) • Column Z (Date oral notification provided to member) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for PN only

Requirement	Evaluation:
Not to exceed 14 calendar days within receipt of the request, with a possible extension of 14 calendar days	• 1. Column AB (Date written notification provided to member) – Column J (Date request was received) must be equal to or less than 14 calendar days • 2. If Column U (Request Disposition) = Approved, then calculate: Column Z (Date oral notification provided to member) - Column J (Date the request was received) must be less than or equal to 14 calendar days • 3. If Column U (Request Disposition) = Denied, then calculate: If Column Z (Date oral notification provided to member) is before the date in Column AB (Date of written notification), AND Column Z (Date oral notification provided to member) - Column J (Date the request was received) is less than or equal to 14 calendar days, then Column AB – Column Z must be equal to or less than 3 calendar days • 4. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column AB (Date of written notification) – Column J (Date the request was received) must equal be equal to or less than 28 calendar days. • If any of the above calculations are compliant, then case is counted as timely

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records
Total number of records when filtered for CMC & preservice non urgent (PN)

Performance Benchmarks:			
RED (2 points)	**RED (2 points)**	**YELLOW (1 point)**	**GREEN (0 points)**
NR	0 – 84%	85-94%	95-100%
References			

3-Way Contract 2.11.5.6.1
42 CFR 422.5680
Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance – 10.5.3, 40.12.1

Measure 2.1.22 - Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within Two Business Days of the Decision

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column U (Request Disposition) • Column W (Date of decision) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for PN only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify the member within 2 business days of the decision (denials only)	• 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 2 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for LACC, Preservice Nonurgent (PN), and denied cases

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)
Enforcement Matter 16-227

Measure 2.1.23 - Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within Two Business Days of the Decision

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column U (Request Disposition) • Column W (Date of decision) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for PN only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify the member within 2 business days of the decision (denials only)	• 1. Column AB (Date of written notification provided to member) - Column W (Date of Decision) must be less than or equal to 2 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/Total number of records in report when filtered for LACC, Preservice Nonurgent (PN), and denied cases

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)

Measure 2.1.24 - Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for PN only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Preservice Nonurgent (PN), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)

Measure 2.1.25 - Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision) • Column AD (Date notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for PN only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 14 calendar days of receipt of the request, with a possible extension of 14 calendar days	• 1. Column AD (Date notification provided to provider) - Column J (Date the request was received) must be equal to or less than 14 calendar days • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W (Date of decision) – Column J (Date the request was received) must be less than or equal to 28 calendar days. • (If any of the above calculations are compliant, then case is counted as timely)

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Preservice Nonurgent (PN), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.5.6.1
42 CFR 422.572
Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance – 40.12.1

Measure 2.1.26 - Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for PN only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Preservice Nonurgent (PN), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99%	100%

References

HSC 1367.01(h)(3)

Measure 2.1.27 - Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for PN only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC, Preservice Nonurgent (PN), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95%-100%

References

HSC 1367.01(h)(3)

Measure 2.1.28 - Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column K (Time the request was received) • Column R (Was a timeframe extension taken?) • Column S (If an extension was taken, did the organization notify the member of the reason(s) for the delay and of their right to file an expedited grievance?) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for CU only

Requirement	Evaluation:
Within 72 hours from receipt of request	• 1. Column W (Date of decision) and Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W & X (Date and time of Decision) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days. • (If any of the above calculations are compliant, then case is counted as timely)

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA and Concurrent Urgent (CU)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99%	100%

References

HSC 1367.01 (h)(2)

Measure 2.1.29 - Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column K (Time the request was received) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for CU only

Requirement	Evaluation:
Within 72 hours from receipt of request	• 1. Column W (Date of decision) and Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours • 2. If Column R (Was a timeframe extension taken) is "Y" and Column S (If an extension was taken, did the MMP notify the member of the reasons for the delay and of their rights to file and expedited grievance) is "Y", then calculate: Column W & X (Date and time of Decision) – Column J & K (Date and time the request was received) must be less than or equal to 17 calendar days. • (If any of the above calculations are compliant, then case is counted as timely)

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA and Concurrent Urgent (CU)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99%	100%

References

HSC 1367.01 (h)(2)

Measure 2.1.30 - Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column K (Time the request was received) • Column W (Date of decision) • Column X (Time of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for CU only

Requirement	Evaluation:
Within 72 hours from receipt of request	• 1. Column W (Date of decision) and Column X (Time of decision) – Column J (Date the request was received) and Column K (Time the request was received) must be less than or equal to 72 hours

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC and Concurrent Urgent (CU)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99%	100%

References

HSC 1367.01 (h)(2)

Measure 2.1.31 - Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for CU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Concurrent Urgent (CU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99%	100%

References

HSC 1367.01 (h)(2)
HSC 1367.01 (h)(3)

Measure 2.1.32 - Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for CU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Concurrent Urgent (CU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)

Measure 2.1.33 - Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for CU only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC, Concurrent Urgent (CU), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (h)(3)

Measure 2.1.34 - Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Information

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for CN only

Requirement	Evaluation:
Within 5 business days from receipt of information	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Concurrent Nonurgent (CN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)
DHCS contract – Exhibit A, Attachment 5, 3D

Measure 2.1.35 - Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Information

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for CN only

Requirement	Evaluation:
Within 5 business days from receipt of information	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Concurrent Nonurgent (CN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.7.2

Measure 2.1.36 - Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Information

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for LACC only • Filter column G (review type) for CN only

Requirement	Evaluation:
Within 5 business days from receipt of information	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Concurrent Nonurgent (CN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.37 - Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Information

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column W (Date of decision)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for PASC only • Filter column G (review type) for CN only

Requirement	Evaluation:
Within 5 business days from receipt of information	• 1. Column W (Date of decision) - Column J (Date the request was received) must be equal to or less than 5 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC, Concurrent Nonurgent (CN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.38 - Notify Members of Standard/Routine Concurrent Service Authorization Request Decisions within 5 Business Days from Receipt of Information

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column U (Request disposition) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for CN only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify member within 5 business days of receipt of information (denials only)	• 1. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be equal to or less than 5 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Concurrent Non-urgent (CN), and DENIED

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

DHCS contract – Exhibit A, Attachment 5, 2F & 3D

Measure 2.1.39 - Notify Members of Standard/Routine Concurrent Service Authorization Request Decisions within 5 Business Days from Receipt of Information

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column U (Request disposition) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for CMC only • Filter column G (review type) for CN only • Filter column U (request disposition) for denied only

Requirement	Evaluation:
Notify member within 5 business days of receipt of information (denials only)	• 1. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be equal to or less than 5 business days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Concurrent Non-urgent (CN), and DENIED

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.7.2
3-way contract – 2.11.6.3.5

Measure 2.1.40 - Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter column D (line of business) for MCLA only • Filter column G (review type) for CN only • Filter column H (who made the request?) For CP and NCP

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Concurrent Non-urgent (CN), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3DHCS contract – Exhibit A, Attachment 5, 2J & 3D
HSC 1367.01 (h)(3)

Measure 2.1.41 - Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **CMC** only • Filter Column G (Review Type) for **CN** only • Filter Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Concurrent Nonurgent (CN), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.6.3.9
3-way contract – 2.11.7.2
HSC 1367.01 (h)(3)

Measure 2.1.42 - Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **LACC** only • Filter Column G (Review Type) for **CN** only • Filter Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA and Preservice Urgent (PU)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)

Measure 2.1.43 - Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request?) • Column W (Date of decision) • Column X (Time of decision) • Column AD (Date notification provided to provider) • Column AE (Time notification provided to provider)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **PASC** only • Filter Column G (Review Type) for **CN** only • Filter Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 24 hours of the decision	• 1. Column AD (Date notification provided to provider) & Column AE (Time notification provided to provider) - Column W (Date of decision) & Column X (Time of decision) must be equal to or less than 24 hours..

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA and Preservice Urgent (PU)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(3)

Measure 2.1.44 - Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **MCLA** only • Filter Column G (Review Type) for **PS** only

Requirement	Evaluation:
Notify the member within 30 calendar days of receipt of information	• 1. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be equal to or less than 30 calendar days.

