L.A. Care HEALTH PLAN®

For A Healthy Life

Universal Provider Manual

Serving Los Angeles County

LA4289 0124

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Glossary of Terms

Acronym or Word	Definition	Additional Information
AAN	American Academy of Neurology	--
AAP	American Academy of Pediatrics	--
ABA	Applied Behavioral Analysis	--
ACH	Automated Clearing house	--
ACHA	Annual Cognitive Health Assessment	--
ADL	Activities of Daily Living	--
AFS	Alternative Format Selection	--
AHC	Accountable Health Communities	--
ALS	Advanced Life Support	--
AMSC	Alcohol Misuse Screening and Counseling	--
APL	All Plan Letter	--
ASD	Autism Spectrum Disorder	--
ASH	American Specialty Health	--
ALS	Advanced Life Support	--
ASL	American Sign Language	--
BAA	Business Associate Agreement	--
--	Balance Billing	When a Provider bills for the difference between the Provider's charge and the allowed amount.
BHT	Behavioral Health Treatment	--
BIPOC	Black, Indigenous, and all other People of Color	--
BLS	Basic Life Support	--
C&L	Cultural and Linguistics	--
CAHPS	Consumer Assessment of Healthcare Providers and Systems	--
CAIR	California Immunization Registry	--
CalAIM	California Advancing and Innovating Medi-Cal	--
Cap	Capitation	--
CAP	Corrective Action Plan	--
Carelon	Carelon Behavioral Health	L.A. Care's behavioral health vendor, Carelon Behavioral Health (Carelon) (formerly known as Beacon Health Options). For commercial LOBs, all services other than PCP screenings are provided by Carelon Behavioral Health.

Acronym or Word	Definition	Additional Information
CBAS	Community Based Adult Services	--
CCA	Center for Caregiver Advancement	--
CCM	Complex Case Management	--
CCS	California Children Services	CCS program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified Providers.
CCT	Critical Care Transport	--
CE	Continuing Education	--
CHCAC	Children's Health Consultant Advisory Committee	--
CHDP	Child Health and Disability Prevention	CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California.
CHF	Chronic Heart Failure	--
CHIA	California Healthcare Interpreting Association	--
CHW	Community Health Worker	--
CIN	Client Identification Number	--
--	Clinical Practice and Preventive Health Guidelines	L.A. Care systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from professionally recognized standards of care from both government and non-government organizations for disease and health conditions.
CKD	Chronic Kidney Disease	--
CLIA	Clinical Laboratory Improvement Amendments	--
CLTCEC	California Long-Term Care Education Center	--
CME	Continuing Medical Education	--
CMIA	Confidentiality of Medical Information Act	--
CMR	Compliance, Material Review	Contracted Providers that want to create and use marketing materials at marketing events or other marketing activities, must receive prior approval from the L.A. Care Compliance, Material Review (CMR) Unit before distributing to Members or prospective Members.
CMS	Centers for Medicare and Medicaid Services	--
COC	Continuity of Care	--
COPD	Chronic Obstructive Pulmonary Disease	--
--	Covered Entities	Covered Entities are defined in the HIPAA rules as 1. Health plans, 2. Health care clearinghouses and 3. Health care providers who electronically transmit any health information in connection with transactions for which the U.S. Department of Health & Human Services (HHS) has adopted standards.

Acronym or Word	Definition	Additional Information
CPA	Certified Public Accounting	--
CPO	Care Plan Options	--
CPR	Cardiopulmonary Resuscitation	--
CPSP	Comprehensive Perinatal Services Program	Pregnancy and Postpartum Services for pregnant Members provide comprehensive, multidisciplinary pregnancy and postpartum services with case coordination.
CPT	Current Procedural Terminology	--
CRC	Community Resource Centers	The CRCs offer a broad array of no-cost programming, classes and resources to help health plan Members and others in the community stay active, healthy and informed.
CRS	California Relay Service	--
CTC	Call the Car	--
CUBS	Comprehensive Universal Behavior Screen	--
CURES	Controlled Substance Utilization Review and Evaluation System	--
D&O	Directors and Officers Insurance	Policy coverage for claims made against directors and officers of a company.
DEA	Drug Enforcement Administration	--
DHCS	Department of Health Care Services	--
DME	Durable Medical Equipment	--
DMH	Los Angeles County Department of Mental Health	--
DMHC	Department of Managed Health Care	--
DMP	Drug Management Program	--
DOFR	Division of Financial Responsibility	--
DOT	Directly Observed Therapy	--
DPA	Department of Aging	--
DPH	Los Angeles County Department of Public Health	--
DPH/SAPC	Los Angeles County Department of Public Health/Substance Abuse Prevention and Control	--
DPP	Diabetes Prevention Program	--
DPSS	Los Angeles County Department of Public Social Services	--
DROH	Days Receipt on Hand	--
DUR	Drug Utilization Review	--

Acronym or Word	Definition	Additional Information
E&M	Evaluation & Management	--
E&O	Errors and Omissions Insurance	Errors and Omissions (E&O) Insurance covers managed care activities.
ECAC	Executive Community Advisory Committee	--
ECM	Enhanced Care Management	--
EDI	Electronic Data Interchange	EDI is the electronic interchange of business information using a standardized format.
EFT	Electronic Funds Transfer	EFT is the electronic transfer of money from a bank account to another, either within a single financial institution or across multiple institutions.
EHR	Electronic Health Records	--
E-List	Monthly Eligibility List	Member-level roster of all eligible Members assigned to the Provider, which included all Primary Care Physician (PCP) and Member demographics.
EOB	Explanation of Benefits	--
EOC	Evidence of Coverage	--
ePHI	Electronic Protected Health Information	ePHI is protected health information (PHI) that is produced, saved, transferred or received in an electronic form.
EPLS	Excluded Parties List System	--
EPO	Enterprise Performance Optimization	--
EPSDT	Early and Periodic Screening, Diagnostic and Treatment	--
ER	Emergency Room	--
ERA	Electronic Remittance Advice	--
FDA	United States Food and Drug Administration	--
FDR	First Tier, Downstream, and Related Entities	--
FFS	Fee-for-Service	--
FQHC	Federally Qualified Health Centers	--
FSR	Facility Site Review	--
FTCA	Federal Tort Claims Act	--
FTP	File Transfer Protocol	--
FWA	Fraud, Waste, and Abuse	--
GAAP	Generally Accepted Accounting Principles	--
HCPCS	Healthcare Common Procedure Coding System	--
HDO	Health Delivery Organizations	--

Acronym or Word	Definition	Additional Information
HEAR	Health Education Audio Reference	The HEAR library has pre-recorded messages on various health topics for Members.
HEDIS	Healthcare Effectiveness Data and Information Set	--
HHS	U.S. Department of Health and Human Services	--
HIPAA	Health Insurance Portability and Accountability Act	--
HITECH	Health Information Technology for Economic and Clinical Health	--
HIV	Human Immunodeficiency Virus	--
HMO D-SNP	L.A. Care Medicare Plus	A dual eligible special needs plan which offers complete care that coordinates benefits for Members eligible for both Medicare and Medi-Cal benefits.
HMO	Health Maintenance Organization	--
HOS	Health Outcomes Survey	--
IBNR	Incurred but not Reported	--
ICD	International Classification of Disease	Diagnosis code sets.
ICT	Interdisciplinary Care Team	--
IHA	Initial Health Appointment	--
IHEBA	Individualized Health Education Behavioral Assessment	IHEBA is a comprehensive assessment that is completed during a Member's initial encounter with a selected or assigned PCP, appropriate medical specialist, or non-physician medical Provider.
IHSS	In-Home Supportive Services	--
IMR	Independent Medical Review	--
IPA	Independent Practice Associations	--
IUD	Intra-uterine Device	--
IVR	Interactive Voice Response	--
Joint PICC	Joint Performance Improvement Collaborative Committee	--
--	L.A. Care Network	L.A. Care Network is a list of the doctors, other health care providers, and hospitals that is contracted with to provide medical care to its Members.
LACC	L.A. Care Covered	As a state selected qualified health plan, L.A. Care provides the opportunity for all members of a family to receive health coverage under one (1) health plan in the Covered California state exchange.
LACCD	L.A. Care Covered Direct	L.A. Care Covered Direct (LACCD) is also offered to those who prefer not to purchase coverage through Covered California.
LEP	Limited English Proficiency	--

Acronym or Word	Definition	Additional Information
LMS	Learning Management System	--
LOB	Line of Business	--
LTC	Long Term Care	--
LTSS	Long Term Support Services	--
MA	Medicare Advantage	--
--	Medical Necessity or Medically Necessary	Medical Necessity means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. Activities that may be justified as reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care.
MCLA	L.A. Care Medi-Cal	Medi-Cal is a public program that provides health care coverage to young adults, families, older adults, and people with disabilities who meet the income requirements.
--	Member	A person enrolled into L.A. Care Health Plan.
MH	Mental Health	--
MLTSS	Managed Long Term Services and Supports	--
MNT	Medical Nutrition Therapy	--
MOOP	Maximum Out-of-Pocket	--
MOU	Memorandum of Understanding	--
MRR	Medical Record Review	--
MSO	Management Services Organization	--
MSSP	Multipurpose Senior Services Program	--
MTM	Medication Therapy Management	--
MTM	Medically Tailored Meal	--
MyHIM	My Health in Motion™	MyHIM houses multiple resources including health education materials and videos, access to health coaches via messaging, and self-paced workshops.
NAL	Nurse Advice Line	A service provided by L.A. Care free of charge, intended to give Members general health information, education, advice, and to assist Members in taking a more informed role in decisions regarding their health care options.
NCIHC	National Council on Interpreting in Health Care	--
NCQA	National Committee for Quality Assurance	--
NDN	Non-Discrimination Notice	--
NEMT	Non-Emergency Medical Transportation	--
NF-A	Nursing Facility Level A	--
NF-B	Nursing Facility Level B	--

Acronym or Word	Definition	Additional Information
NMT	Non-Medical Transportation	--
NOA	Notice of Action	--
NPI	National Provider Identifier	--
NSMHS	Non-Specialty Mental Health Services	--
NUBC	National Uniform Billing Committee	--
NUCC	National Uniform Claim Committee	--
O&M	Oversight and Monitoring	--
OB/GYN	Obstetrics and Gynecology	--
OIG	Office of Inspector General	--
ORP	Ordering, Referring and Prescribing	--
P&L	Profit and Loss	--
P4P	Pay-for-Performance	A Provider incentive program.
PA	Prior Authorizations	--
PAD	Physician Administered Drugs	--
PASC-SEIU	Homecare Workers Health Care Plan	PASC-SEIU Homecare Workers Health Plan - L.A. Care provides health coverage to Los Angeles County's In-Home Supportive Services (IHSS) workers, who enable seniors and people with disabilities to remain safely in their homes by providing services such as meal preparation and personal care services.
PBM	Pharmacy Benefit Manager	--
PCE	Provider Continuing Education	--
PCP	Primary Care Physician/Provider	A PCP is a physician, including practitioners of general medicine, family practice, internal medicine, obstetrics and gynecology (OB/GYN), and pediatrics, who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.
PCS	Physician Certificate Statement	--
PDF	Portable Document Format	--
PDR	Provider Dispute Resolution	--
PDU	Provider Data Unit	--
PHI	Protected Health Information	Protected Health Information (PHI) is any information related to a Member's health condition, care, or payment for care that identifies the person or provides a reasonable likelihood that the information may result in identification.
PHM	Population Health Management	--

Acronym or Word	Definition	Additional Information
PICC	Performance Improvement Collaborative Committee	--
PMPM	Per Member, Per Month	A monthly Provider capitation payment.
PNM	Provider Network Management	--
PPG	Participating Physician Group	--
PQC	Physician Quality Committee	--
PQI	Potential Quality of Care Issues	--
PQR	Provider Quality Review	--
--	Provider	A doctor, hospital and other licensed health care professionals or licensed health facility that works with, and is contracted with, L.A. Care Health Plan.
PSI	Pain Safety Initiative	--
PRAPARE	Protocol for Responding to and Assessing Patient's, Risks, and Experiences	--
QHP-EES	Qualified Health Plan Enrollee Engagement Survey	--
QI	Quality Improvement	--
QOC	Quality Oversight Committee	The Quality Oversight Committee (QOC), which reports to the Board of Governors through the Compliance and Quality Committee, is a cross-functional L.A. Care staff committee that is the cornerstone for quality improvement steering and decision making within the organization.
QOS	Quality of Service	--
RCAC	Regional Community Advisory Committee	--
RD	Registered Dietitian	--
RSS	Risk Stratification and Segmentation	--
--	Sensitive Services	Sensitive Services are services that require some form of confidentiality in the way services are provided and the way medical records are disclosed for the Medi-Cal Member.
S&I	Suspended and Ineligible	--
SABIRT	Screening, Assessment, Brief Intervention, and Referral to Treatment	--
SAPC	Substance Abuse Prevention and Control	--
SCT	Specialty Care Transport	--
SDOH	Social Determinants of Health	--
SHA	Staying Healthy Assessments	--
SIU	Special Investigation Unit	--