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Postservice (PS)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)
DHCS contract – Exhibit A, Attachment 5, 2F & 3E

Measure 2.1.45 - Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **CMC** only • Filter Column G (Review Type) for **PS** only

Requirement	Evaluation:
Report is deemed "accurate" if 4 out of 5 samples (80%) passes.	• 1. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Postservice (PS)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.6.3.5
3-way contract – 2.11.7.3

Measure 2.1.46 - Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **LACC** only • Filter Column G (Review Type) for **PS** only

Requirement	Evaluation:
Notify the member within 30 calendar days of receipt of information	• 1. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Postservice (PS)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.47 - Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **PASC**only • Filter Column G (Review Type) for **PS** only

Requirement	Evaluation:
Notify the member within 30 calendar days of receipt of information	• 1. Column AB (Date of written notification provided to member) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC, Postservice (PS)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.48 - Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column J (Date the request was received) • Column AB (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **MCLA** only • FILTER Column G (Review Type) for **PS** only • FILTER Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 30 calendar days of receipt of information	• 1. Column AD (Date notification provided to provider) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Postservice (PS), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)
DHCS contract – Exhibit A, Attachment 5, 2J & 3E

Measure 2.1.49 - Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column J (Date the request was received) • Column AD (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **CMC** only • FILTER Column G (Review Type) for **PS** only • FILTER Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 30 calendar days of receipt of information	• 1. Column AD (Date notification provided to provider) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Postservice (PS), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-way contract – 2.11.6.3.9
3-way contract – 2.11.7.3

Measure 2.1.50 - Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column J (Date the request was received) • Column AD (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **LACC** only • FILTER Column G (Review Type) for **PS** only • FILTER Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 30 calendar days of receipt of information	• 1. Column AD (Date notification provided to provider) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Postservice (PS), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.51 - Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column H (Who made the request) • Column J (Date the request was received) • Column AD (Date written notification provided to member)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **PASC** only • FILTER Column G (Review Type) for **PS** only • FILTER Column H (Who made the request?) for **CP** and **NCP**

Requirement	Evaluation:
Notify the requesting provider within 30 calendar days of receipt of information	• 1. Column AD (Date notification provided to provider) - Column J (Date the request was received) must be equal to or less than 30 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for PASC, Postservice (PS), and CP/NCP

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(1)

Measure 2.1.52 - Clinical Decision Making for Service Authorization Request Denials

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Denial File Contains Appropriate Clinical Information. (UM 6A) ** 2. Practitioner Provided Opportunity to Discuss Decision with MD Reviewer. (UM 7A) ** 3. Hierarchical criteria, LCDs, NCDs, and other applicable and complete criteria were utilized appropriately 4. Evidence that Medical Director made medical necessity denial/modification decision. 5. MD provided denial explanation 6. MD provided notation of criteria used and/or the benefit limitation referenced in the Member's EOC 7. Appropriate Criteria used in decision making and cited correctly in the case

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

DHCS Contract
Exhibit A, Attachment 5 - Utilization Management
2. Prior Authorizations and Review Procedures

Measure 2.1.53 - Clinical Decision Making for Service Authorization Request Denials

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Denial File Contains Appropriate Clinical Information. (UM 6A) ** 2. Practitioner Provided Opportunity to Discuss Decision with MD Reviewer. (UM 7A) ** 3. Medi-Cal criteria was applied before denying the Service Auth Request - CMC ONLY 4. Hierarchical criteria, LCDs, NCDs, and other applicable and complete criteria were utilized appropriately 5. Evidence that Medical Director made medical necessity denial/modification decision. 6. MD provided denial explanation 7. MD provided notation of criteria used and/or the benefit limitation referenced in the Member's EOC 8. Appropriate Criteria used in decision making and cited correctly in the case

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

42 CFR § 438.210/CA 3-Way Contract 2.11.5.3
CA 3-Way Contract 2.11.6.3.3
3-Way Contract 2.11.6.3.4

Measure 2.1.54 - Clinical Decision Making for Service Authorization Request Denials

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Denial File Contains Appropriate Clinical Information. (UM 6A) ** 2. Practitioner Provided Opportunity to Discuss Decision with MD Reviewer. (UM 7A) ** 3. Hierarchical criteria, LCDs, NCDs, and other applicable and complete criteria were utilized appropriately 4. Evidence that Medical Director made medical necessity denial/modification decision. 5. MD provided denial explanation 6. MD provided notation of criteria used and/or the benefit limitation referenced in the Member's EOC 7. Appropriate Criteria used in decision making and cited correctly in the case

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (c)(e)(f)

Measure 2.1.55 - Clinical Decision Making for Service Authorization Request Denials

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Denial File Contains Appropriate Clinical Information. (UM 6A) ** 2. Practitioner Provided Opportunity to Discuss Decision with MD Reviewer. (UM 7A) ** 3. Hierarchical criteria, LCDs, NCDs, and other applicable and complete criteria were utilized appropriately 4. Evidence that Medical Director made medical necessity denial/modification decision. 5. MD provided denial explanation 6. MD provided notation of criteria used and/or the benefit limitation referenced in the Member's EOC 7. Appropriate Criteria used in decision making and cited correctly in the case

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 94%	95-99.9%	100%

References

HSC 1367.01 (c)(e)(f)

Measure 2.1.56 - Letter Content for Service Authorization Request Denials

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written Notification of Denial Contains Specific Reasons for Denial (UM 7B) ** 2. Written Notification Contains Reference to the Criterion on Which Denial is Based (UM 7B) ** 3. Written Notification of Denial Contains Notification that Member can obtain a Copy of the Criterion 4. The Appropriate "State Citation" is noted within the letter (MCLA) 5. Inclusion of adequate rationales 6. Complete and accurate information specific to denial 7. Written in a manner that an enrollee can easily understand 8. Use of most current LAC and CMS approved IDN letter template 9. Letter was also sent to the member in their threshold language

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

DHCS 17-006
42 CFR § 438.404
HSC 1367.01

Measure 2.1.57 - Letter Content for Service Authorization Request Denials

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written Notification of Denial Contains Specific Reasons for Denial (UM 7B) ** 2. Written Notification Contains Reference to the Criterion on Which Denial is Based (UM 7B) ** 3. Written Notification of Denial Contains Notification that Member can obtain a Copy of the Criterion 4. Inclusion of adequate rationales 5. Complete and accurate information specific to denial 6. Written in a manner that an enrollee can easily understand 7. Use of most current LAC and CMS approved IDN letter template 8. Letter was also sent to the member in their threshold language

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

42 CFR § 438.210/
3-Way Contract 2.11.5.3
3-Way Contract 2.11.6.3.4

Measure 2.1.58 - Letter Content for Service Authorization Request Denials

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written Notification of Denial Contains Specific Reasons for Denial (UM 7B) ** 2. Written Notification Contains Reference to the Criterion on Which Denial is Based (UM 7B) ** 3. Written Notification of Denial Contains Notification that Member can obtain a Copy of the Criterion 4. Inclusion of adequate rationales 5. Complete and accurate information specific to denial 6. Written in a manner that an enrollee can easily understand 7. Use of most current LAC and CMS approved IDN letter template 8. Letter was also sent to the member in their threshold language

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01

Measure 2.1.59 - Letter Content for Service Authorization Request Denials

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written Notification of Denial Contains Specific Reasons for Denial (UM 7B) ** 2. Written Notification Contains Reference to the Criterion on Which Denial is Based (UM 7B) ** 3. Written Notification of Denial Contains Notification that Member can obtain a Copy of the Criterion 4. Inclusion of adequate rationales 5. Complete and accurate information specific to denial 6. Written in a manner that an enrollee can easily understand 7. Use of most current LAC and CMS approved IDN letter template 8. Letter was also sent to the member in their threshold language

3. Monitoring Report

Overall Compliance Score Calculation:

number of "pass" cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01

Measure 2.1.60 - Denial Rate for Service Authorizations

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column U (Request Disposition)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	

Requirement	Evaluation:
Copy and paste as is	1. N/A. This is a statistical measure based on reported data

3. Monitoring Report

Overall Compliance Score Calculation:

number of denials / total number of records in report

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

Measure 2.1.61 - Denial Rate for Service Authorizations

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column U (Request Disposition)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	

Requirement	Evaluation:
N/A	1. N/A. This is a statistical measure based on reported data

3. Monitoring Report

Overall Compliance Score Calculation:

number of denials / total number of records in report

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

Measure 2.1.62 - Denial Rate for Service Authorizations

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column U (Request Disposition)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	

Requirement	Evaluation:
N/A	1. N/A. This is a statistical measure based on reported data

3. Monitoring Report

Overall Compliance Score Calculation:

number of denials / total number of records in report

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

Measure 2.1.63 - Denial Rate for Service Authorizations

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column U (Request Disposition)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	

Requirement	Evaluation:
N/A	1. N/A. This is a statistical measure based on reported data

3. Monitoring Report

Overall Compliance Score Calculation:

number of denials / total number of records in report

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

Measure 2.1.64 - Appeal Rights for Service Authorization Requests Denials

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column U (Request Disposition)

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written notification of denial contains description of Appeal Rights 2. Written notification of denial contains description of expedited appeal process 3. Written notification of denial contains description of expedited appeal 4. Availability of concurrent external review for urgent/ongoing treatment

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

DHCS 17-006
42 CFR § 438.404
22 CCR § 51014.1

Measure 2.1.65 - Appeal Rights for Service Authorization Requests Denials

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written notification of denial contains description of Appeal Rights 2. Written notification of denial contains description of expedited appeal process 3. Written notification of denial contains description of expedited appeal 4. Availability of concurrent external review for urgent/ongoing treatment

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

42 CFR § 438.404
CMS Medicare Managed Care Manual

Measure 2.1.66 - Appeal Rights for Service Authorization Requests Denials

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written notification of denial contains description of Appeal Rights 2. Written notification of denial contains description of expedited appeal process 3. Written notification of denial contains description of expedited appeal 4. Availability of concurrent external review for urgent/ongoing treatment

3. Monitoring Report

Overall Compliance Score Calculation:

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

42 CFR § 438.404

Measure 2.1.67 - Appeal Rights for Service Authorization Requests Denials

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Written notification of denial contains description of Appeal Rights 2. Written notification of denial contains description of expedited appeal process 3. Written notification of denial contains description of expedited appeal 4. Availability of concurrent external review for urgent/ongoing treatment

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

42 CFR § 438.404

Measure 2.1.68 - Notify Members of the Deferral of Standard/ Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column T (Date of Notification of Extension

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **MCLA** only • Filter Column G (Review Type) for **PN** only • Filter Column R (Was a timeframe extension taken?) for **Y** only

Requirement	Evaluation:
Provide notice within 14 calendar days from receipt of request	1. Column T (Date of Notification of Extension) – Column J (Date the request was received) must be less than or equal to 14 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for MCLA, Preservice Nonurgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

DHCS Contract Exhibit A, Attachment 13, 8E

Measure 2.1.69 - Notify Members of the Deferral of Standard/ Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column T (Date of Notification of Extension

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **CMC** only • Filter Column G (Review Type) for **PN** only • Filter Column R (Was a timeframe extension taken?) for **Y** only

Requirement	Evaluation:
Provide notice within 14 calendar days from receipt of request	1. Column T (Date of Notification of Extension) – Column J (Date the request was received) must be less than or equal to 14 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for CMC, Preservice Nonurgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

CMS 3-Way Contract 2.11.6.3.5.
CMS 3-Way Contract 2.11.7.5.

Measure 2.1.70 - Notify Members of the Deferral of Standard/ Routine Preservice Service Authorization Request Decisions within 5 Business Days from Receipt of Information

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column T (Date of Notification of Extension

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **LACC** only • Filter Column G (Review Type) for **PN** only • Filter Column R (Was a timeframe extension taken?) for **Y** only

Requirement	Evaluation:
Provide notice within 5 business days from receipt of information	1. Column T (Date of Notification of Extension) – Column J (Date the request was received) must be less than or equal to 5 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Preservice Nonurgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(5)

Measure 2.1.71 - Notify Members of the Deferral of Standard/ Routine Preservice Service Authorization Request Decisions within 5 Business Days from Receipt of Information

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• Column D (Line of business) • Column G (Review type) • Column J (Date the request was received) • Column R (Was a timeframe extension taken?) • Column T (Date of Notification of Extension

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	• Filter Column D (Line of Business) for **PASC** only • Filter Column G (Review Type) for **PN** only • Filter Column R (Was a timeframe extension taken?) for **Y** only

Requirement	Evaluation:
Provide notice within 5 business days from receipt of information	1. Column T (Date of Notification of Extension) – Column J (Date the request was received) must be less than or equal to 5 calendar days

3. Monitoring Report

Overall Compliance Score Calculation:

# of compliant records/
Total number of records in report when filtered for LACC, Preservice Nonurgent (PN)

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC 1367.01 (h)(5)

Measure 2.1.72 - Letter Content for Deferral Notices

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. The deferral notice shall include: (1) the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required, and (2) the anticipated date on which a decision may be rendered. 2. Must use the NOA "delay" template

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

California Health and Safety Code § 1367.01(h)(5)
DHCS APL 17-006 (II)(A)(4)

Measure 2.1.73 - Letter Content for Deferral Notices

Line of Business:	Functional Area:
CMC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. notify the enrollee in writing of the reasons for the delay and 2. Inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension.

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

42 CFR 422.568 (b)(1)(ii) - Standard determinations
42 CFR 422.572 (b)(2) - Expedited determinations

Measure 2.1.74 - Letter Content for Deferral Notices

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. The deferral notice shall include: (1) the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required, and (2) the anticipated date on which a decision may be rendered.

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC § 1367.01(h)(5)

Measure 2.1.75 - Letter Content for Deferral Notices

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. The deferral notice shall include: (1) the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required, and (2) the anticipated date on which a decision may be rendered.

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC § 1367.01(h)(5)

Measure 2.1.76 - Letter Content for Deferral Notices

Line of Business:	Functional Area:
MCLA	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. If an extension was taken for a routine auth, did (a) the Member or the Member's Provider request the extension, or (b) is there justification of (1) the need for additional information and (2) how it is in the member's interest. 2. If an extension was taken for an expedited auth, (a) did the Member request the extension, or (b) is there justification of (1) the need for additional information and (2) how it is in the member's interest. 3. Acceptable reasons for a deferral include: (a) the plan is not in receipt of all of the information reasonably necessary and requested, or (b) because the plan requires consultation by an expert reviewer, or (c) because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

DHCS Contract, Exhibit A, Attachment 3 Utilization Management, 3 Timeframes for Medical Authorization, G & H
DHCS APL 17-006
HSC § 1367.01(h)(5)

Measure 2.1.77 - Appropriate Delay/Extension Taken

Line of Business:	Functional Area:
	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. The reason for the extension must be: (a) The enrollee* requests the extension, (b) The extension is justified, in the enrollee's interest, and additional medical evidence from a non-contract provider is needed in order to make a decision favorable to the enrollee (i.e., the MA plan should not extend the timeframe to get evidence to deny the coverage request); or (c) The extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the enrollee's interest * or the Enrollee's Provider, in the case of standard determinations

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

3-Way Contract 2.11.7.5
42 CFR 422.568 (b) (1)(i)
3-Way Contract 2.11.7.6
42 CFR 422.572 (b)(1)

Measure 2.1.78 - Appropriate Delay/Extension Taken

Line of Business:	Functional Area:
LACC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Acceptable reasons for a deferral: (a) the plan is not in receipt of all of the information reasonably necessary and requested, or (b) because the plan requires consultation by an expert reviewer, or (c) because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice.

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC § 1367.01(h)(5)

Measure 2.1.79 - Appropriate Delay/Extension Taken

Line of Business:	Functional Area:
PASC	Utilization Management

1. Data Source

Report:	Applicable Data Fields:
2A. SAR Log	• N/A

2. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	• 8/30 Methodology

Requirement	Evaluation:
Pass evaluation criteria	1. Acceptable reasons for a deferral: (a) the plan is not in receipt of all of the information reasonably necessary and requested, or (b) because the plan requires consultation by an expert reviewer, or (c) because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice.