Acronym or Word	Definition	Additional Information
SMHS	Specialty Mental Health Services	--
SNF	Skilled Nursing Facility	--
SOC	Share of Cost	A Share of Cost (SOC) is the amount of money an individual is responsible to pay towards their medical-related services, supplies, or equipment before Medi-Cal will begin to pay.
SPC	Specialists	--
STD	Sexually Transmitted Disease	--
SUD	Substance Use Disorder	--
TAC	Technical Advisory Committee	--
TB	Tuberculous	--
TJC	The Joint Commission	--
TNE	Tangible Net Equity	--
TPL	Third Party Tort Liability	TPL means the responsibility of persons other than contractor or the Member, for payment of claims for injuries or trauma sustained by Members.
TPO	Treatment, Payment, and Other Standard Operations	--
TTY	Text Telephone Relay	--
--	Transgender Services	Transgender Services, also known as gender-affirming care, includes the prevention, diagnosis and treatment of physical and mental health conditions, as well as sex reassignment therapies, for transgender individuals.
UCR	Usual, Customary, and Reasonable	--
UM	Utilization Management	--
UMC	Utilization Management Committee	--
UPM	Universal Provider Manual	The purpose of this Universal Provider Manual (UPM) is to furnish pertinent Providers with information on the important processes related to L.A. Care's different product lines. The UPM is a communication tool for Providers and their staff related to accessing and providing comprehensive, effective, and quality medical services to L.A. Care Members.
VA	Veteran Affairs	--
--	Vital Documents	Vital Documents are generally documents that affect access to, retention in, or termination or exclusion from a recipient's program services or benefits.
VSP	Vision Service Plan	--
WIC	Women, Infants, and Children Program	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five (5) who are found to be at nutritional risk.
WPATH	World Professional Association for Transgender Health	--

Chapter 1 – Introduction

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

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

1.0 Welcome to L.A. Care Health Plan

L.A. Care Health Plan (L.A. Care) serves more than 2.9 million Members in the Los Angeles County, making it the largest publicly operated health plan in the country. L.A. Care offers five (5) health coverage plans dedicated to being accountable and responsive to Members. As a public entity, the L.A. Care mission is to provide access to quality health care for L.A. County's vulnerable and low-income communities, and to support the safety net required to achieve that purpose.

1.1 Two-Plan Model

Medi-Cal is California's Medicaid program. It is a public health insurance program administered by the California Department of Health Care Services (DHCS). In Los Angeles County, Medi-Cal is operated through the Two-Plan Model consisting of a local initiative health plan and a commercial health plan. L.A. Care is the local initiative managed health care plan in Los Angeles County. Currently, Health Net is the commercial health plan. Medi-Cal beneficiaries represent a vast majority of L.A. Care Members.

1.2 Plan Partner Collaboration

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

These include:

- Anthem Blue Cross
- Blue Shield of California Promise Health Plan (Blue Shield Promise)

1.3 Product Lines

L.A. Care offers five (5) product lines, which are also called lines of business (LOBs).

Below are the LOBs offered by L.A. Care:

1. **L.A. Care Medi-Cal (MCLA)**
   Medi-Cal is a public program that provides health care coverage to young adults, families, older adults, and people with disabilities, and undocumented immigrants who meet the income and age requirements. In addition to offering a direct Medi-Cal LOB, L.A. Care works with two (2) subcontracted health plans to provide coverage to Medi-Cal Members. These Plan Partners are Anthem Blue Cross and Blue Shield of California Promise Health Plan (Blue Shield Promise). For more information on the MCLA LOB and for eligibility criteria, please visit: **https://www.lacare.org/health-plans/medi-cal**.

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

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

4. **L.A. Care Medicare Plus (HMO D-SNP)**
   L.A. Care Medicare Plus (HMO D-SNP) is a dual eligible special needs plan, which offers complete care that coordinates benefits for Members eligible for both Medicare and Medi-Cal benefits. This plan offers many benefits at no cost, like care managers, an over-the-counter allowance of up to $150 every three (3) months for approved items, a fitness benefit, a companionship benefit, and 24/7 customer service. For more information on HMO D-SNP LOB and for eligibility criteria, please visit: **https://medicare.lacare.org/**. For HMO D-SNP details, please see Chapter 4 – Scope of Benefits and the HMO D-SNP Chapter starting on page 29.

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

1.4 Community Resource Centers (CRC)

L.A. Care and Blue Shield Promise jointly operate a Community Resource Center (CRC) network across Los Angeles County. By 2024, the health plans will jointly operate 14 centers. The CRCs offer a broad array of no-cost programming, classes, and resources to help health plan Members and others in the community stay active, healthy, and informed. The centers also provide on-site support from community social service organizations focused on addressing social determinants of health such as food and income security.

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

1.4.A Resources currently offered:

- Dance and Fitness Classes
- Health and Wellness Classes
- Social Services Assistance
- Medi-Cal Enrollment and Renewal Support
- Free WiFi and private space for telemedicine consultations

For the most up-to-date information regarding CRC locations, hours of operation, classes, resources, and events, visit **www.communityresourcecenterla.org** or call the L.A. Care and Blue Shield Promise Health Plan Community Resource Centers phone line at (877) 287-6290.

For more information on the CRCs, please refer to Chapter 9 – Health Education.

1.5 Universal Provider Manual (UPM)

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

- Section Coverage

Every chapter of this UPM includes the following:

  - Introduction to chapter or section
  - Objectives and Provider responsibilities
  - Department reference contacts
  - Helpful website links and policies and procedures, as applicable

1.6 Responsibility of Participating Providers

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

1.6.A Notice to Providers:

- **Amendments to Contracts, UPM, and Policies and Procedures**
  Periodically, L.A. Care amends its Provider contracts, the UPM, and L.A. Care's policies and according to the terms of the procedures. Updates are done to ensure Providers have the necessary information on the most up-to-date laws, regulations, and revisions to provide the highest quality services to L.A. Care Members and ensure legal, contractual, and regulatory compliance. Providers will be notified about important changes made to the UPM and updated policies and procedures via the communication channels below.
- **Communication Channels**
  L.A. Care is committed to providing the latest information about policy, regulatory, and legal changes, education and training opportunities, as well as updates on the UPM and clinical best practices.

L.A. Care will communicate with its Providers through the following:

  - Email
  - Fax
  - Letter
  - Newsletter: The Pulse, Progress Notes, and Health Advisories
    To register to receive the newsletters, please visit:
    https://www.lacare.org/providers/provider-central/news
  - Provider Portal:
    To register for the Provider Portal, please visit:
    https://www.lacare.org/providers/provider-central/la-care-provider-central
  - Select Provider Communications
    Communications to Providers regarding critical, regulatory, and/or contractual updates.
    Please visit: **https://www.lacare.org/provider-comms**

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

1.6.B Provider Expectations:

- **Code of Conduct**
  The Code of Conduct is a guide to ensure compliance with the rules and regulations that govern our business. While the Code of Conduct is not designed to cover every possible situation, it does provide examples of everyday scenarios to assist Providers with proactively addressing issues.

  For more information on the L.A. Care Code of Conduct, please visit:
  https://www.lacare.org/sites/default/files/universal/DES1804_Code_of_Conduct_0918.pdf.

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

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

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

- **By Email:**
  ProviderRelations@lacare.org

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

1.6.C Resources to Meet Service Requirements

- **Provider Programs**
  L.A. Care offers Provider opportunities in the areas of education, training, and grants.
  Programs include:

  - Trainings, Classes, and Seminars
  - Elevating the Safety Net
  - Managed Care Pharmacy Residency Program
  - Physician Leadership Program

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

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

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

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

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

1.7 L.A. Care is Committed to its Providers

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

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

- Child Health and Disability Prevention (CHDP) Providers
- Federally Qualified Health Centers (FQHCs)
- Licensed community clinics

1.8 Join Our Network

If you are a physician or group practice interested in joining the L.A. Care Direct Network, please visit the L.A. Care contracting site to submit a letter of interest: **https://www.lacare.org/providers/provider-central/join-our-network**.

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

1.9 Statement of Principles on Social Justice and Systemic Racism

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

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

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

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

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

Thank you,
L.A. Care Health Plan

Chapter 2 – Membership and Membership Services

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

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

2.0 Introduction

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

2.1 Membership Identification Card

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

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

Line of Business (LOB)	Confirmation of Enrollment
LACC/D	Within 10 business days from receipt of payment.
MCLA	Must be provided within seven (7) calendar days of the new Member's effective date of enrollment or seven (7) calendar days from receipt of the eligibility (834) file, whichever is later.
PASC-SEIU	Within 10 business days from receipt of eligibility file.

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

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

Prescription medication information is available on all identification cards except for the MCLA LOB. MCLA Rx needs are managed by Magellan. For more information on Medi-Cal Rx, please refer to Chapter 16 – Pharmacy and Formulary.

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

To request access to the Provider Portal or to sign-in, please visit: **https://www.lacare.org/providers/provider-central/la-care-provider-central**.

2.2 Eligibility Verification

Providers can check Member eligibility 24 hours a day/seven (7) days a week. Membership and eligibility must be verified on the date the Member is to be seen as services are subject to eligibility at the point of service. Verification is necessary to assure that payment is made, correctly, for health care services rendered by the Provider to the Member.

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

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

- **L.A. Care Provider Solutions Center at** (866) 522-2736
  1. Select option: one (1) for Eligibility
  2. Follow Interactive Voice Response (IVR) instructions
  3. Enter requested Member information
  4. IVR will telephonically disclose Member eligibility information
  5. For further inquiries, related to the following, Providers can stay on the line to speak with a representative during business hours: Monday through Friday (7:00 AM to 6:00 PM PST)
     - Prior Authorization Status
     - Claim Status (The self-serve option via IVR is available 24 hours a day.)
     - Claim Appeal Status

2.3 Member Rights and Responsibilities

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

Member Rights and Responsibilities include:

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

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

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

- **Voice Concerns**
  Members have the right to file a grievance about L.A. Care, the health plans, and in-network Providers, or the care received without fear of losing their benefits.

- **Service outside the Provider Network**
  Members have the right to receive emergency or urgent services, as well as family planning and sexually transmitted disease services, outside of the L.A. Care network.

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

- **Know your Rights**
  Members have the right to receive information about their rights and responsibilities, including a copy of their medical records.

For details on Member Rights and Responsibilities, please visit:
https://www.lacare.org/members/welcome-la-care/rights-responsibilities.

2.4 Member Grievances and Appeals

L.A. Care Members have the right to file a grievance and/or appeal through a formal process. Members may elect a personal representative or a Provider to file the grievance and/or appeal on their behalf. A grievance may include concerns about the operations of L.A. Care and/or its Providers. Common complaints include long wait times, the demeanor of health care personnel, the inadequacy of facilities, and the lack of courteous service.

Members can obtain assistance in filing a grievance or appeal by contacting the L.A. Care Customer Solution Center, 24 hours a day, 7 days a week, including holidays, by calling the number on the back of their Member identification card.

2.4.A Other options include:

- **By Mail:**
  L.A. Care Health Plan
  Appeals and Grievance Department
  1055 West 7th Street
  Los Angeles, CA 90017

A Provider's office should have complaint forms available for Members. Providers can also call the L.A. Care Customer Solution Center and request to have a form sent to the Member. Once received, the Member will need to complete the form and include the following:

1. Member Name
2. Health Plan Identification Number
3. Reason for Complaint
4. And mail the form to the L.A. Care address (above)

By Online Grievance and Appeal Form:
Members can also access the Grievance form by visiting the L.A. Care website and completing the online form here:
https://www.lacare.org/members/member-support/file-grievance/grievance-form

- **By Fax:**
  L.A. Care Appeals and Grievance Department at (213) 438-5748

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

2.5 Public Advisory Committee Meetings

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

The L.A. Care public meetings include:

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

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

To view the L.A. Care upcoming schedule of events, please visit: **https://www.lacare.org/events**.

2.6 Healthy Living and Prevention

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

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

2.6.A Available resources include:

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

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

- **https://www.lacare.org/healthy-living/health-resources/healthy-living-prevention**
- **https://www.lacare.org/healthy-living/community-engagement/community-resource-centers**

2.7 Provider Termination

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

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

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

2.8 For More Information

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

Chapter 3 – Access to Care

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

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

3.0 Introduction

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

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

3.1 Access to Care – Provider Requirements

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

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

For more information on Access to Care Quick Tips, please visit:
https://www.lacare.org/sites/default/files/la2573_access_to_care_tips_202301rev.pdf.