3. Monitoring Report

Overall Compliance Score Calculation:

# of pass cases / total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	0 – 84%	85-94%	95-100%

References

HSC § 1367.01(h)(5)

3.2 Care Management – Individualized Care Plans

Measure 3.2.01 – Core 3.2 - Care Plan completed within 30 days of enrollment (1-month progress)

Line of Business:	**Functional Area:**
Cal MediConnect	Care Management

10. Data Source

Report:	**Applicable Data Fields:**
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment

11. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	All

Evaluation:

Pass evaluation criteria

Total number of ICPs completed within applicable cohort (Element D)/Total number of members within applicable cohort (Element A)

12. Monitoring Report

Overall Compliance Score Calculation:

Total number of ICPs completed within applicable cohort (Element D)/Total number of members within applicable cohort (Element A)

Performance Benchmarks:

RED (2 points)	**YELLOW (1 point)**	**GREEN (0 points)**
NR	≤0% - 51.2%<	≥ 51.2%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.02 – Core 3.2 - Care Plan completed within 60 days of enrollment (2 months progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

13. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment

14. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Pass evaluation criteria

Total number of ICPs completed within applicable cohort (Element D)/Total number of members within applicable cohort (Element A)

15. Monitoring Report

Overall Compliance Score Calculation:

Total number of ICPs completed within applicable cohort (Element D)/Total number of members within applicable cohort (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NA	≤0% - 51.2%<	≥ 51.2%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.03 – Core 3.2 - Care Plan completed within 90 days of enrollment (3 months progress)

Line of Business:	**Functional Area:**
Cal MediConnect	Care Management

16. Data Source

Report:	**Applicable Data Fields:**
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment

17. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	All

Evaluation:

Pass evaluation criteria

Total number of ICPs completed within applicable cohort (Element D)/Total number of members within applicable cohort (Element A)

18. Monitoring Report

Overall Compliance Score Calculation:

Total number of ICPs completed within applicable cohort (Element D)/Total number of members within applicable cohort (Element A)

Performance Benchmarks:

RED (2 points)	**YELLOW (1 point)**	**GREEN (0 points)**
<17.8%	≤17.8% - 51.2%<	≥ 51.2%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.04 – Core 3.2 - Unable to reach (UTC) members to complete Care Plan within 30 days of enrollment of enrollment (1 month progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

19. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after **Column U** UTC for ICP completion date 3 within 3 months of enrollment

20. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Pass evaluation criteria

Total number of UTC members within applicable cohort (Element C)/Total number of members within applicable cohort (Element A)

21. Monitoring Report

Overall Compliance Score Calculation:

Total number of UTC members within applicable cohort (Element C)/Total number of members within applicable cohort (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
N/A	>15.9%	≥15.9%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.05 – Core 3.2 - Unable to reach (UTC) members to complete Care Plan within 60 days of enrollment of enrollment (2 months progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

22. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after **Column U** UTC for ICP completion date 3 within 3 months of enrollment

23. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Pass evaluation criteria

Total number of UTC members within applicable cohort (Element C)/Total number of members within applicable cohort (Element A)

24. Monitoring Report

Overall Compliance Score Calculation:

Total number of UTC members within applicable cohort (Element C)/Total number of members within applicable cohort (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
N/A	>15.9%	≥15.9%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.06 – Core 3.2 - Unable to reach (UTC) members to complete Care Plan within 90 days of enrollment of enrollment (3 months progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

25. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after **Column U** UTC for ICP completion date 3 within 3 months of enrollment

26. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Pass evaluation criteria

Total number of UTC members within applicable cohort (Element C)/Total number of members within applicable cohort (Element A)

27. Monitoring Report

Overall Compliance Score Calculation:

Total number of UTC members within applicable cohort (Element C)/Total number of members within applicable cohort (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
>41.2%	>15.9% - 41.2%<	≥15.9%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.07 – Core 3.2 - Unwilling to complete Care Plan (Refusal) within 30 days of enrollment (1 month progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

28. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after

29. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Total number of members who were documented as unwilling to complete a care plan within applicable cohort (Element B)/Total number of members within applicable cohort (Element A)

30. Monitoring Report

Overall Compliance Score Calculation:

Total number of members who were documented as unwilling to complete a care plan within 30 days of enrollment. (Refusal) (Element B) / Total number of members whose 30th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. (Total number of members) (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NA	>9.0%	≤9.0%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.08 – Core 3.2 - Unwilling to complete Care Plan (Refusal) within 60 days of enrollment (2 months progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

31. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after

32. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Total number of members who were documented as unwilling to complete a care plan within applicable cohort (Element B)/Total number of members within applicable cohort (Element A)

33. Monitoring Report

Overall Compliance Score Calculation:

Total number of members who were documented as unwilling to complete a care plan within 60 days of enrollment. (Refusal) (Element B) / Total number of members whose 60th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. (Total number of members) (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NA	>9.0%	≤9.0%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.09 – Core 3.2 - Unwilling to complete Care Plan (Refusal) within 90 days of enrollment (3 months progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

34. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after

35. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

Total number of members who were documented as unwilling to complete a care plan within applicable cohort (Element B)/Total number of members within applicable cohort (Element A)

36. Monitoring Report

Overall Compliance Score Calculation:

Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment. (Refusal) (Element B) / Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period. (Total number of members) (Element A)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
>29.6%	≤9.0-29.6%<	<9.0%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.10 –Core 3.2 - Compliance rate of Care Plan completion within 30 days of enrollment (1 month progress)

Line of Business:	**Functional Area:**
Cal MediConnect	Care Management

37. Data Source

Report:	**Applicable Data Fields:**
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after **Column U** UTC for ICP completion date 3 within 3 months of enrollment

38. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	All

Evaluation:

(Total number of ICPs completed within applicable cohort (Element D) / Total number of members within applicable cohort (Element A) – Total number of members who were documented as unwilling to complete a care plan within 30 days of enrollment (Element B) – Total number of UTC members within applicable cohort (Element C)

39. Monitoring Report

Overall Compliance Score Calculation:

(Element D / (Element A – Element B – Element C)

Performance Benchmarks:

RED (2 points)	**YELLOW (1 point)**	**GREEN (0 points)**
NA	≤0% - 72.2%<	≥ 72.2%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.11 –Core 3.2 - Compliance rate of Care Plan completion within 30 days of enrollment (1 month progress)

Line of Business:	**Functional Area:**
Cal MediConnect	Care Management

40. Data Source

Report:	**Applicable Data Fields:**
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after **Column U** UTC for ICP completion date 3 within 3 months of enrollment

41. Performance Evaluation

Method:	**Frequency:**	**Cases Evaluated:**
Quantitative	Monthly	All

Evaluation:

(Total number of ICPs completed within applicable cohort (Element D) / Total number of members within applicable cohort (Element A) – Total number of members who were documented as unwilling to complete a care plan within 30 days of enrollment (Element B) – Total number of UTC members within applicable cohort (Element C)

42. Monitoring Report

Overall Compliance Score Calculation:

(Element D / (Element A – Element B – Element C)

Performance Benchmarks:

RED (2 points)	**YELLOW (1 point)**	**GREEN (0 points)**
NA	≤0% - 72.2%<	≥ 72.2%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

Measure 3.2.12 –Core 3.2 - Compliance rate of Care Plan completion within 90 days of enrollment (3 months progress)

Line of Business:	Functional Area:
Cal MediConnect	Care Management

43. Data Source

Report:	Applicable Data Fields:
3B. Core 3.2 - Monthly Report	**Column F** Effective Date of Enrollment **Column G** Disenrollment Date **Column L** ICP completion date with member involvement within 3 months of enrollment **Column N** ICP refusal date within 3 months of enrollment **Column Q** Follow up date Beneficiary was non responsive after **Column U** UTC for ICP completion date 3 within 3 months of enrollment

44. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Monthly	All

Evaluation:

(Total number of ICPs completed within applicable cohort (Element D) / Total number of members within applicable cohort (Element A) – Total number of members who were documented as unwilling to complete a care plan within 30 days of enrollment (Element B) – Total number of UTC members within applicable cohort (Element C)

45. Monitoring Report

Overall Compliance Score Calculation:

(Element D / (Element A – Element B – Element C)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
<35.6%	≤35.6% - 72.2%<	≥ 72.2%

References

CMS - CY2021 Medicare Medicaid Capitated Financial Alignment Model Core Reporting Requirements (Published Nov- 2020)

3.3 Care Management – Initial Health Assessment
Measure 3.3.01 – IHA Timeliness (21 and Over)

Line of Business:	Functional Area:
MCLA	Care Management

46. Data Source

Report:	Applicable Data Fields:
33C. IHA Due Date Report	NA

47. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG.

Requirement/Evaluation:

Case file review to ensure the following:

- The IHA was performed within 120 calendar days of enrollment.
- If the member has not scheduled the initial PCP/IHA appointment, documentation includes evidence of 3 outreach attempts to schedule an appointment within the required timeframe
- If the member missed the initial PCP/IHA appointment, documentation includes evidence of 2 outreach attempts to reschedule the appointment (1 verbal attempt, 1 written attempt) within the required timeframe.

One or more of the above criteria needs to be met for the case to be compliant

48. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples

Performance Benchmarks:

RED (2 points)	RED (2 points)	YELLOW (1 point)	GREEN (0 points)
NR	≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract – Exhibit A, Attachment 10, 6A.1
2019 DHCS Audit Finding 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5

Measure 3.3.02 – IHA Timeliness (Under 21)

Line of Business:	Functional Area:
MCLA	Care Management

49. Data Source

Report:	Applicable Data Fields:
3C. IHA Due Date Report	NA

50. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

Case file review to ensure the following:

- For members under the age of 18 months, the IHA was performed within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages 2 or younger, whichever is less. For members 18 months of age or older upon enrollment, IHA was performed within 120 calendar days of enrollment.
- For members 18 months of age or older upon enrollment, IHA was performed within 120 calendar days of enrollment.
- If the member has not scheduled the initial PCP/IHA appointment, documentation includes evidence of 3 outreach attempts to schedule an appointment within the required timeframe
- If the member missed the initial PCP/IHA appointment, documentation includes evidence of 2 outreach attempts to reschedule the appointment (1 verbal attempt, 1 written attempt) within the required timeframe.

One or more of the above criteria needs to be met for the case to be compliant.

51. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples (excluding NA when applicable)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract – Exhibit A, Attachment 10, 3, 3D, 5A
PL 08-003
2019 DHCS Audit Finding 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5

Measure 3.3.03 – IHA Components (All Members)

Line of Business:	Functional Area:
MCLA	Care Management

52. Data Source

Report:	Applicable Data Fields:
3C. IHA Due Date Report	NA

53. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

Case file review to ensure the following:

- The medical record includes a history of the member's physical and mental health, an identification or risks, an assessment of need for preventive screens or services, and health education, and the diagnosis and plan for treatment for any diseases.
- The medical record includes documentation of need for ACIP-recommended immunizations.
- The medical records includes an SHA/IHEBA using an age-appropriate DHCS-approved assessment tool.
- The medical record includes a dental screening or oral health assessment.

54. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples (excluding NA when applicable)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract – Exhibit A, Attachment 10, 3, 5; Attachment 11, 15
APL 18-004
PL 13-0012019
DHCS Audit Finding 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5

Measure 3.3.04 – IHA Components (21 and Over)

Line of Business:	Functional Area:
MCLA	Care Management

55. Data Source

Report:	Applicable Data Fields:
3C. IHA Due Date Report	NA

56. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

Case file review to ensure the following:

- For members considered high-risk, the medical record includes TB screening, including a Mantoux skin test.
- For women over 40 years of age, the medical record includes a documented clinical breast examination.
- For women ages 50 and over, the medical record includes a documented mammogram.
- For sexually active females ages 21 and over who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines, the medical record includes a documented chlamydia screening.
- The medical record includes documented blood pressure, height, and weight.
- For all males ages 35 and over and all females ages 45 and over, the medical record includes a documented total serum cholesterol measurement.
- For all sexually active females, the medical record includes a documented pap smear or arrangements for a pap smear to be performed.

57. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples (excluding NA when applicable)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract – Exhibit A, Attachment 10, 6A.2
DHCS Audit Finding 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5

Measure 3.3.05 – IHA Components (Under 21)

Line of Business:	Functional Area:
MCLA	Care Management

58. Data Source

Report:	Applicable Data Fields:
3C. IHA Due Date Report	NA

59. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

Case file review to ensure the following:

- For members under 21 years of age, the medical record includes a documented California Child Health and Disability Prevention (CHDP) age-appropriate assessment.
- The initial assessment includes, or arranges for provision of, all immunizations to ensure that the child is up-to-date on age-appropriate immunizations.
- For sexually active females under 21 years of age, the medical record includes a documented chlamydia screening.
- If the IHA has not been completed, the medical record includes documented attempts to contact the member and schedule an IHA *(IHA Outreach measures)*.

60. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples (excluding NA when applicable)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract – Exhibit A, Attachment 10, 3, 3D, 5
PL 08-003
APL 18-004
DHCS Audit Finding 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5

Measure 3.3.06 – IHA Components (WIC Program)

Line of Business:	Functional Area:
MCLA	Care Management

61. Data Source

Report:	Applicable Data Fields:
3C. IHA Due Date Report	NA

62. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

Case file review to ensure the following:

- Documented referral to the Women, Infants, and Children (WIC) program for pregnant, breastfeeding, or postpartum women or parent/guardian under the age of five (5).

63. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples (excluding NA when applicable)

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract – Exhibit A, Attachment 11, 17A
DHCS Audit Finding 2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5

3.4 Care Management – California Children's Services (CCS)
Measure 3.4.01 – CCS Eligibility

Line of Business:	Functional Area:
MCLA	Care Management

64. Data Source

Report:	Applicable Data Fields:
33D. Managed Care Plan (MCP) File	NA

65. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

Plan shall develop and implement policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program:

- The documentation includes evidence that the PCP is aware of the member's CCS eligibility status and/or a referral has been made to CCS to determine eligibility.
- The documentation includes evidence of appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition.

66. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract - Exhibit A, Attachment 11, 9
2019 DHCS Audit Finding 2.1.1

Measure 3.4.02 – CCS Care Coordination

Line of Business:	Functional Area:
MCLA	Care Management

67. Data Source

Report:	Applicable Data Fields:
33D. Managed Care Plan (MCP) File	NA

68. Performance Evaluation

Method:	Frequency:	Cases Evaluated:
Quantitative	Quarterly	Sample size determined by % of total cases per PPG

Evaluation:

The policies and procedures...shall ensure that...once eligibility for the CCS program is established for a member, Plan shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its PCPs, the CCS specialty providers, and the local CCS program:

- For members pending CCS eligibility, the documentation includes evidence that all medically necessary covered services and referral(s) to specialty provider(s) were provided as needed.
- For CCS-eligible members, the documentation includes evidence that all medically-necessary covered services not authorized by CCS continue to be provided.
- For CCS-eligible members, the documentation includes evidence of care coordination and joint case management between the PCP, CCS specialty providers, and CCS.
- For members who are 19 years old and will continue to require services until age 21, the documentation includes evidence of transition planning from CCS to other programs.

69. Monitoring Report

Overall Compliance Score Calculation:

# of compliant cases/total number of samples

Performance Benchmarks:

RED (2 points)	YELLOW (1 point)	GREEN (0 points)
≤ 95%	<95% - 99.9%<	≥ 99.9%

References

DHCS Contract - Exhitbit A, Attachment 11, 9
LA Care Policy MMUM-040 Section 2.1.2
2019 DHCS Audit Finding 2.1.1

APPENDIX A: PPG Fraud, Waste and Abuse and Program Integrity Responsibilities

MEMBER AND PROVIDER FRAUD, WASTE, & ABUSE OF SERVICES

A. Delegation. Fraud, Waste, and Abuse (FWA) requirements are established by CMS, and state Medicaid requirements and guidelines and LAC business needs. LAC retains the right, at its discretion, to change or modify its delegation policies, procedures, and assessment program documents.

B. Delegated Responsibilities. PPG is specifically delegated for the following FWA functions for Covered Services:

1. Compliance Program Description detailing compliance with the Deficit Reduction Act §6032, Federal False Claims Act 31 U.S.C §§ 3729-3733, Knox-Keene Act §1348 and Anti-Kickback 42 U.S.C §§ 1320a-7b(b) and Whistleblower protection laws CA Labor Code §1102.5;
2. Appropriate staffing of an investigation unit to detect, investigate and resolve FWA;
3. Systems to audit and monitor service patterns to identify outlier activities including overutilization, unnecessary approval of services, and verification of services billed;
4. Identification of suspected Member and/or Provider FWA based upon delegated Claims Administration Services, Call Center Services, and/or Utilization Management Services;
5. Investigation and final determination of Member or Provider fraud, waste, or abuse investigations;
6. Toll-free 24-hour compliance hotline that allows for anonymous reporting of FWA, Member harm, misconduct, and/or compliance concerns;
7. Compliance and FWA training for all staff within thirty (30) calendar days of hire, and annually thereafter;
8. Reporting to LAC of FWA investigations using mutually agreeable reporting templates and within timelines mandated by state or federal agencies;
9. Compliance with response requirements during investigation activities, as identified by LAC

C. Fraud Waste and Abuse Program. PPG shall be responsible for maintaining FWA processes that are in full compliance with LAC requirements. LAC requirements include, but are not limited to:

1. Policies describing an effective program that detects, prevents and corrects FWA and Compliance Training guidelines that include timeframes for training, and remediation options for non-compliance with training requirements 42 C.F.R. §§422.503(b)(4)(vi);
2. Policies describing monitoring of the compliance hotline including documentation of call intake, follow-up on new calls within one (1) business day, and reporting outcomes to LAC according to reporting requirements identified below in Section E (Fraud, Waste, and Abuse Reporting Requirements);
3. Policies describing compliance with the Deficit Reduction Act §6032 including how Provider will detect and prevent FWA, and educate all staff to identify and report potential FWA;
4. Policies describing compliance with the False Claims Act 31 U.S.C §§ 3729-3733 including provisions for identifying intentional fraud such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted;

5. Policies describing compliance with Anti-Kickback statutes 42 U.S.C §§ 1320a-7b(b) including identification of Provider or Practitioner Providers encouraging use of Provider for Covered Services through monetary or other incentives;
6. Policies describing compliance with qui tam or Whistleblower protections CA Labor Code §1102.5, including how a whistleblower's identity is kept confidential, and no retaliatory actions are taken against the individual;
7. Policies describing compliance with Stark Law 42 U.S.C. §1395nn including identification of Provider or Practitioner Providers referring Members or services to entities they are part or full owner of;
8. Policies describing compliance with Knox-Keene Act §1348 including identification of designee with fraud investigation management experience responsible for FWA investigations;
9. Policies describing processes that prohibit Provider from encouraging Member solicitation for medically unnecessary services based on benefit availability;
10. Policies describing process to identify and investigate any suspected Member or provider FWA within ten (10) calendar days of identification;
11. Policies describing process to report all investigation activities of Member or Provider FWA activities to LAC in compliance with timeframes identified below in Section D (State Medicaid Requirements) and Section E (Fraud, Waste, and Abuse Reporting Requirements);
12. Policies describing process to immediately notify LAC of any potential Member harm through analysis of claims or utilization data, or alerts to the compliance hotline;
13. Policies describing process to comply with LAC FWA activities that Provider is involved in; and
14. Policies describing the process to ensure that Member and Provider information is kept confidential during all FWA activities.
15. Policies describing Coordination of Benefits.
16. Policies describing Cost Avoidance. Plan shall cost avoid and seek post-payment recoveries, as defined by the Medi-Cal Agreement, for the costs of Health Care Services rendered to a Plan Member to the extent a Plan Member is covered for such services under any other state or federal medical care program or under other contractual or legal entitlement, including but not limited to, private group or individual indemnification programs, in accordance with applicable coordination of benefits laws and regulations and the Medi-Cal Agreement. Plan shall comply with all policies and procedures adopted by the Local Initiative to implement the reporting requirements regarding cost avoidance and post payment recovery efforts as provided in the Medi-Cal Agreement.
17. Policies describing Claims Editing. PPG shall implement a Claims Editing System to ensure provider billing compliance with CMS and/or Medi-Cal Billing Guidelines or PPG shall cooperate with LAC and LAC's Affiliates (or vendors) in pursuing any claims overpayments associated with provider incorrect coding or billing.

18. Policies describing Third Party Liability. Pursuant to the Medi-Cal Agreement, DHCS is responsible for follow-up and collection of third party liability payments where it has paid for related care. Accordingly, neither Plan nor Plan Participating Providers may attempt to recover costs of Health Care Services in circumstances involving casualty insurance, tort liability or workers' compensation or uninsured motorist coverage. And, neither Plan nor Plan Participating Providers may make a claim against the estate of any deceased Plan Member. Plan shall notify Local Initiative within ten (10) working days of Plan or a Plan Participating Provider discovering any circumstances involving a Plan Member, which may result in the Plan Member recovering tort liability payments, casualty or other insurance payments or workers' compensation awards. Upon Local Initiative request, Plan shall also timely provide such additional information or records regarding such third party liability claims as may be required to be transmitted by Local Initiative to DHCS. Local Initiative, at its sole option, may also communicate directly with any Plan Participating Provider to facilitate such transmission of additional information and records to DHCS. If Local Initiative receives requested third party liability information directly from Pan Participating Provider, Local Initiative shall inform Plan of such receipt of information.

19. Policies describing Reimbursement/Subrogation. PPG shall cooperate with LAC and LAC's Affiliates (or vendors) in pursuing LAC's reimbursement/ subrogation claims for all lines of business which are reimbursed on a Fee-For-Service basis by providing to LAC information indicating potential liability by a third party for conditions in which Health Services are provided to Members.

D. Fraud, Waste, and Abuse Reporting Requirements.In addition to reporting requirements described in other sections of this Addendum, PPG shall provide LAC with information necessary on FWA activities. Reports are due to LAC SIU within the timeframes specified:

1. Within two (2) business days/forty-eight (48) hours of identification, report any potential Member or provider FWA to identified LAC contacts using the LAC provided FWA Template *(Refer to Intake Referral and Investigation Report Template)*;

2. On the same business day as completion of FWA investigations, report FWA activities and final determinations to identified LAC contacts using the LAC provided FWA Template;

3. Utilizing the LAC provided reporting template is required when reporting on specific investigation activities;

4. Monthly FWA reporting, by the fifteenth (15th) of the month following the close of each month (e.g. March reports are due on or before April 15th), a complete list of all suspected allegations of Member or Participating Provider FWA using LAC provided template to identified LAC contacts *(Refer to PPG FWA Reporting Template);*

5. The list of required reports may be revised by LAC to include additional reports as required by state Medicaid or Medicare requirements. LAC will provide Provider with a minimum of sixty (60) days advanced written notice of additional reports, unless a shorter timeframe is required by state or federal regulators.

E. Performance Standards. Provider will be evaluated on an ongoing and annual basis against current FWA requirements. Ongoing evaluation of monthly reports as identified above in Section D (Fraud, Waste, and Abuse Reporting Requirements) will be completed to determine completeness of PPG information submitted to LAC. CAP will be implemented for any deficiencies identified in monthly reports, including incomplete or missing investigation information, not being submitted on time, or non-compliance with investigation timeframes.

Annual assessments will include a review of policies and procedures and files as applicable. PPG will be evaluated against current FWA requirements as dictated by CMS, state Medicaid and LAC requirements and placed on CAP for any missing policy or documentation requirement.

F. LAC Responsibilities. In addition to other LAC identified responsibilities LAC shall retain the following FWA functions:

1. Reporting to appropriate regulatory and/or state or federal government agencies of Member or Participating Provider FWA investigations;

2. Notification to PPG of LAC identified FWA activities, when applicable.

APPENDIX A-1: Intake Referral and Investigation Report Template

This report should be used to notify LA Care Health Plan of the original identification of potential FWA events as well as reporting on final investigation outcomes. Initial reporting of suspected FWA is required within 48 hours of identifying an incident.

Send to: reportingfraud@lacare.org Attention: Joe Christensen

Partner Name (Company)	
Date of Report	
Individual Reporting Incident	
Contact Information	Phone: E-mail:

INITIAL REPORT

(Include with both Initial Report and Investigation Outcome)

Name (member, provider, or target of investigation)	
NPI/CIN	
Partner's Case Number	
How Reported (Compliance line, Member/ Provider Complaint, Employee Referral, etc.)	
Reporter Contact Info (If available, contact information for person filing allegation)	
Referral Type (Upcoding, Services not Rendered, Drug Diversion, Doctor Shopping, Patient Harm, Identity Theft, etc.)	
Received Date (Date Delegated Entity received allegation)	
Referral Type (Upcoding, Services not Rendered, Drug Diversion, Doctor Shopping, Patient Harm, Identity Theft, etc.)	
Received Date (Date Delegated Entity received allegation)	
Allegation (A narrative that fully describes the allegation including all parties, claims, etc.)	
Status (Open, Closed, or Intent to Investigate)	
Resolution (If status is "Closed", a narrative that describes the entirety of the investigation, who, what, when, where, how and how much. It will describe the logic regarding any CAP and/or overpayment.)	
Resolution. Date (If status is "Closed", Date case is completed.	

INVESTIGATION OUTCOME

Status (Open, Closed, or Intent to Investigate)	
Resolution (If status is "Closed", a narrative that describes the entirety of the investigation, who, what, when, where, how and how much. It will describe the logic regarding any CAP and/or overpayment.)	
Resolution. Date (If status is "Closed", Date case is completed.	