3.2 Provider Appointment Availability and After-Hours Survey

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

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

- **Access:**
  - Recording or answering service must state emergency instructions to address medical emergencies
  - Recording or answering service must state a way of contacting the Provider
- **Timeliness:**
  - Recording or answering service must state that Provider will call back within 30 minutes

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

3.3 Timely Access Standards

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

Providers must follow the Timely Access Standards below:

Timely Access Standards – By Line of Business (LOB)				
Type of Service	**Timeframe**	**LACC**	**MCLA**	**PASC**
Primary Care Provider – Routine Care	Within 10 business days	•	•	•
Primary Care Provider – Urgent Care	Within 48 hours	•	•	•
Specialist – Routine Care	Within 15 business days	•	•	•
Specialist – Urgent Care	Within 96 hours	•	•	•
Preventive Health Exams – Adults	Within 30 calendar days	•	•	•
Preventive Health Exams – Pediatrics	Within 10 business days	•	•	•
Routine Ancillary	Within 15 business days	•	•	•
Initial Prenatal	Within 10 business days	•	•	•
Normal Business Hours – Call Back	Within 30 minutes	•	•	•
Missed Appts – Call Back (Rescheduling)	Within 48 hours	•	•	•
Behavioral Health – Routine Care (MD)	Within 15 business days	•	•	•
Behavioral Health – Routine Care (Non-MD)	Within 10 business days	•	•	•
Behavioral Health – Urgent Care	Within 96 hours	•	•	•
Behavioral Health – Routine Care Follow Up Appointment (Non-MD)	Within 10 business days	•	•	•
Behavioral Health – Routine Care Follow Up Appointment (MD)	Within 90 calendar days	•	•	•
Emergency Care and After-Hours Care	24 hours a day, seven (7) days a week	•	•	•

3.4 Minimum Site Hours

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

3.4.A Minimum Site Hours Requirements

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

The Requirements are as follows:

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

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

3.5 Changes to Office (Site) Hours

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

3.6 Facility Site Review (FSR)

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

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

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

3.7 Population Health Management (PHM) Program, Department of Health Care Services (DHCS), California Advancing and Innovating Medi-Cal (CalAIM)

The Department of Health Care Services (DHCS) is innovating and transforming the Medi-Cal delivery system. California Advancing and Innovating Medi-Cal (CalAIM) is moving Medi-Cal toward a population health approach that prioritizes prevention and whole-person care. CalAIM's Population Health Management (PHM) program, launched on January 1, 2023, adopts the quadruple aim to enhance the patient experience, improve population health, reduce costs, and improve health care Provider's work life, including clinicians and staff.

CalAIM supports a unified approach for PHM across delivery systems to promote accountability and transparency, integrating national standards and evidence-based practices. In tandem with the PHM Program rollout, DHCS is building a statewide PHM Service, which will launch in July 2023 and is designed to collect and integrate disparate information to support DHCS' vision for PHM in myriad ways.

Most notably, the PHM Service will provide the following:

- Provide Health Plans, Providers, counties, health plan Members, and other authorized users with access to comprehensive, historical data on Members' health history, needs, and risks;
- Include a single, statewide, open-source risk stratification and segmentation (RSS) methodology with standardized risk tier criteria that will place all Medi-Cal Members into high-risk, medium-rising-risk, and low-risk tiers.

3.7.A Population Health Management Requirements for L.A. Care Providers:

- **Basic Population Health Services**: In partnership with L.A. Care, Providers will be expected to offer basic population health services to every Medi-Cal Member regardless of the Member's risk tier. Below are highlights of the key requirements for providers as detailed in the PHM Program Guide.

- **Providers must ensure that Members**: Have a source of care that is appropriate, ongoing, and timely to meet the Member's needs. Receive and have access to all needed preventive services, care coordination, navigation, and referral across all health and social services, including community supports, wellness and prevention programs, management, and support for chronic diseases.

Lower risk Members who do not meet the criteria for High Risk or Complex Case Management (CCM) or Enhanced Care Management (ECM) will receive care management and coordination of care services conducted by their Provider/PPG.

Given the rising incidence of mild to moderate physical and behavioral health conditions, Health Plans and Providers will be required to ensure effective networks for treating these conditions and integration with physical health interventions, ensuring coordination of care and follow-up. The transitional care service requirements may be subject to review and audit by L.A. Care.

3.7.B Transitional Care Services: Providers/PPGs are responsible for knowing in a timely manner when their Members are admitted, discharged, or transferred, and therefore experiencing a transition.

Providers conducting transitional care services must ensure that all Members have:

- Transitional care services offered and are assigned a Care Manager upon transition from one (1) level of care to another.
    - The assigned Care Manager is the single point of contact responsible for ensuring the completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.
    - The assigned Care Manager will be engaged after notification of admission and is responsible for collaborating with the facility and knowing when the Member is transferred or discharged.
    - The responsibilities of the Care Manager also include ensuring non-duplication of services provided by other team members (including facility or PCP based Care Managers); and collaboration, communication, and coordination with Members and their family/support persons/guardians, hospitals, emergency departments, Long Term Support Services (LTSS), physicians, nurses, social workers, discharge planners, and service Providers.
    - A core responsibility of the Care Manager is to ensure that a discharge risk assessment is completed and that a discharge planning document is created and shared with appropriate parties.
        - The discharging facility should complete a risk assessment that informs the discharge planning document. It is the responsibility of the Care Manager assigned to transitional care services to ensure the discharge planning document complete and accurate, coordinated, and shared with appropriate parties. It is also the responsibility of the Care Manager to ensure non-duplication so that Members do not receive two (2) different discharge documents (one (1) from the discharging facility and a separate one (1) from the Care Manager).
- The ability to transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- The support and coordination needed to have a safe and secure transition with the least burden on the Member as possible and the needed support and connections to services that make them successful in their new environment.
- Discharge planning until they have been successfully connected to all needed services and supports (regardless of acuity level).

3.8 Initial Health Appointment (IHA)

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

*The Initial Health Appointment (IHA) is a comprehensive assessment completed during a Member's initial encounter within a primary care setting (usually the assigned PCP). The IHA enables the Member's Provider to understand the acute, chronic, and preventative health needs of the Member and must be provided in a culturally and linguistically appropriate manner and documented in the Member's medical record.

The components may be provided in person or virtually, though all components cannot be provided virtually.

3.8.A Providers are responsible to complete all components of the IHA. Providers shall complete an IHA (complete physical and mental health history, identification of or risks, assessment of need for preventive screens or services, health education, and diagnosis and plan for treatment of any disease) for each new Member within 120 calendar days of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) years and younger, whichever is less). Providers are encouraged to continue offering and completing the IHA and all its required components, even if after the 120 day requirement has passed.*

3.9 Annual Cognitive Health Assessment (ACHA)

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

*The Annual Cognitive Health Assessment (ACHA) is a component of the Evaluation & Management (E&M) visit for Medi-Cal Members 65 years and older who do not have Medicare coverage. The ACHA is used to identify if a Member has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN). To facilitate the ACHA, Providers must first complete the DHCS Dementia Care Aware cognitive health assessment training. Providers should use validated ACHA screening tools and complete necessary follow-up services based on the assessment findings, such as additional assessments and appropriate referrals.

3.9.A PPGs/PCPs are responsible to complete the Dementia Care Aware cognitive health assessment training prior to conducting the ACHA with eligible Members. Providers should conduct the ACHA with eligible Members annually and are responsible for completing follow-up based on the ACHA findings.*

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

3.10 For More Information

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

Chapter 4 – Scope of Benefits

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

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

4.0 Introduction

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

4.1 Covered Benefits/Services Chart

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

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

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

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

This list is for illustrative purposes only to provide general information. Covered Benefits available to a Member can change from time to time. Please see the applicable EOC for the most current benefits available or call L.A. Care. Please refer to your Provider contract for those Covered Services that a Provider may be contracted to provide.

COVERED BENEFITS/SERVICES	PRODUCT LINE			
	HMO D-SNP	MCLA	LACC/D	PASC-SEIU
Abortion	☒	☒	☒	☒
Acupuncture	☒	☒	☒	☐
Allergy Testing and Treatment	☒	☒	☒	☒
Alcohol Misuse Screening and Counseling	☒	☒	☒	☒
Ambulance Services (emergent) – Ground and Air Transportation	☒	☒	☒	☒
Audiology	☒	☒	☒	☒
Behavioral Health Treatment	☒	☒	☒	☐
Behavioral/Mental Health – Outpatient Mild to Moderate	☒	☒	☒	☒
Behavioral Health – Inpatient Severe Mental Illness and Alcohol and Drug Abuse Treatment	☒	☒	☒	☒
Biofeedback	☒	☐	☒	☒
Chiropractic	☒	☒	☐	☐
Chemical Dependency Services	☒	☒	☒	☒
Chemotherapy	☒	☒	☒	☒
Circumcision	☐	☐	☒	☒
Community Based Adult Services (CBAS)	☐	☒	☐	☐
Community Health Worker (CHW) Services	☐	☒	☐	☐
Dental Services	☐	☒	☒	☐
Detoxification (Acute Phase)	☒	☒	☒	☒
Diagnostic Services	☒	☒	☒	☒
Diabetic Services	☒	☒	☒	☒
Dialysis	☒	☒	☒	☒
Directly Observed Therapy (DOT)	☒	☒	☐	☐
Doula Services	☐	☒	☐	☐
Durable Medical Equipment (DME) ordered by a Physician	☒	☒	☒	☒
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	☐	☒	☐	☒
Emergency Services	☒	☒	☒	☒
Family Planning Services	☐	☒	☒	☒
Genetic Testing	☒	☒	☒	☒
Health Education	☒	☒	☒	☒
Hearing Aids	☐	☒	☐	☒
Home Health	☒	☒	☒	☒
Hospice	☐	☒	☒	☒
Inpatient Facility	☒	☒	☒	☒
Immunization	☒	☒	☒	☒
Infusion Therapy	☒	☒	☒	☒
Injectable Medications - Outpatient	☒	☒	☒	☒
Interpreter Services	☒	☒	☒	☒
Lab & Pathology Services	☒	☒	☒	☒
Long Term Care	☐	☒	☒	☒
Major Solid Organ, Bone Marrow and Stem Cell Transplants	☒	☒	☒	☒

COVERED BENEFITS/SERVICES	PRODUCT LINE			
	HMO D-SNP	MCLA	LACC/D	PASC-SEIU
Mammography	☒	☒	☒	☒
Nutritionist/Dietician	☒	☒	☒	☒
Obstetrics/Gynecology	☒	☒	☒	☒
Office Visit	☒	☒	☒	☒
Ophthalmology	☒	☒	☒	☒
Physical, Occupational & Speech Therapies	☒	☒	☒	☒
Pharmacy	☒	☒	☒	☒
Physician Services	☒	☒	☒	☒
Podiatry	☒	☒	☒	☒
Pregnancy & Maternity Care	☒	☒	☒	☒
Prosthetics & Orthotics	☒	☒	☒	☒
Radiation Therapy	☒	☒	☒	☒
Radiology Services	☒	☒	☒	☒
Reconstructive Surgery - Non cosmetic	☒	☒	☒	☒
Rehabilitation Services	☒	☒	☒	☒
Retail Clinics	☒	☒	☒	☐
Skilled Nursing Facility (SNF)	☒	☒	☒	☒
Specialists	☒	☒	☒	☒
Telehealth	☒	☒	☒	☒
Transfusions (Blood and Blood Products)	☒	☒	☒	☒
Transgender Services	☒	☒	☒	☒
Transportation nonmedical transportation (NMT)	☐	☒	☐	☐
Transportation nonemergency medical transportation (NEMT)	☐	☒	☒	☒
Urgent Care	☒	☒	☒	☒
Vision Care	☒	☒	☒	☐

4.2 Exclusions

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

4.2.A Services excluded:

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

EXCLUSIONS			
HMO D-SNP	**MCLA**	**LACC/D**	**PASC-SEIU**
• Services considered not "reasonable and medically necessary" • Experimental medical and surgical treatments, items, and drugs • Surgical treatment for morbid obesity • A private room in a hospital • Private duty nursing • Personal items in patient's room at a hospital or a nursing facility • Full-time nursing care in home • Fees charged by immediate relatives or members of patient's household • Elective or voluntary enhancement procedures or services • Cosmetic surgery • Orthopedic shoes and Supportive devices for feet (covered under specific conditions) • Radial keratotomy, LASIK surgery, and other low-vision aids • Reversal of sterilization procedures and non-prescription • Naturopath services • Services provided to veterans in Veteran's Affairs (VA) facilities	• Cosmetic surgery • Experimental services • Fertility preservation • In vitro fertilization • Home modifications • Vehicle modifications	• Chiropractic care • Cosmetic surgery • Dental care (Adult) • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private duty nursing • Routine eye care (Adult) • Weight loss programs	• Acupuncture • Chiropractic care • Cosmetic surgery • Habilitation services • Infertility treatment • Long term care • Private duty nursing • Routine dental care • Routine eye care • Routine foot care

For more information, please review the EOC located here: **https://www.lacare.org/members/welcome-la-care/member-documents.**

4.3 Responsibility of Providers

L.A. Care requires that its contracted Providers (including, but not limited to, medical groups, hospitals, sub-delegated and other specialized health plans) meet specific requirements. This section is provided to assist you with an understanding of which functions are the responsibility of L.A. Care and which functions apply to the Provider.

4.4 Utilization Management (UM)

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

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

4.5 Behavioral/Mental Health Services

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

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

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

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

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

  - **LACC/D**
    Behavioral/Mental Health services out-of-pocket responsibility varies between metal levels.

    All services are provided through Carelon Behavioral Health. To access behavior health Providers (mental health or substance use disorder), Members do not need a referral from their Provider.

    No prior authorization is required for most outpatient behavioral/mental health services. For more information on Behavioral Health Treatment (BHT), please call Carelon Behavioral Health at (877) 344-2858 or TTY (800) 735-2929 or visit: **https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered**.

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

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

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

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

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

- **PASC-SEIU**
  All services are provided through Carelon Behavioral Health. To access behavior health Providers (mental health or substance use disorder), Members do not need a referral from their Provider.

  No prior authorization is required for most outpatient behavioral/mental health services. For more information on BHT, please call Carelon Behavioral Health at (877) 344-2858 or TTY (800) 735-2929 or visit: **https://www.lacare.org/members/welcome-la-care/member-documents/pasc-seiu-plan**.

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

Organization	Phone Number	Fax Number
Carelon Behavioral Health	(877) 344-2858	(866) 422-3413
L.A. Care Behavioral Health Department	(888) 347-2264	(213) 438-5054
DMH	(800) 854-7771	(562) 863-3971
DPH and SAPC	(844) 804-7500	--

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

4.6 Supplemental Benefits

4.6.A Acupuncture Services are provided by American Specialty Health (ASH) for HMO D-SNP and LACC/D. Providers can reach ASH at (800) 848-3555.

- **HMO D-SNP**
  Authorization is not required for the first two (2) visits per month, or more often if they are medically necessary. L.A. Care will also pay for up to 12 acupuncture visits in 90 days if the patient has chronic low back pain, and an additional eight (8) sessions of acupuncture for chronic low back pain if shown improvement. L.A. Care also covers up to 45 combined visits every year for non-Medicare covered acupuncture, routine chiropractic and therapeutic massage services. Please reference the EOC/Member Handbook for coverage details. Please reference the EOC for coverage details.
- **LACC/D**
  Limitations may apply to acupuncture services. For coverage details, please visit: **https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered**.
- **MCLA**
  Acupuncture services are provided through L.A. Care directly contracted acupuncturists. Authorization is not required for the first two (2) visits per month; additional appointments will need a referral. L.A. Care may pre-approve additional services as medically necessary.
- **PASC-SEIU**
  Excluded service.

4.6.B Dental Services

- **HMO D-SNP**
  Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program. It will provide up to $1,800 in covered services per year, if medically necessary. For more information about dental services, please call Medi-Cal Dental Program at (800) 322-6384 or TTY (800) 735-2922 or visit: **https://smilecalifornia.org/**.
- **LACC/D**
  L.A. Care Covered and L.A. Care Covered Direct cover dental services for Members up to the age of 19. The annual deductible is waived. Dental benefits are provided by Liberty Dental through its extensive network of dental Providers. Members can contact Liberty Dental regarding provider information at (888) 700-5243 or TTY (877) 855-8039 or visit: **https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered**.
- **MCLA**
  Certain dental services for Medi-Cal Members are available through the Medi-Cal Dental Program as fee-for-service (FFS) or dental managed care. For more information about Medi-Cal Dental, please call at (800) 322-6384 or TTY (800) 735-2922 or visit: **www.dental.dhcs.ca.gov** or **https://smilecalifornia.org/**.
- **PASC-SEIU**
  Dental benefits and coverage are administered by PASC-SEIU. For information on Dental insurance, please contact the SEIU Member Action Center at (855) 810-2015.

4.6.C Vision Services are provided by Vision Service Plan (VSP), unless otherwise noted. VSP provides routine vision services, such as annual exams and eyewear (glasses and contacts), if covered under the benefit. Providers can reach VSP at (800) 877-7195 or visit: **https://www.vsp.com/**.

- **HMO D-SNP**
  HMO D-SNP covers one (1) routine eye exam every year, and up to $500 for eyeglasses (frames and lenses) or up to $500 for contact lenses every two (2) years. For more coverage details, please call VSP at (800) 877-7195.
- **LACC/D**
  LACC and LACCD provide vision coverage for Members up to the age of 19 through VSP. For more coverage details, please call VSP at (800) 877-7195.
- **MCLA**
  Medi-Cal covers routine eye exams once every 24 months for Members of all ages. Eyeglasses (frames and lenses) and replacement glasses are covered once every 24 months. Low vision devices for those with vision impairment and medically necessary contact lenses are also covered when required for medical conditions. For coverage details, please call VSP at (800) 877-7195.
- **PASC-SEIU**
  Vision benefits and coverage are administered by PASC-SEIU. For information on Vision insurance, please contact the SEIU Member Action Center at (855) 810-2015.

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

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

- **4.6.D.1 Non-Medical Transportation (NMT)**

  Members who qualify may use unlimited NMT when it is for travel to and from medically necessary covered services and/or picking up prescriptions and/or medical supplies.

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

- **4.6.D.2 Non-Emergency Medical Transportation (NEMT)**

  Members who qualify are entitled to unlimited NEMT when they are physically or medically unable to access medically necessary covered services and/or pick up pharmacy prescriptions and/or medical supplies by ordinary means of public or private conveyance. Services for the Members' medical or physical condition must be covered by L.A. Care or carved out to Department of Health Care Services (DHCS) and/or County Departments.

- Transportation Types:
  - Advanced Life Support (ALS)
  - Air Ambulance
  - Basic Life Support (BLS)
  - Litter/Gurney Van, Bariatric Gurney
  - Specialty Care Transport (SCT)
  - Wheelchair Van, Bariatric Wheelchair

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

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

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

- **4.6.D.4 Scheduling Transportation**
  Transportation services, NMT or NEMT, for Members can be scheduled by calling:
  - **For Providers:**
    Health Services Department at (877) 431-2273 or TTY 711
  - **For HMO D-SNP Members:**
    Customer Solution Center at (833) 522-3767 or TTY 711
  - **For LACC/D Members:**
    Customer Solution Center at (855) 270-2327 or TTY 711
  - **For MCLA Members:**
    Customer Solution Center at (888) 839-9909 or TTY 711
  - **For PASC-SEIU Members:**
    Customer Solution Center at (844) 854-7272 or TTY 711

1. All NEMT services will require a Physician Certification Statement (PCS) form to be submitted before transportation is arranged. The PCS form can be found here: **Referral Form for Transportation Services and Physician Certification Statement**.
2. Send the signed PCS form to the L.A. Care UM Department for approval via fax at (213) 438-2201.
3. UM Department reviews prior authorization requests and can approve requests for the duration of up to 12 months maximum.
4. Please be advised that all transportation must be arranged by Call the Car.
   - If the facility arranges transportation using its own preferred vendor, L.A. Care will not reimburse the cost, excluding the below exception:

     If NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient psychiatric facility is not provided within a 3 hour timeframe, then the facility may arrange for NEMT services and L.A. Care will cover the out-of-network NEMT services.
5. Once services have been approved, L.A. Care will notify the Member, Provider and transportation broker via verbal and written notification within five (5) calendar days of receiving a routine PCS form request, and within three (3) calendar days of receiving an urgent PCS form request.
6. After receiving notification of approval, the Member will be able to schedule their transportation.
7. Facilities can also call to arrange an appointment or obtain an update on discharge, transfer, or auto approval transportation by calling the L.A. Care Health Services Department at (877) 431-2273, select Transportation, and then follow the prompts.
8. For NMT requests and scheduling, advance notice of at least two (2) business days (Monday thru Friday) before the Member's scheduled appointment is required.

   - Appointments will be verified by CTC.

4.7 Sensitive Services

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

* "Sensitive Services" are defined as services related to the following:

- Family planning
- Pregnancy
- Sexual assault
- Sexually transmitted diseases (STDs) for Members 12 years of age and older, if sexually active
- Substance or alcohol abuse

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

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

Examples of covered Sensitive Services:

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

4.8 Sexually Transmitted Disease (STD) Services

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

- **Chlamydia**
- **Chancroid**
- **Gonorrhea**
- **Hepatitis B**
- **Hepatitis C**
- **HIV**
- **Syphilis**

For more information on how to report nationally notifiable STDs and other communicable diseases and conditions to the local health jurisdiction of the Member's residence in Los Angeles County, please visit the health department's website(s) here:

- Los Angeles County Department of Public Health: **http://publichealth.lacounty.gov/dhsp/reportcase.htm#STD_Reporting_Information**
- Long Beach Department of Health and Human Services: **http://publichealth.lacounty.gov/dhsp/reportcase.htm#STD_Reporting_Information**
- Pasadena Public Health Department: **https://www.cityofpasadena.net/public-health/healthcare-providers/**

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

4.9 Carve-Out Services

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

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

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

- **Alcohol and Drug Treatment**
  - Alcohol misuse screening and counseling
- **Acute inpatient California Children Services (CCS)** The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified Providers. Identified children with CCS eligible conditions are referred to CCS immediately upon identification.

  For more information on CCS program, please visit: **https://www.dhcs.ca.gov/services/ccs**.

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

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

- **Comprehensive Perinatal Services Program (CPSP)** Pregnancy and Postpartum Services for pregnant Members provide comprehensive, multidisciplinary pregnancy and postpartum services with case coordination. For more information, please visit: **http://publichealth.lacounty.gov/mch/cpsp/CPSPwebpages/cpsp_rev.htm**.
- **Dental Services**
- **Directly Observed Therapy for Tuberculous (TB) – provided by local health jurisdiction**
- **Local Education Agency Services**

- **Pharmacy (Medi-Cal Rx)**
- **Women, Infants, and Children Program (WIC)** The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk. For more information, please visit: **https://www.fns.usda.gov/wic**.

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

4.10 Balance Billing

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

Providers who engage in Balance Billing may be subject to sanctions by L.A. Care, Centers for Medicare and Medicaid Services (CMS), DHCS, and other industry regulators.

For more information on Balance Billing, please visit: **https://dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf**.

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

4.11 Cost Sharing, Share of Cost, Deductibles and Co-payments

- **HMO D-SNP**
  Members eligible for L.A. Care's HMO D-SNP plan are full dual-eligible enrolled who receive benefits and services from both Medicare and Medicaid (Medi-Cal) programs. Medical premiums, deductibles, and cost sharing will be covered by the Medi-Cal wrap around benefits. Therefore, these individual are not subject to out-of-pocket costs or cost sharing for covered services, with the exception of certain Part D prescription drugs, which may incur a cost share based on low income subsidy level. Providers may not impose cost sharing on Members for any plan covered benefits or services. Medi-Cal benefits must be provided with no co-payment.

  For more information on HMO D-SNP benefits, please visit: **https://medicare.lacare.org/**.

- **LACC/D**
  Members may have a co-pay, coinsurance, and/or deductibles.

  For LACC/D Member's out-of-pocket responsibility for certain services, please visit: **https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered**.

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

  For more information on SOC, please visit: **www.medi-cal.ca.gov**.

- **PASC-SEIU**
  Members may have a co-pay or coinsurance.

  For PASC-SEIU Member's out-of-pocket responsibility for covered services, please visit: **https://www.lacare.org/members/welcome-la-care/member-documents/pasc-seiu-plan**.

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

4.12 Pharmacy Benefits and Services

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

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

For Medi-Cal, pharmacy benefits are carved-out to the DHCS Medi-Cal Rx. For additional information about contracted pharmacies, please visit **Medi-CalRx.dhcs.ca.gov**.

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

4.13 Nurse Advice Line (NAL)

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

4.13.A The HEAR library has pre-recorded messages on health topics that provide information Members need to help:

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

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

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

Providers are encouraged to share this information with Members.

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

4.14 Plan Coverage Resources

For detailed information on plan coverage, Providers can visit:

- **HMO D-SNP**
  https://medicare.lacare.org/
- **LACC/D**
  https://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered
- **MCLA**
  https://www.lacare.org/health-plans/medi-cal/benefits-guide
- **PASC-SEIU**
  https://www.lacare.org/health-plans/pasc-seiu/benefits-guide

4.15 Medi-Cal Renewal

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

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

For more information about how Medi-Cal beneficiaries can update their personal information and/or renew their Medi-Cal coverage, please contact the Los Angeles County Department of Public Social Services (DPSS) at (866) 613-3777 TTY (800) 660-4026 or visit BenefitsCal at **https://benefitscal.com/**.

For more information, please visit **KeepMediCalCoverage.org** to sign up for email and text message alerts.

DPSS is open Monday through Friday from 7:30 am – 6:30 pm excluding holidays.

4.16 For More Information

For questions regarding the information provided in this chapter, please contact the Provider Solutions Center via phone at (866) 522-2736. For additional L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

Chapter 5 – Utilization Management (UM)

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

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

5.0 Introduction

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

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

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

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

5.1 Program Structure

5.1.A Delegation

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

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

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

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

5.1.B Authorization Exemptions

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

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

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

5.1.B.1 Delegated entities have the discretion to create prior authorization exemptions for services where they hold financial responsibility. For services where L.A. Care holds financial responsibility, delegated entities must follow authorization requirements located here on the Provider Prior Authorization Tool: **https://www.lacare.org/providers/provider-resources/prior-authorization-search**

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

5.1.C Validity

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

Providers can verify Member eligibility 24 hours a day, seven (7) days a week by calling the L.A. Care Provider Solution Center at (866) 522-2736 or by visiting the Provider Section at: **https://www.lacare.org/**.

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

5.2 Authorization Types

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

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

Prior Authorization/Pre-Service is the formal process requiring an L.A. Care Provider to obtain advance approval for coverage of specific services or procedures. It allows for benefit and Medical Necessity determination, clinical appropriateness, level of care assessment, assignment of the length of stay for inpatient admissions, appropriate facility placement prior to the delivery of service, and identification of the intensity of case management that may be needed for optimal patient outcomes.