APPENDIX A-2: PPG FWA Monthly Reporting Template

2021 LACARE Fraud Waste and Abuse Report

Report: LA Care FWA Report
Report Frequency: Monthly
Report Due Date: 15th of every month
Report Due To: reportingfraud@lacare.org
Attention: Joe Christensen

	January	February	March	April	May	June	July	August	September	October	November	December
Monthly Allegation Activity												
New Allegations Received												
Allegation/Investigations Completed												
Allegation/Investigations In Process												
Average TAT for Investigation												
Oldest Aging Investigation for the Month												
Allegation Source:												
# of Hotline Allegations												
# of Member/Provider Allegations												
# of Vendor/Provider Employee Allegations												
# of Anonymous Allegations												
# of Other												
Investigation Outcomes												
# of Substantiated Allegations												
# of Unsubstantiated Allegations												
# of CAPs issued												
# of Provider Terminations												
# of Contract Terminations												

Case # (PPG Case #)	How Allegation was Received (Compliance Hot-line, Member/Provider Compliant, Employee Referral, etc.)	Referral Type (Upcoding, Doctor Shopping, Patient Harm, etc.)	Receive Date (Date received by Delegate)	Report Date (Date repored to LAC)	Allegation (Full description of allegtion, including all parties, claims, etc.)	Status (Open, Closed, Investigation in process, Pending receipt of records, CAP, etc.)	New Details (Most recent activity since last reported)	Case Investigation Details (Full description including who, what, when, where, how, etc.)	Resolution (i.e. CAP, recovery, provider education, termination options, etc.)	Resolution Date (Date case is completed)

APPENDIX B: Cost Avoidance and Post Payment Recovery for Other Health Coverage (APL 20-010)

On April 20, 2020, DHCS issued APL20-010, Cost Avoidance and Post-Payment Recovery for Other Health Coverage. This APL requires Medi-Cal managed MCP's to implement cost avoidance and post-payment recovery processes when a member has OHC.

This APL contains several requirements that need to be addressed by your organization to ensure full compliance to the OHC policies defined by DHCS. These requirements pertain to OHC Reporting, Cost Avoidance and Post-Payment Recovery which we are summarizing below.

However, please be sure you read APL20-010 in its entirety, in addition to all attachments so that you have a detailed understand of all the information contained in APL20-010.

OHC Reporting Requirements

- Report to DHCS all instances of OHC from sources other than the Medi-Cal eligibility record. This can be done by submitting an OHC Removal or Addition form or through batch updates. (Consult the DHCS web-site for detailed instructions on these processes.)
- Report to DHCS all instances of new OHC information not found on the Medi-Cal eligibility record or OHC information that is different from what is found on the Medi-Cal eligibility record. (Consult the DHCS web-site for detailed instructions on these processes.)
- Include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC provider, the policy number, and contact or billing information. (DHCS deadline to implement this notification is currently TBD. But we strongly recommend this be implemented as soon as possible.)

Cost Avoidance

- Prior to delivering services to members, review the Medi-Cal eligibility record for the presence of OHC. If the member has active OHC, compare the OHC code to the requested service. If the requested service is covered by the OHC instruct the member to seek the service from the OHC carrier.
- Regardless of the presence of OHC, do not refuse a covered Medi-Cal service to a Medi-Cal member.
- Do not process claims for a member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless there is proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly. (Consult the DHCS web-site for detailed information on the sources of proof that is acceptable.)

Post-Payment Recovery

- You must engage in post-payment recovery if OHC is discovered retroactively or the member had an OHC indicator code of A on their Medi-Cal eligibility record at the time of service.
- If you initiate and complete post-payment recovery within 12 months from the date of payment of a service are entitled to retain all monies recovered.
- DHCS' TPLRD will conduct post-payment recoveries and/or leverage its recovery contractor to initiate post-payment recovery beginning the 13th month following the date of payment of a service.

Post-Payment File Submission to LA Care

Starting on March 1st, 2021, LA Care will require all Partners and PPGS to submit their files of post-payment recovery to LA Care. LA Care will then be responsible for submitting your file to DHCS. The file must conform to all the requirements identified in APL20-010, Appendix B, which include:

- All data fields and descriptions
- File should be in xlsx format
- Use the following naming convention: MCPPR.LACare YYYY_MM_ DD.xslx

LA Care will submit the compiled file to DHCS by the 15th of each month, so we ask that you submit your file to us by the 1st. This will allow time to review each file before submission and to resolve any discrepancies. The submission timeline for this process is included in the following table:

Due Date	Description
03/01/2021	Partners and PPGs submit their post-payment recovery file to LA Care
03/01 to 03/10/2021	LA Care works with Partners and PPGs to address file formatting issues.
03/15/2021	LA Care submits the compiled file to DHCS.

APPENDIX C: Business Associate Security Requirements

In addition to any provisions in the BAA, Provider shall, at a minimum, implement the below security protocols. Provider shall ensure that its subcontractors who use, access, store, maintain, create, transfer, or disclose Member Information, including PHI and PI, on its behalf also implement the below security protocols.

I. Personnel Controls

A. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of Provider, or access or disclose Member Information must complete information privacy and security training, at least annually, at Provider's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy or security policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. Confidentiality Statement. All persons that will be working with Member Information must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to Member Information. The statement must be renewed annually. The Provider shall retain each person's written confidentiality statement for a period of six (6) years.

D. Background Check. Before a member of the workforce may access Member Information, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Provider shall retain each workforce member's background check documentation for a period of three (3) years.

II. Technical Security Controls

A. Workstation/Laptop encryption. All workstations and laptops that process and/or store Member Information must be encrypted using a FIPS 140-2 certified algorithm which is 128 bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the Healthplan's Information Security Officer.

B. Server Security. Servers containing unencrypted Member Information must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. Minimum Necessary. Only the minimum necessary amount of Member Information to perform necessary business functions may be copied, downloaded, or exported.

D. Removable media devices. All electronic files that contain Member Information must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, CD/DVD, smartphones, PDAs, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. Antivirus software. All workstations, laptops and other systems that process and/or store Member Information must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. Patch Management. All workstations, laptops and other systems that process and/or store Member Information must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor's release.

G. User IDs and Password Controls. All users must be issued a unique username for accessing Member Information. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in a readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. Data Destruction. When no longer needed, all Member Information must be permanently deleted and devices wiped using the Gutmann or US Department of Defense (DOD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the Healthplan's Information Security Office.

I. System Timeout. Provider's systems providing access to Member Information must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. Warning Banners. Provider's systems providing access to Member Information must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. System Logging. Provider's systems must maintain an automated audit trail which can identify the user or system process which initiates a request for Member Information, or which alters Member Information. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If Member Information is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three 3 years after occurrence.

L. Access Controls. Provider's systems providing access to Member Information must use role-based access controls for all user authentications, enforcing the principle of least privilege.

M. Transmission encryption. All data transmissions of Member Information outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128 bit or higher, such as AES. Encryption can be end-to-end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of Member Information in motion such as website access, file transfer, and E-Mail.

N. Intrusion Detection. Provider's systems involved in accessing, holding, transporting, and protecting Member Information that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III Audit Controls

A. System Security Review. Provider's systems processing and/or storing Member Information must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. Log Reviews. Provider's systems processing and/or storing Member Information must have a routine procedure in place to review system logs for unauthorized access.

C. Change Control. Provider's systems processing and/or storing Member Information must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity/Disaster Recovery Controls

A. Emergency Mode Operation Plan. Provider must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic Member Information in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. Data Backup Plan. Provider must have established documented procedures to backup Member Information to maintain retrievable exact copies of Member Information. The procedures must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore Member Information should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of Member Information.

V. Paper Document Controls

A. Supervision of Data. Member Information in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. Member Information in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. Escorting Visitors. Visitors to Provider's facilities and areas where Member Information is contained, stored, or managed shall be escorted. In addition, Member Information shall be kept out of sight while visitors, except patients and their representatives, are in any area where Member Information may be used, accessed, or present.

C. Confidential Destruction. Member Information must be disposed of through confidential means in compliance with HIPAA standards, such as cross cut shredding and pulverizing, such that information is rendered unreadable, indecipherable, and otherwise unable to be reconstructed. A certificate of destruction should be obtained if Provider is using a third party vendor or service.

D. Removal of Data. Except as provided in this BAA to comply with an Individual's or government agency's request, or for the rendition of services contemplated under the Agreement, Member Information shall not be removed or transferred from Provider or its premises except with express written permission of Healthplan.

E. Faxing. Faxes containing Member Information shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. Mailing. Mailings of Member Information shall be sealed and secured from damage or inappropriate viewing of Member Information, including PHI or PI, to the extent possible. Mailings which include 500 or more individually identifiable records of Member Information in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of Healthplan to use another method is obtained.