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

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

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

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

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

5.2.B 2. Concurrent Review/Hospital Admissions

Concurrent review requests occur while a Member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent review occurs during, or as part of, the clinical workflow to support point of care decisions.

They typically are associated with the following:

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

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

5.2.B.1 Member Transfers

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

5.2.B.2 Member Post Care

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

- **By Phone:**
  L.A. Care UM Department at (877) 431-2273
- **By Fax:**
  (213) 438-5748

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

Please note that emergency room admissions to observation level of care do not require authorization for all LOBs. Additionally, emergency room admission (face) sheets are not considered a request for admission, but rather the notification of services rendered by an emergency room department. Please ensure notification includes the level of care to which the Member was admitted.

To ensure the medically necessity of the admission and continued stay, including the appropriateness of the level of care, bed type and care duration, all reviews are performed by a UM Nurse Specialist for the following:

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

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

Objectives of continued stay:

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

5.2.B.3 Member Discharge Planning

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

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

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

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

5.2.C.3 Post-Service/Retrospective Review

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

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

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

5.3 Utilization Management (UM) Review Process

5.3.A Review Criteria

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

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

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

5.3.B Under-Utilization

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

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

5.3.C Third-Party Independent Medical Review

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

5.3.C.1 Guidelines for Review

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

- Input from the treating Provider
- Age of Member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of service to include, but not limited to:
  - Availability of inpatient, outpatient and transitional facilities

  - Availability of outpatient services, includes contracted and non-contracted specialists and specialty centers
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of SNF, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Local hospitals' ability to provide all recommended services
- Benefit coverage

5.3.C.2 Absence of Applicable Criteria

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

5.3.C.3 Review Documentation

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

The following information should be provided on all requests:

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

5.4 Determination Types

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

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

1. Administrative
2. Benefit
3. Medical Necessity

5.4.A Administrative Denial

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

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

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

5.4.B Adverse Determination (Modifications, Delay, Extension, Denial)

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

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

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

5.4.C Dispute an Adverse Determination

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

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

- **By Mail:**
  L.A. Care Health Plan
  Attn: Appeals and Grievances Department
  1055 W. 7th Street, 10th floor
  Los Angeles, CA 90017
- **By Fax:**
  (213) 438-5748

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

5.5 Independent Medical Review (IMR) / Complaint Form

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

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

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

5.6 Timeliness of Utilization Management (UM) Decisions

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

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

1. **Non-Urgent/Routine Requests**
   A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

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

5.7 Continuity of Care (COC)

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

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

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

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

L.A. Care approves COC requests when all of the following criteria are met:

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

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

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

Line of Business	Phone Number
L.A. Care Covered/Direct (LACC/D)	(855) 270-2327
Medi-Cal (MCLA)	(888) 839-9909
PASC-SEIU	(844) 854-7272

5.8 Behavioral Health Services

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

Line of Business	Outpatient Non-Specialty (mild to moderate)	Outpatient Specialty (mild to moderate)	Substance Use Disorder Services	Inpatient Mental Health	BHT/ABA
L.A. Care Covered (LACC)	Carelon	Carelon	Carelon	Carelon	Carelon
Medi-Cal (MCLA)	Carelon	DMH	DPH	DMH	L.A. Care
Medicare FFS or Medicare Advantage (MA) – (primary) & L.A. Care Medi-Cal -(secondary)	Medicare FFS or MA Plans	DMH	DPH	Medicare FFS or MA Plans	Medicare FFS or MA Plans
PASC-SEIU	Carelon	Carelon	Carelon	Carelon	Carelon

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

- Individual therapy
- Group therapy
- Medication management

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

- Intensive outpatient
- Day Treatment Services & Day RehabilitationTargeted case management

For Behavioral Health Treatment (BHT), common services include, but are not limited to Applied Behavior Analysis (ABA) and a variety of related evidence-based treatments that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction and promote, to the maximum extent practicable, the functioning of a beneficiary.

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

- Outpatient medication management
- Medication assisted treatment for substance use disorders
- Brief counseling/support/education
- Routine screenings including, but not limited to:
  - Depression ScreeningsAlcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)
  - Developmental screening
  - Autism screenings
  - Maternal mental health screening
  - Childhood trauma screenings

5.9 Behavioral Health Contact Information

Organization	Phone Number	Fax Number
Carelon Behavioral Health	(877) 344-2858	(866) 422-3413
L.A. Care Behavioral Health Treatment (BHT) Program	(888) 347-2264	(213) 438-5054
L.A. County Department of Mental Health (DMH)	(800) 854-7771	(562) 863-3971
L.A. County Department of Public Health/Substance Abuse Prevention and Control (DPH SAPC)	(844) 804-7500	--

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

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

5.10 Utilization Management Forms

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

5.11 For More Information

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

Chapter 6 – Quality Improvement and Health Equity (QIHE)

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

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

6.0 Introduction

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

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

QI is responsible for:

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

6.1 Committee Structure

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

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

6.2 Quality Oversight Committee (QOC)

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

6.2.A The QOC conducts the following activities:

- Assures compliance with the requirements of accrediting and regulatory agencies, including but not limited to, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), NCQA and Covered California
- Escalates concerning issues per protocols, policies, and procedures
- Ensure follow-up, as appropriate
- Improves quality, safety, and equity of care and service to Members
- Identifies appropriate performance measures, standards, and opportunities for performance improvement
- Ensures that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions
- Ensures that the information available to the Plan regarding accessibility, availability, and continuity of care (COC) is reviewed and evaluated, including but not limited to, information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services
- Ensures that opportunities for improvement are prioritized and closed based on the analysis of performance data
- Ensures that QIHE Program activities and related outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks
- Ensures all departments have the opportunity to align project goals and map out responsibilities and deadlines prior to project implementation
- Formulates organization-wide improvement activities and gains support from appropriate departments
- Provides and/or reviews and approves recommended changes to the QIHE Program and QIHE Work Plan activities based on updates and information sources available
- Reviews the analysis and evaluation of QI activities of other committees or staff, identifies needed actions, and ensures follow-up, as appropriate
- Reviews current quality improvement projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts
- Identifies actions to improve quality and prioritizes based on analysis and significance; and indicates how the committee determines these actions and ensures satisfactory closure
- Reviews performance requirements of strategic projects and performance improvement activities to enhance effectiveness and makes modifications as appropriate
- Reviews, evaluates, and makes recommendations regarding oversight of delegated activities, such as audit findings, trending, and reports
- Reviews and provides thoughtful consideration of changes in its QI and other policies and procedures and work plan, and makes changes to policies/work plan as needed
- Reviews and modifies the QIHE Program description, annual QIHE Work Plan, quarterly work plan reports, and annual evaluation of the QIHE Program
- Reviews and evaluates actions taken to determine if actions are effective in improving quality and what revisions, if any, need to be made to the actions

6.3 Quality Improvement and Health Equity Committee (QIHEC)

The primary objective of the Quality Improvement and Health Equity Committee (QIHEC) is to ensure network Provider and Member participation in the QIHE program through planning, design, and review of programs, QI activities, and interventions designed to improve performance.

For example, the QIHEC reviews and approves the updated Clinical Practice and Preventive Health Guidelines so that the QOC Members know that the guidelines have been approved by the body with network physicians included.

Upon approval, the updated information is posted here: **https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines**. Providers are notified of the updates in the next newsletter, which includes a link to the updated guidelines.

6.3.A The QIHEC conducts the following activities:

- Provides an opportunity to enhance collaboration and align between L.A. Care and delegated Plan Partners/ provider groups and practitioners, including hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers and gather feedback on equitable clinical and service initiatives.
- L.A. Care Member representatives will be included to ensure input on health equity activities and be involved in the decision-making process.
- Reports to the QOC through the QI Medical Director (or designee)
- Serves as an advisory group to the L.A. Care QI infrastructure for the delivery of healthcare services to L.A. Care Members.

Participation in the QIHEC, including committee membership, is open to network Providers representing a broad spectrum of appropriate primary care specialties serving L.A. Care Members, including, but not limited to, Providers who provide health care services to dually-eligible Members or who have expertise in managing chronic conditions (e.g., asthma, diabetes, congestive heart failure).

6.4 Social Determinants of Health (SDOH) Data Collection

L.A. Care is committed to achieving health equity, ensuring everyone has a fair and just opportunity to be as healthy as possible. Regulatory agencies, including DHCS, Covered California, and NCQA, continue to see the benefits of collecting Member data on social determinants of health (SDOH). DHCS All Plan Letter (APL) 21-009, titled *Collecting Social Determinants of Health Data*, communicates the importance of screening for SDOH and collecting reliable data. They also recognize that consistent and reliable collection of SDOH data is vital to the success of the CalAIM Population Health Management (PHM) initiative.

Covered California has now required all Marketplace Members to be screened for food security. In addition to the screening, an intervention must be completed with a positive food screening.

L.A. Care recommends Providers utilize one (1) of the following tools to capture SDOH data:

1. Accountable Health Communities Health-Related Social Needs Screening Tool (AHC)
2. Comprehensive Universal Behavior Screen (CUBS)
3. Protocol for Responding to and Assessing Patient's, Risks, and Experiences (PRAPARE)

Providers can use the L.A. Care Community Link as a resource to identify and refer individuals to programs and services that reduce SDOH disparities.

L.A. Care Community Link can be found here: **https://communitylink.lacare.org/**

L.A. Care has also added an SDOH metric to the Value Initiative for Independent Physician Associations (IPA) Performance (VIIP) to continue to strengthen Member data collection. The metric will inform Providers of their performance, benchmarks, and an opportunity to improve performance. It is important that Participating Physician Groups (PPGs) continually review and train on all required and appropriate assessments that are needed to assess clinical, behavioral, and social needs.

DHCS identified 25 priority SDOH Z codes based on the International Classification of Diseases, Tenth Revision, and Clinical Modification (ICD-10-CM) to be utilized.

See below:

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in the past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness, or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance and death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in the family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problems)

6.5 Clinical Practice and Preventive Health Guidelines

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

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

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

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

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

6.6 Service Measures

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

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

6.6.A The following data sets are collected annually:

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

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

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

- Document all immunizations through the California Immunization Registry (CAIR) and enter race and ethnicity
- Comply with all state and federal directives

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

6.7 Access to Care Standards

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

Access to Care Quick Tips can be found here:
https://www.lacare.org/sites/default/files/la2573_access_to_care_tips_202301rev.pdf

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

6.8 Minimum Site Hours (Requirements)

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

6.8.A The Requirements are as follows:

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

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

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

6.9 Population Health Management (PHM) Program, Department of Health Care Services (DHCS), California Advancing and Innovating Medi-Cal (CalAIM)

The Department of Health Care Services (DHCS) is innovating and transforming the Medi-Cal delivery system. California Advancing and Innovating Medi-Cal (CalAIM) is moving Medi-Cal toward a population health approach that prioritizes prevention and whole-person care. CalAIM's Population Health Management (PHM) program, launched on January 1, 2023, adopts the quadruple aim to enhance the patient experience, improve population health, reduce costs, and improve health care Provider's work life, including clinicians and staff.

CalAIM supports a unified approach for PHM across delivery systems to promote accountability and transparency, integrating national standards and evidence-based practices. In tandem with the PHM Program rollout, DHCS is building a statewide PHM Service, which will launch in July 2023 and is designed to collect and integrate disparate information to support DHCS' vision for PHM in myriad ways.

Most notably, the PHM Service will provide the following:

- Provide Health Plans, Providers, counties, health plan Members, and other authorized users with access to comprehensive, historical data on Members' health history, needs, and risks;
- Include a single, statewide, open-source risk stratification and segmentation (RSS) methodology with standardized risk tier criteria that will place all Medi-Cal Members into high-risk, medium-rising-risk, and low-risk tiers.

6.9.A Population Health Management Requirements for L.A. Care Providers:

- **Basic Population Health Services:** In partnership with L.A. Care, Providers will be expected to offer basic population health services to every Medi-Cal Member regardless of the Member's risk tier. Below are highlights of the key requirements for providers as detailed in the PHM Program Guide.

- **Providers must ensure that Members:** Have a source of care that is appropriate, ongoing, and timely to meet the Member's needs. Receive and have access to all needed preventive services, care coordination, navigation, and referral across all health and social services, including community supports, wellness and prevention programs, management, and support for chronic diseases.

Lower risk Members who do not meet the criteria for High Risk or Complex Case Management (CCM) or Enhanced Care Management (ECM) will receive care management and coordination of care services conducted by their Provider/PPG.

Given the rising incidence of mild to moderate physical and behavioral health conditions, Health Plans and Providers will be required to ensure effective networks for treating these conditions and integration with physical health interventions, ensuring coordination of care and follow-up. The transitional care service requirements may be subject to review and audit by L.A. Care.

6.9.B Transitional Care Services: Providers/PPGs are responsible for knowing in a timely manner when their Members are admitted, discharged, or transferred, and therefore experiencing a transition.

Providers conducting transitional care services must ensure that all Members have:

- Transitional care services offered and are assigned a Care Manager upon transition from one (1) level of care to another.
  - The assigned Care Manager is the single point of contact responsible for ensuring the completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.
  - The assigned Care Manager will be engaged after notification of admission and is responsible for collaborating with the facility and knowing when the Member is transferred or discharged.
  - The responsibilities of the Care Manager also include ensuring non-duplication of services provided by other team members (including facility or PCP based Care Managers); and collaboration, communication, and coordination with Members and their family/support persons/guardians, hospitals, emergency departments, Long Term Support Services (LTSS), physicians, nurses, social workers, discharge planners, and service Providers.
  - A core responsibility of the Care Manager is to ensure that a discharge risk assessment is completed and that a discharge planning document is created and shared with appropriate parties.
    - The discharging facility should complete a risk assessment that informs the discharge planning document. It is the responsibility of the Care Manager assigned to transitional care services to ensure the discharge planning document complete and accurate, coordinated, and shared with appropriate parties. It is also the responsibility of the Care Manager to ensure non-duplication so that Members do not receive two (2) different discharge documents (one (1) from the discharging facility and a separate one (1) from the Care Manager).
- The ability to transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- The support and coordination needed to have a safe and secure transition with the least burden on the Member as possible and the needed support and connections to services that make them successful in their new environment.
- Discharge planning until they have been successfully connected to all needed services and supports (regardless of acuity level).

6.10 Initial Health Appointment (IHA)

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

*The Initial Health Appointment (IHA) is a comprehensive assessment completed during a Member's initial encounter within a primary care setting (usually the assigned PCP). The IHA enables the Member's provider to understand the acute, chronic, and preventative health needs of the Member and must be provided in a culturally and linguistically appropriate manner and documented in the Member's medical record.

The components may be provided in person or virtually, though all components cannot be provided virtually.

6.10.A Providers are responsible to complete all components of the IHA. Providers shall complete an IHA (complete physical and mental health history, identification of- risks, assessment of need for preventive screens or services, health education, and diagnosis and plan for treatment of any disease) for each new Member within 120 calendar days of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) years and younger, whichever is less). Providers are encouraged to continue offering and completing the IHA and all its required components, even if after the 120 day requirement has passed.*

6.11 Annual Cognitive Health Assessment (ACHA)

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

*The Annual Cognitive Health Assessment (ACHA) is a component of the Evaluation & Management (E&M) visit for Medi-Cal Members 65 years and older who do not have Medicare coverage. The ACHA is used to identify if a Member has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN). To facilitate the ACHA, Providers must first complete the DHCS Dementia Care Aware cognitive health assessment training. Providers should use validated ACHA screening tools and complete necessary follow-up services based on the assessment findings, such as additional assessments and appropriate referrals.

6.11.A PPGs/PCPs are responsible to complete the Dementia Care Aware cognitive health assessment training prior to conducting the ACHA with eligible Members. Providers should conduct the ACHA with eligible Members annually and are responsible for completing follow-up based on the ACHA findings.*

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

6.12 Potential Quality of Care Issue (PQI)

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

Providers may report any quality concern with a potential or suspected deviation from accepted standards of care to the L.A. Care Provider Quality Review (PQR) team of the QI Department by submitting a referral for further investigation.

6.12.A PQI Review

Provider's responsibilities include the following:

- Providers shall ensure and monitor the safety and quality of services provided to L.A. Care Members.
- Providers shall have a written policy and procedure for the recordkeeping of care information provided to L.A. Care Members.
- Providers shall respond timely and provide accurate medical records as requested on the Information Request form for PQI review.
    - Providers are to respond fully and completely within five (5) business days after receipt of the request, in accordance with the PPG Services Agreement for quality of care review by L.A. Care. PQR will conduct three (3) attempts to collect the requested information and may escalate to Provider Network Management (PNM) if needed.

  - Upon exhausting all attempts to obtain the requested information, PQR may request assistance from the L.A. Care Enterprise Performance Optimization (EPO) team with remediating the noncompliance, request a corrective action plan (CAP), or take additional disciplinary actions, up to and including the issuance of sanctions.
  - Under the Health Insurance Portability and Accountability Act (HIPAA), the Provider as a covered entity may use or disclose Protected Health Information (PHI) for treatment, payment, and health care operations, without the patient's permission or authorization to another covered entity, such as L.A. Care.
- Providers may be asked to perform a formal root cause analysis prior to developing a CAP/quality improvement plan for a quality finding. Root cause analysis is an in-depth process or technique for identifying the most basic factor(s) underlying a variation in performance (problem).
- Providers shall report any quality concern(s) with a potential or suspected deviation from accepted standards of care to the L.A. Care QI Department by submitting a PQI referral to PQR for further investigation. The PQR team can be reached via email and fax.

- **By Email**:
  PQI@lacare.org
- **By Fax:**
  (213) 438-4860

PQI referral forms can be found here:
https://www.lacare.org/sites/default/files/la2138_referral_quality_care_issues.pdf

6.13 For More Information

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

Chapter 7 – Credentialing

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.
For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.

7.0 Introduction

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

Key Functions:

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

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

7.1 Provider Requirements

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

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

L.A. Care does not contract, credential, refer, or pay claims to Providers who have opted out of participation in the Medicare and Medicaid programs.

7.1.A.1 Practitioners, Providers, individuals, and businesses must not be:

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

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

7.2 Credentialing Requirements

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

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

7.2.A Providers must:

1. Submit completed credentialing applications and provide supporting documentation
   - Credentialing applications and reapplications are required to include a list of all practice locations for which the Provider will service an L.A. Care Member
   - Also, it must include facility office hours, Provider's specific hours onsite, National Provider Identifier (NPI) for each Provider, and tax ID for claims billing
2. Provide evidence of a valid license to practice in the State of California
3. Have a valid Drug Enforcement Administration (DEA) license and be able to dispense schedules II through V, as applicable to their specialty type
   - If a Provider is unable to dispense (schedules II through V), or schedules according to their Provider type, they must have an agreement with a practitioner (who is contracted and credentialed with L.A. Care) and who is able and willing to dispense (schedules II through V) or schedules according to their Provider type to L.A. Care Members
   - The practitioner willing to dispense (schedules II through V) or schedules according to their Provider type must be present at the same site as the Provider who is unable to dispense these schedules
   - The agreement must be signed and dated by the contracted Provider providing coverage, and a copy of the agreement must be submitted to the L.A. Care Credentialing Department
4. Have current professional or general liability insurance coverage in the minimum amount of $1 million per occurrence and $3 million aggregate
5. Have clinical privileges in good standing at an L.A. Care contracted facility and not have any history of loss or limitation of clinical privileges or disciplinary action(s)

- If a Provider does not have clinical privileges, they must submit a written agreement for inpatient coverage at an L.A. Care contracted facility for the Members that should or may require hospitalization
- The arrangement must be with a Provider participating in the L.A. Care network with an appropriate specialty

6. All primary care physicians (PCPs) must have a valid Facility Site Review (FSR) completed within 36 months of initial and recredentialing
7. Must maintain licensure or certifications in good standing
8. Must be enrolled in CMS or DHCS fee-for-service (FFS) or DHCS Ordering, Referring and Prescribing (ORP), for all Providers with a state level pathway
9. Promptly notify the L.A. Care Credentialing Department of any changes in information submitted as part of the credentialing eligibility criteria, and submit these changes no later than 15 business days from the date of action
10. Race and ethnicity information may be provided on a voluntary basis and will be collected for diversity, inclusion, and equity measures

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

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

7.2.C.1 If the identified Provider has Member enrollment**:**

- Close Provider's panel to new Members upon license expiration.
- Notify Participating Physician Group (PPG) of expiration and possible reassignment of Members.
- Remove assigned Members from unlicensed Provider within five (5) business days following license expiration, if not renewed.
- Reassign members to a qualified licensed and credentialed Provider.
- Remove unlicensed Provider from the L.A. Care network.

7.2.C.2 If the identified Provider does not have Member enrollment:

- Close Provider's panel to new Members.
- If Provider has not renewed their license by the fifth business day following the expiration date, the unlicensed Provider will be removed from the L.A. Care network.

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

- **By Fax:**
  (213) 438-5705
- **By Email:**
  Credinfo@lacare.org

7.3 Provider Extenders

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

7.3.A Employed extenders include the following:

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

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

7.4 Adverse Issues, Complaints, and Sanctions

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

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

7.4.A Any identified Providers are informed through a letter, directly or through their contracted entity, as appropriate. Providers and/or contracted entity will have five (5) business days to respond to L.A. Care's notifications. The Chair will determine if a corrective action plan (CAP) is required from the Provider or contracted entity. Providers and contracted entity must submit a response to the L.A. Care Credentialing department via email.

- **By Email:**
  JClark@lacare.org
  Cc: Credinfo@lacare.org

7.4.B Based upon the sanction type, additional safeguards and actions may be put in place to ensure no potential risk to L.A. Care Members that could adversely affect a Member's health, safety, or welfare.

Appropriate action will be taken to improve quality of care or professional conduct of a Provider which may include, but is not limited to, the following:

- Corrective action plan (CAP)
- Verbal warning and counseling
- Written warning notification
- Educational letter with policies and procedures
- Mandatory continuing medical education (CME)
- Mandatory skill competency training
- Proctoring
- Restriction

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

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

7.4.C Provider and/or contracted entity must notify Credentialing, promptly and no later than 14 calendar days from the occurrence of any of the following:

- Receipt of written notice of any adverse action taken by or pending on the part of the Medical Board of California, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting Provider's license to practice medicine;
- Any adverse action taken by any healthcare organization which resulted in the filing of a Health & Safety Code Section 805 report with the Medical Board of California or with the National Practitioner Data Bank;
- The denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of medical staff membership or clinical privileges at any Healthcare organization;
- Any material reduction in professional liability insurance coverage;
- Receipt of written notice of any legal action including, without limitation, any filed and served malpractice or arbitration action;
- Conviction of any crime (excluding minor traffic violations);
- Receipt of written notice of any adverse actions taken by the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

7.5 Credentialing Requirements for Health Delivery Organizations (HDOs)

Providers are institutions or organizations where Members are directed for services rather than being directed to a specific practitioner. L.A. Care defines these as Health Delivery Organizations (HDO).

Prior to contracting with an HDO, the Credentialing Department evaluates the quality and verifies the eligibility of all HDOs to ensure they have the legal authority and have met all applicable state and federal regulations, accreditation standards, and the policies and procedures of L.A. Care as part of the initial credentialing, ongoing monitoring, and recredentialing process.

7.5.A HDOs must:

1. Submit a completed, signed, and dated L.A. Care ancillary application and provide supporting documentation
   - Be enrolled in CMS or DHCS fee-for-service (FFS) for all Providers with a state-level pathway
   - Include a list of all practice locations where services will be provided to an L.A. Care Member, including a list of services provided at those locations
   - Include facility office hours, National Provider Identifier (NPI), languages spoken at the practice location, availability of, translation services, and tax ID for claims billing
2. Provide evidence of a valid license to operate or practice in the State of California

3. Have current professional or general liability insurance coverage in the minimum amount of $1 million per occurrence and $3 million aggregate
4. Provide Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
5. Provide evidence of Accreditation or DHCS state survey/approval within three (3) years of the date of the application
6. Submit Department of Aging (DPA) approval letter for Community Based Adult Services (CBAS) and Adult Day Care Health Center (ADHC)
7. Provide current Request for Taxpayer Identification Number and Certification (Form W-9)

7.6 Credentialing Requirements for Hospitals

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

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

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

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

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

7.6.A.2 Hospitals are required to maintain valid accreditation; failure to do so will result in termination. Hospitals shall submit credentialing documents to the L.A. Care Credentialing Department via fax or email.

- **By Fax:**
  (213) 438-5705
- **By Email:**
  Credinfo@lacare.org

7.7 Delegation Agreement

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

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

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

7.8 Delegation of Credentialing

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

7.8.A L.A. Care will:

- Retain responsibility for credentialing and recredentialing Providers in its network, whether it delegates all or part of these activities
- Retain the right, based on eligibility requirements and quality issues, to approve, suspend, and terminate individual Providers in situations where it has delegated decision making
- Determine, at its sole discretion, to delegate credentialing functions regardless of audit results or scores

7.8.B L.A. Care may delegate any credentialing activities and, upon the decision to do so, shall ensure that the delegated entity passes a pre-delegation assessment and continues to meet all L.A. Care requirements on an ongoing basis by reviewing monthly and quarterly credentialing activity reports, as well as conducting periodic and annual delegation oversite audits.

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

7.9 Audit Activities

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

7.9.A Upon completion of a pre-contractual assessment, focus, periodic, or annual oversight audit, the Credentialing Department will analyze and score the audit appropriately, identify any deficiencies, and report results to the Compliance Enterprise Performance Optimization (EPO) Department.

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

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

7.10 Delegated Entities Required Reporting

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

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

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

- Actions taken by the PPG or delegated entity
- Type of monitoring being performed
- Interventions being implemented, including closing panels, moving Members, or removal from the network
- Timeframe for responding to L.A. Care

7.10.B L.A. Care retains the sole authority to determine the timeframe which will be on a case-by-case basis depending on the severity of the adverse event. The objective is to ensure our delegates perform their delegated functions fairly and objectively. Proper safeguards are put in place to ensure that L.A. Care Members are protected from potential quality of care concerns.