APPENDIX D: Functions and Responsibilities of Extended Delegation (Utilization Management)

In addition to any provisions in the BAA, Provider shall, at a minimum, implement the below security protocols. Provider shall ensure that its subcontractors who use, access, store, maintain, create, transfer, or disclose Member Information, including PHI and PI, on its behalf also implement the below security protocols.

PARTICIPATING PROVIDER GROUP OVERSIGHT REQUIREMENTS

The Extended Utilization Management and Oversight Requirements outlined below apply to Participating Provider Groups ("PPGs", also referred to as "Delegates") who are contracted with L.A. Care Healthplan ("L.A. Care") to perform Extended Delegation functions, and have been delegated such responsibility per the terms and conditions of their respective provider service contracts with L.A. Care ("Agreement"). Extended Delegation and Oversight requirements are set forth below:

PPG shall comply with the oversight requirements related to Extended Delegation on the date specified by L.A. Care. Healthplan may periodically update and issue a Utilization Management ("UM') Technical Bulletin, and PPGs shall comply with the requirements therein by the date specified by L.A. Care.

The PPG's responsibilities for Electronic Load of Delegated Authorizations ("ELDA") and L.A. Care's oversight requirements include, but are not limited to, the following:

1. **Timely Authorization Submissions.** Facility and ancillary authorizations (pre-service, concurrent, urgent, expedited, and all authorizations) the Delegate processes and issues, per the terms of its Agreement, must be submitted to L.A. Care within two (2) business days from the date of the authorization decision for timely authorization review. Failure to submit the authorization on a timely basis may result in a denial of the facility or ancillary provider's claims, or delay the processing of the claim. If the Delegate fails to submit the authorization to L.A. Care, and the facility or ancillary provider renders the service, and its claim is denied due to lack of authorization, then the facility or ancillary provider may submit a request for Provider Dispute Resolution ("PDR') for a first level review to the PPG. If after the first level review, the facility or ancillary provider receives a denial, the facility or ancillary provider can appeal the denial to L.A. Care for a second level PDR review, including for clinical appropriateness. Facility and ancillary providers have the right to request a post-service retroactive review of all claims processing decisions pursuant to applicable L.A. Care policies and procedures, and the Provider Manual.

2. **Clinical Quality Review.** The Delegate is required to submit, on a monthly basis, both facility authorizations issued (via its ELDA report) and professional authorizations issued (via the Service Authorization Requests ("SAR") log). L.A. Care shall review the Delegate's monthly ELDA file submission for facility authorizations against its monthly submission of SAR log on at least a quarterly basis, as a part of its oversight and monitoring program. If necessary, L.A. Care may review such submission more frequently. L.A. Care will conduct a qualitative review to assess appropriateness of decision making by selecting a sample of the information submitted in the files which shall include the following:
    a. File Contains Appropriate Clinical Information. (UM 6A)
    b. Practitioner Provided Opportunity to Discuss Decision with MD Reviewer. (UM 7A) **
    c. Hierarchical criteria, Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and other applicable and complete criteria were utilized appropriately

d. Evidence that the Delegate's Medical Director ("MD") made medical necessity denial/modification decision.

e. MD provided authorization explanation.

f. MD provided notation of criteria used and/or the benefit limitation referenced in the Member's Evidence Of Coverage.

g. Appropriate Criteria used in decision making and cited correctly in the case.

3. Compliance Timeliness. L.A. Care shall review the monthly SAR log for compliance timeliness for all lines of business per the following guidelines:

Line of Business	Timeliness Standard
CMC	Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request
	Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 hours from Receipt of the Re-quest
	Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 Hours of Receipt of the Re-quest
	Standard/Routine Preservice Service Authorization Request Decisions Made within 14 Calendar Days of Receipt of the Request
	Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request
	Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request
	Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Infor-mation
	Notify Members of Standard/Routine Concurrent Service Authorization Request Decisions within 5 Business Days from Receipt of Information
	Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Denial Rate for Service Authorizations
	Notify Members of the Deferral of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business	Timeliness Standard
LACC	Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request
	Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Deci-sion
	Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision
	Standard/Routine Preservice Service Authorization Request Decisions Made within 5 Business Days from Receipt of Information
	Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within Two Business Days of the Deci-sion
	Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision
	Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request
	Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Infor-mation
	Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Denial Rate for Service Authorizations
	Notify Members of the Deferral of Standard/Routine Preservice Service Authorization Request Decisions within 5 Business Days from Receipt of Information

Line of Business	Timeliness Standard
MCLA	Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request
	Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision
	Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 hours from Receipt of the Request
	Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision
	Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 Hours of Receipt of the Request
	Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Infor-mation
	Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within Two Business Days of the Decision
	Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request
	Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision
	Denial Rate for Service Authorizations
	Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request
	Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Infor-mation
	Notify Members of Standard/Routine Concurrent Service Authorization Request Decisions within 5 Business Days from Receipt of Information
	Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Denial Rate for Service Authorizations
	Notify Members of the Deferral of Standard/Routine Preservice Service Authorization Request Decisions within 14 Calendar Days from Receipt of the Request

Line of Business	Timeliness Standard
PASC	Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of Request
	Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision
	Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision
	Standard/Routine Preservice Service Authorization Request Decisions Made within 5 Business Days from Receipt of Information
	Notify Members of Standard/Routine Preservice Service Authorization Request Decisions within Two Business Days of the Decision
	Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision
	Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request
	Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Standard/Routine Concurrent Service Authorization Request Decisions Made within 5 Business Days from Receipt of the Infor-mation
	Notify Providers of Standard/Routine Concurrent Service Authorization Request Decisions within 24 Hours of the Decision
	Notify Members of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Notify Providers of Retrospective Service Authorization Request Decisions within 30 Calendar Days of Receipt of Information
	Denial Rate for Service Authorizations
	Notify Members of the Deferral of Standard/Routine Preservice Service Authorization Request Decisions within 5 Business Days from Receipt of Information

4. **Interest/Penalties on Late Claims Payments and Sanctions.** If a claim is paid late due to the PPG's late submission or non-submission of an authorization, then the PPG must provide a statement regarding the delay or non-submission, as applicable. L.A. Care will review the reasons for the late submission or non-submission. Repeat failures to timely submit authorizations to L.A. Care may result in sanctions pursuant to the terms of the Agreement, and applicable L.A. Care policies and procedures, including financial sanctions. The amount of a financial sanction may include, but is not limited to, estimated administrative costs incurred by L.A. Care, and interest paid on late claims resulting from Delegate's late submissions. Sanctions will be calculated on a monthly basis and, upon written notice to Delegate, will be deducted from Delegate's monthly capitation payments, or any other payment due to Delegate.

   Sanctions will also be imposed, including financial sanctions, in the instances where PPG fails to process authorizations in accordance with regulatory timelines and clinical quality standards in accordance with the Agreement, L.A. Care's policies and procedures, rules, regulations and guidance applicable to Healthplan's Managed Care Program, and Healthplan's contracts with the government program or payor

5. **Health Plan Specific Data for Tracking & Trending.** Industry Collaborative Effort (ICE) Utilization Reports do not report L.A. Care specific data, therefore L.A. Care will require each PPG to submit L.A. Care specific data in the ICE report, and will utilize the SAR log and other measures, as specified in the Monitoring Section of the Delegated Entities Manual, to obtain certain PPG specific information such as approval and denial trends for authorizations, bed days, length of stay, delays in discharge coordination, and concurrent reviews. This information will be utilized to assess PPG's overall performance and cross-walk to MSO overall delegate performance, identify outliers, and proactively detect risk areas.

6. **ELDA Error Report.** All ELDA error reports will be escalated to both the PPG and L.A. Care's Delegation Oversight and Compliance department. If the error is not corrected by the PPG within five (5) business days, as specified in the ELDA Technical Bulletin and the ELDA Amendment to the Agreement, then L.A. Care may impose sanctions on PPG as provided in Section 4 above.

7. **Regulatory Guidelines.** During the qualitative review of the Facility Authorizations and Professional Authorizations, the PPG must demonstrate that all authorizations were processed according to the regulatory guidelines and time frames for urgent, routine, and pre-service standards, as applicable, as measured from the date on which the authorization was requested by the facility or professional provider. Failure to submit requisite information may result in sanctions and imposition of administrative fines as provided in Section 4 above.

NOTES:

NOTES:

L.A. Care
HEALTH PLAN®

For All of L.A.

1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

lacare.org

LA3369 06/21

ELEVATING HEALTHCARE
IN LOS ANGELES COUNTY
SINCE 1997