7.11 For More Information

For questions regarding the information provided in this chapter, please contact the Credentialing Department via email at **Credinfo@lacare.org**.

Chapter 8 – Provider Network Management (PNM)

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

For information tailored to our Direct Network Providers, please refer to ***Direct Network Contracted Provider Reference Guide.***

8.0 Introduction

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

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

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

8.1 Provider Agreement

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

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

8.2 Newly Contracted Participating Physician Groups (PPGs)

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

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

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

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

8.3 Provider's Point-of-Contact

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

8.4 Important Updates

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

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

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

8.5 Provider Network Management (PNM) Contact Information

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

- **By Mail:**
  L.A. Care Health Plan
  Attn: Provider Network Management
  1055 W. 7th Street, 10th Floor
  Los Angeles, CA 90017
- **By Phone:**
  Provider Solution Center at (866) 522-2736
- **By Email:**
  Assigned Provider Network Account Manager or **ProviderRelations@lacare.org**

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

8.6 Provider Network Changes

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

8.7 Changes to Service Locations or Scope of Services

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

8.8 Provider Panels

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

8.9 Primary Care and Mid-Level Practitioner Capacity

Primary Care Physicians, including practitioners of general medicine, family practice, internal medicine, obstetrics and gynecology (OB/GYN) and pediatrics (PCPs), are allowed a maximum membership capacity of 2,000 Members when there is no non-physician practitioner (mid-level extender) support. A single non-physician practitioner can potentially increase the supervising PCP's total membership capacity by 1,000 Members. However, the PCP cannot be assigned a total of more than 5,000 Members, including membership assigned across all product line, Plan Partners, or PPG contracts within the L.A. Care network. Please note that physician panels are closed at 95% of capacity.

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

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

8.10 Reporting Directory Inaccuracies

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

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

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

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

8.11 Updates to the Provider Directory

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

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

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

8.11.B Printed Provider Directory is updated monthly.

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

8.11.C Removing a Provider from the Provider Directory L.A. Care shall delete a Provider from the directory upon confirmation of any of the following:

- Provider has retired or otherwise has ceased to practice
- Provider is no longer under contract with L.A. Care or an affiliate
- If a provider does not verify information as requested by L.A. Care

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

8.12 Provider Compliance with Required Updates to the Provider Directory

L.A. Care, at least annually, will review and update the entire Provider Directory. Each calendar year, each PPG will validate their provider network. PPGs must submit accurate and timely provider data through the appropriate established process in order to ensure complete and updated in-network provider information is available to Members and prospective beneficiaries. Updated provider directories are located on the L.A. Care website. Directories are also available to Providers in hard copy upon request.

8.12.A L.A. Care's notice to its Providers for failure to timely respond to a request to verify and update their information shall include all of the following:

- The information L.A. Care has in its directory regarding the Provider, including a list of networks and plan products that include the contracted Provider
- Instructions on how the Provider can update the information in the Provider Directory using the L.A. Care online interface

8.13 Hospital Privileges

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

8.14 Provider's Responsibility

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

8.14.A In the event, the Provider fails to provide the response within 30 business days, L.A. Care shall take the following steps:

- Attempt to verify whether the Provider's information is correct or requires updates for a maximum of 15 business days. L.A. Care shall document the receipt and outcome of each verification attempt.
- If L.A. Care is unable to verify the Provider's information, L.A. Care shall notify the Provider, at least 10 business days in advance of removal, that the Provider will be removed from the Provider Directory.
- The Provider shall be removed from the Provider Directory at the next required update of the Provider Directory after the 10 business day notice period.

8.14.B If the Provider responds before the end of the 10 business day notice period, the Provider shall not be removed from the Provider Directory. Upon completion of verification of or submission of changes to the information, the Provider shall receive an electronic acknowledgment from L.A. Care.

8.15 Economic Profiling

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

8.16 After-Hours System

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

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

8.17 Provider Training

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

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

PPGs, which are delegated activities in their agreements, for more information on regulatory required Provider Trainings, please visit the Delegation Oversight Delegated Entities Manual here: **https://www.lacare.org/sites/default/files/la3369_delegation_oversight_manual_202103.pdf**.

8.18 Provider Grievance

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

PPGs, which are delegated activities in their agreements, for more information on the minimum standards for Appeals and Grievances, please visit the Delegation Oversight Delegated Entities Manual here: **https://www.lacare.org/sites/default/files/la3369_delegation_oversight_manual_202103.pdf**.

8.19 For More Information

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

Chapter 9 – Health Education

This chapter applies to: L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), L.A. Care Medicare Plus (HMO D-SNP), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

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

9.0 Introduction

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

9.1 Provider Responsibility

Providers are responsible for:

- Conducting point-of-service education during routine office visits and wellness exams.
- Accessing the appropriate Health Education Referral Form(s) to refer Members. To access the forms, please visit the Forms and Manuals section under Provider Resource at: **https://www.lacare.org/providers/provider-resources/forms-manuals**
- Maintaining and distributing an adequate supply of health education materials in topics and languages appropriate for the Provider's patient population. Easy-to-read, culturally sensitive materials may be ordered by visiting the L.A. Care Health Education/Cultural & Linguistic Materials Portal at: **https://www.lacare.org/providers/provider-resources/tools-toolkits/health-education-tools**
- Conducting an initial and annual assessment of tobacco use for each adolescent and adult beneficiary and providing or referring Members to tobacco cessation counseling as appropriate

For more information on Initial Health Appointments, please refer to Chapter 3 – Access to Care.

9.2 Provider Education

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

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

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

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

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

- Communication to Providers of both applicable regulatory agencies and L.A. Care Health Education Program requirements
- The availability of health education services and resources
- The availability of health education materials and the process for obtaining materials
- The inclusion of health education material requirements:
  - Availability of materials in alternative formats
  - Cultural and linguistic appropriateness
  - Medical accuracy
  - Reading level and field testing (if applicable)
  - Qualified health educator oversight
- HMO D-SNP initial and annual Model of Care training
- HMO D-SNP Dementia caregiver training*

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

9.3 Health Education Programs

L.A. Care Health Education Programs are a combination of coordinated and systematic health education services, resources, and Member outreach designed to target a specific health problem or population. Eligible Members are identified for participation in these programs based on specific inclusion criteria for each program.

9.3.A Programs are available at no cost to Members:

- **Diabetes Prevention Program**
  L.A. Care identifies pre-diabetic Members to provide in-person and/or online health education and coaching to help Members prevent or delay the onset of type 2 diabetes through healthy lifestyle choices and weight loss.

- **Fight the Flu Program**
  L.A. Care uses a coordinated series of communication methods to encourage Members to obtain a flu shot. Outreach efforts include:
  - Newsletters
  - Emails
  - Postcards
  - Promotional incentives (HMO D-SNP Members Only)
  - Automated phone calls with targeted flu messaging
  - Thank you cards which also help Members remember they received a flu shot

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

- **Topics of expertise include the following:**
  - Diabetes Self-Management Education
  - Pre-Diabetes
  - Senior health topics such as fall prevention and osteoporosis
  - Smoking cessation
  - Weight Management for Adults
  - Pediatric Healthy Lifestyle

- **Medical Nutrition Therapy (MNT) and Medically Tailored Meals (MTM)**
  Registered Dietitian (RD) consults for common conditions which are available with a treating Provider referral.

  PPGs are responsible for providing MNT for conditions treated though specialty care such as:
  - Bariatric surgery;
  - Dialysis;
  - Eating disorders;
  - Gestational diabetes;
  - High risk pediatrics; and
  - Complex cases needing a higher level of nutrition care.

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

  *MTM are meals designed and/or approved by a Registered Dietitian that reflect appropriate nutrition therapy based on evidence-based guidelines.

  L.A. Care MCLA Members with select conditions qualify for 12 weeks of two (2) meals per day of home-delivered meals, with possible extension when medically indicated.*

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

- **Healthy Pregnancy Program**
  L.A. Care identifies pregnant Members by conducting outreach through the provision of educational materials and assistance. L.A. Care educates Members on the importance of prenatal visits and links them to community resources.

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

  *L.A. Care offers doula services to eligible Medi-Cal Members who are pregnant or pregnant within one (1) year. Doula services are available for prenatal, perinatal and postpartum Members. HMO D-SNP Members may access doula services through their Medi-Cal benefits.

Doulas offer various types of support, including:

- Development of a birth plan
- Health navigation
- Lactation support
- Linkages to community-based resources*

- **Smoke-Free Program**
  Adult L.A. Care Members who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, inhaler, nasal spray, Bupropion SR, Varenicline) receive health education mailings that include smoking cessation health education materials and community resources that offer free in-person education and over-the-phone counseling provided by Kick It California. For more information, please visit: **https://kickitca.org/**.

- **Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes/Diabetes + Chronic Kidney Disease (CKD) and High-Risk Pregnancy Education**
  "L.A. Cares about Asthma," "L.A. Cares about COPD," "L.A. Cares about Diabetes," and "Healthy Pregnancy" are programs focusing on education and support. Identified Members are sent a welcome letter inviting them to create an account for the L.A. Care health and wellness portal, My Health in MotionTM (MyHIM). MyHIM houses multiple resources including health education materials and videos, access to health coaches via messaging, and self-paced workshops. Health education materials and access to telephone consults are available for members unable to access MyHIM online.

- **Digital Health Literacy**
  The following section/sentence is only applicable to (as denoted between the asterisks) L.A. Care Medicare Plus (HMO D-SNP).

  L.A. Care offers digital health literacy education to Members needing assistance to access digital health information including telehealth.*

To refer a Member, please use the Health Education Referral Form link listed in 9.3.B.

9.3.B Providers can refer Members for Health Education services by completing and faxing the pertinent L.A. Care Health Education Referral form(s) located here:

- **Health Education Referral Form:**
  https://www.lacare.org/sites/default/files/la3144_hecls_form_202010rev.pdf

- **Medical Nutrition Therapy (MNT) Referral Form:**
  https://www.lacare.org/sites/default/files/la3144_mnt_form_202010rev.pdf

- **Medically Tailored Meals (MTM) Referral Form:**
  https://www.lacare.org/sites/default/files/la3710_mtm_referral_form_202201.pdf

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

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

9.4 Health Education Resources

L.A. Care makes available free hard copies of health education materials in multiple topics and languages.

Health Education topics include, but are not limited to the following:

Health Education Topics	
Asthma	Immunizations
Breastfeeding	Injury Prevention
Dental	Nutrition
Diabetes	Parenting
Exercise	Perinatal/Pregnancy
Family Planning	Substance Abuse
HIV/STD Prevention	Tobacco Prevention/Cessation
Hypertension	Weight Management* and more
*Bariatric Nutrition Services are the responsibility of the Providers/PPGs	

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

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

9.5 Community Resource Centers (CRC)

L.A. Care and Blue Shield Promise jointly operate a Community Resource Center (CRC) network across Los Angeles County. By 2024, the health plans will jointly operate 14 centers. The CRCs offer a broad array of no-cost programming, classes, and resources to help health plan Members and others in the community stay active, healthy, and informed. The centers also provide on-site support from community social service organizations focused on addressing social determinants of health such as food and income security.

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

9.5.A Appointment Scheduler

For Members who would like to visit one (1) of the centers, the CRC appointment scheduler tool can be used to schedule an appointment online, please visit: **https://www.communityresourcecenterla.org/services/schedule-your-visit**

9.5.B Resources Currently Offered at the Centers:

- Dance and Fitness Classes
- Health and Wellness Classes
- Social Services Assistance
- Medi-Cal Enrollment and Renewal Support
- Free WiFi and private space for telemedicine consultations

- YouTube Channel for the CRC virtual classes can be located here: **https://www.youtube.com/channel/UC7gl-PNZQz9w1Ju2ArTT9mg/**.

For more information on the CRCs, please call the L.A. Care and Blue Shield Promise Health Plan Community Resource Centers phone line at (877) 287-6290 or visit: **www.communityresourcecenterla.org**.

9.6 Nurse Advice Line (NAL)

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

9.6.A The HEAR library has pre-recorded messages on health topics that provide information you need to help:

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

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

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

Providers are encouraged to share this information with Members.

- L.A. Care Nurse Advice line (NAL): (800) 249-3619 TTY (711)
- Anthem Blue Cross Nurse Line: (800) 224-0336 or TTY (711)
- Blue Shield of California Promise Health Plan Nurse Advise Line (NAL): (800) 609-4166 or TTY (711)

9.7 For More Information

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

Chapter 10 – Cultural and Linguistics

This chapter applies to: L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), L.A. Care Medi-Cal (MCLA), L.A. Care Medicare Plus (HMO D-SNP), and Homecare Workers Health Care Plan (PASC-SEIU), unless otherwise noted.

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

10.0 Introduction

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

Key Responsibilities:

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

10.1 Cultural and Linguistic (C&L) Program

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

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

10.2 Language Assistance and Auxiliary Services

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

10.3 Assessing Bilingual Language Proficiency

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

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

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

10.3.B For HMO D-SNP, Providers must report their cultural and linguistic capabilities to L.A. Care to be included in the Provider Directory. Please see the Chapter 8 – Provider Network Management (PNM) for guidance on updating the Provider Directory.

10.4 Interpreting Services and Auxiliary Services

Providers shall ensure that Members have access to timely interpreting services 24 hours a day, seven (7) days a week, in any language requested by Members including American Sign Language (ASL) at no-cost to Members at both medical and non-medical points of contact. Providers shall make interpreting services available in a manner that does not impede or delay a Member's timely access to care.

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

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

10.4.B Key responsibilities include the following:

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

10.5 Requesting Interpreting Services

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

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

- HMO D-SNP: (833) 522-3767 (TTY 711)
- LACC/D: (855) 270-2327 (TTY 711)
- MCLA: (888) 839-9909 (TTY 711)
- PASC-SEIU: (844) 854-7272 (TTY 711)

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

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

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

10.6 Referral to Culturally and Linguistically Appropriate Services

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

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

10.7 California Relay Service (CRS) – 711

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

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

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

Please see below for a list of the identified languages:

Arabic	Hmong	Korean	Spanish	Vietnamese
Armenian	Hindi	Lao*	Russian	Ukrainian*
Chinese	Japanese	Mien*	Tagalog	--
Farsi	Khmer	Punjabi	Thai	--

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

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

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

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

10.9 Translation Services and Alternative Formats

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

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

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

- MCLA and HMO D-SNP (10 non-English threshold languages):
  1. Arabic
  2. Armenian
  3. Cambodian (Khmer)
  4. Chinese
  5. Farsi
  6. Korean
  7. Russian
  8. Spanish
  9. Tagalog
  10. Vietnamese

- LACC (2 non-English threshold languages):
  1. Chinese
  2. Spanish

- PASC-SEIU (2 non-English threshold languages):
  1. Armenian
  2. Spanish

For L.A. Care Medi-Cal (MCLA), Providers and delegated entities must report any new Member's alternative format selection (AFS) at the time of the Member's request directly to the Department of Health Care Services (DHCS). To make a report, please visit: **https://afs.dhcs.ca.gov/** or call the AFS Helpline at (833) 284-0040.

10.10 Member Informing Documents (also known as Vital Documents)

The written Member Informing Documents are documents that affect access to, retention in, or termination or exclusion from a Member's program services or benefits, which include, but are not limited to, the following:

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

10.10.A To ensure that translation is complete, accurate, and kept confidential, documents must be translated, edited, and proofread by a qualified translator. Additionally, qualified translators must adhere to generally accepted translator ethics principles, including client confidentiality, proficiency in writing and understanding both written English and at least one (1) other written non-English language, and the ability to translate effectively, accurately, and impartially to and from such language and English, using any necessary specialized vocabulary, terminology and phraseology.

10.10.B L.A. Care provides translated notice of action (NOA) letter templates in a regular font size. Delegated entities including PPGs must mail fully translated NOA letters including the inserted Member's specific information in the NOA letter template within the regulatory timelines in the Member's threshold language and format. Please refer to the DHCS All Plan Letter (APL) 21-011 and APL 22-002 for additional requirements and timelines pertaining to translated NOA letters. To obtain the translated NOA letter templates, language assistance notice (taglines) and NDN, delegated entities, including PPGs, can email: **EPOCommunications@lacare.org**. Delegated entities including PPGs must insert their own contact information (e.g. phone number) in the templates before use.

10.11 Reporting Requirements

Delegated entities shall submit the following reports, as specified in the contract, via the L.A. Care File Transfer Protocol (FTP) site or email to the C&L Unit at **CL_Reports_Mailbox@lacare.org**.

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

Annual Reports	Quarterly Reports
• C&L program description • Bilingual staff list	• Translation and Alternative format • Face-to-face and/or telephonic interpreting • C&L referral
• January 31st	• Quarter 1 on May 15th • Quarter 2 on August 15th • Quarter 3 on November 15th • Quarter 4 on February 15th

Delegated entities must use either L.A. Care's reporting template or mutually agreed report format that meets L.A. Care's requirements.

For the most up-to-date reporting templates, please email: **CL_Reports_Mailbox@lacare.org**.

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

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

- Tagline (Language Assistance Notice) signage
- Telephonic interpreting card
- C&L provider toolkit "Providing Language Services for Diverse Populations"
- ember language assistance brochure

10.12.A How to order:

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

10.13 For More Information

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

Chapter 11 – Finance

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

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

11.0 Introduction

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

11.1 Balance Billing

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

11.2 Records, Reports, and Inspection

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

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

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

11.2.B The Provider's books and records must be maintained for a minimum of 10 years from the end of the fiscal year in which its L.A. Care contract expires or is terminated. In the event the Provider has been notified by the DMHC or other applicable regulatory agency that it has initiated an audit or investigation of L.A. Care, the Provider, or the agreement, the Provider will retain these records for the greater of the above timeframe or until the matter under audit or investigation has been resolved.

11.3 Records

All Providers must maintain all books, records, and other pertinent information that will ensure their compliance with the L.A. Care agreement and regulatory agency requirements for 10 years from the end of the fiscal period in which its agreement with L.A. Care terminates. These books, records, and other information must be maintained in accordance with generally accepted accounting principles (GAAP). Also, they must conform to applicable federal and state law and Department of Health Care Services (DHCS) and DMHC regulations.

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

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

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

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

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

11.4 Inspection of Records and Facilities

At any time during normal business hours, the Provider must allow L.A. Care, DMHC, and any authorized state or federal agency to inspect, evaluate and audit any and all books, records, and facilities maintained by the Provider and its affiliates. These records pertain to services rendered under the Provider agreement and are subject to confidentiality restrictions.

11.5 Reimbursement Services and Reports

In accordance with the provisions of the Provider's subcontracts, the Provider will perform all normal reimbursement services, including:

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

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

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

11.6 Monthly Eligibility List (E-List)

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

11.7 Monthly Capitation Input Report

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

11.7.A Summarized Statement – Capitation

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

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

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

11.8 Monthly and Quarterly Claims Reporting

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

11.8.A The Monthly Claims Timeliness Report, that is the first two (2) months of each quarter are due to the health plans on or before the 15th calendar day of each month following the month being reported.

11.8.B The Quarterly Claims Timeliness Report is due for both the third (3rd) month of the quarter and the quarter itself as follows:

Calendar Quarter	Due Date
First	April 30
Second	July 31
Third	October 31
Fourth	January 31

Delegated payer's principal officer(s) must sign or personally transmit those reports to L.A. Care. The reports include a statement attesting to the accuracy of the information. Please submit these reports via e-mail at **AB1455ClaimsReportetal@lacare.org**.

11.9 Financial Statements

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

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

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

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

11.10 Minimum Financial Solvency Standards

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

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

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

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

11.10.C Providers shall also immediately notify L.A. Care if an affiliated Provider is unable to meet its financial obligations and shall forward any findings, recommendations, reports, and other information as requested by L.A. Care.

Requested items should be submitted in writing to the L.A. Care Financial Compliance Department within 30 days as stated in their agreement with L.A. Care and should include the following:

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

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

11.11 Insurance

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

11.11.A Each Provider must maintain adequate insurance as follows:

1. **Directors and Officers Insurance:**
   PPGs must purchase a Directors and Officers (D&O) policy coverage for claims made against directors and officers of the company and must be written on a claims made basis. Minimum liability limits are $100,000 for each claim and $100,000 in aggregate for each policy period.
2. **Errors and Omissions Insurance:**
   PPGs must purchase Errors and Omissions (E&O) Insurance that covers managed care activities. The insurance policy shall be written on a claims made basis. Minimum liability limits are $100,000 for each claim and $100,000 in aggregate for each policy period.
3. **General Liability Insurance:**
   PPGs must have a policy in force for General Liability Insurance, which is maintained at minimum amounts acceptable to L.A. Care. This covers any property loss not covered under any lease agreement with the landlord or contract agreement with the management company. Minimum liability limits are $100,000 for each claim and $300,000 in aggregate under each policy period.

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

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

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

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

   For Capitated Hospitals, the coverage must cover limits of not less than $5,000,000 per occurrence and $10,000,000 in aggregate for the year of coverage. Hospital's Professional Liability Insurance shall be either "claims made" or "per occurrence" at the discretion of the Hospital; provided that if Hospital elects "claims made" coverage, it shall provide tail coverage upon the expiration or termination of its contract with L.A. Care with such commercially reasonable limits and for such commercially reasonable time period as the parties mutually agree.
5. **Stop-Loss Insurance:**
   The Provider will acquire Stop-Loss Insurance in effect to adequately cover the PPG or Provider catastrophic cases in a reasonable amount acceptable to L.A. Care and in accordance with the applicable laws, regulations, and industry standards. Minimum coverage is set at $30,000 plus 50% of any medically necessary billed charges.
6. **Independent Certified Public Accounting (CPA) Firm Liability Insurance:**
   The PPG must engage a CPA firm with adequate Liability Insurance. The PPG will verify that the independent CPA firm conducting its financial statement audit maintains Professional Liability Insurance. The CPA firm must at minimum maintain $250,000 Professional Liability in aggregate, at its own expense throughout the term of this agreement and for the year of coverage. Any other amount of coverage must be acceptable to and permitted by L.A. Care in writing.

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

11.12 License

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

11.13 For More Information

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

Chapter 12 – Claims and Payment

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.

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

12.0 Introduction

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

Key responsibilities include:

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

Main functions include:

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

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

12.1 Member Eligibility and Claim Status

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

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

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

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

6. Please note: Providers can also check claim status from the same menu options
7. From menu, select option: **Search All Claims** or **Search a Claim**
8. Enter requested claim information marked with an asterisk, as required
9. Click: **Submit** to see claim status

- **L.A. Care Provider Solution Center** at (866) 522-2736
  1. Select option: one (1) for **Eligibility**, two (2) for **Claims Status**, three (3) for **Payment Dispute**, four (4) for **Prior Authorization**, and five (5) for **Contracting**
  2. Follow Interactive Voice Response (IVR) instructions
  3. Enter requested Member information
  4. IVR will telephonically disclose Member information
  5. For further inquiries, Providers can stay on the line to speak with a representative during business hours: Monday thru Friday (8:00 AM to 6:00 PM PST).

12.2 Claim Forms

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

Available claim forms include:

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

12.3 Claims Submission (Billing)

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

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

- Hard Copy (Paper) Claims
- Electronic Claims

12.4 Hard Copy (Paper) Claim Submission

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

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

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

12.5 Electronic Claim Submission

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

Advantages of using EDI for submission of claims:

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

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

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

Electronic billing options:

1. **Change Healthcare**
   Change Healthcare is a healthcare technology company that offers services to help simplify billing, collection and payment processes for payers and Providers. L.A. Care has contracted with Change Healthcare to become the exclusive clearinghouse for the submission of all EDI claims at a cost to Providers.

   To register or for questions regarding the submission process of a claim, Providers can call the Change Healthcare Customer Support line at (877) 363-3666 or visit: **https://www.changehealthcare.com/**

   Please note: L.A. Care's Payer ID: LACAR
2. Third (3rd) Party Billing Service or Clearinghouse that bills directly through Change Healthcare

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

12.6 Electronic Funds Transfer (EFT) – Direct Deposit

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

Advantages of using EFT for claims payments:

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

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

12.7 PaySpan Health

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

To request a new registration code:

1. PaySpan Registration Code: **https://www.payspanhealth.com/ProviderPortal/Registration**
   After registration, Providers should log into their account and follow the steps below to add L.A. Care as a new payer to their account.

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

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

12.8 Claim Billing Requirements and Resources

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

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

- Clean Claims Billing CMS 1500 Form:
  https://www.lacare.org/sites/default/files/Clean%20Claim%20Billing%20Requirements%20CMS%201500%20PDF.pdf
- Clean Claims Billing UB-04 Form:
  https://www.lacare.org/sites/default/files/clean_claim_billing_requirements_ub_04_20190425.pdf

12.8.A Claims must include information and/or guidelines as indicated by the following websites:

Regulatory Agency or Organization	Website
Centers for Medicare and Medicaid Services (CMS)	**https://www.cms.gov/**
Department of Health Care Services (DHCS)	**https://www.dhcs.ca.gov/**
Department of Managed Health Care (DMHC)	**https://www.dmhc.ca.gov/**
National Uniform Billing Committee (NUBC)	**https://www.nubc.org/**
National Uniform Claims Committee (NUCC)	**https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42**

Providers are required to have an approved authorization for all services prior to submission of a claim. Authorization exclusions include but are not limited to services such as emergency services, sensitive services, and family planning services.

Billing for services not authorized and/or for services not included in the authorization may result in a denial of the service and/or the entire claim.

12.9 Timely Filing

Submitted claims must be complete with all required information to ensure timely processing and payment as stipulated in the Provider's agreement.

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

Line of Business	Timely Filing Limit
LACC/D	Within 180 days from the date of service
MCLA	Within 180 days from the date of service
PASC-SEIU	Within 180 days from the date of service

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

12.10 Claim Processing Timeframes

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

Line of Business	Timely Processing of a Clean Claim	Regulatory Agency
LACC/D	45 working days	DHCS and DMHC
MCLA	30 calendar to 45 working days	DHCS and DMHC
PASC-SEIU	45 working days	DHCS and DMHC

12.11 Claims Timeliness Report

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

If the aggregate results for the quarter do not meet the on-time standard for the LOB, then the delegate must include the days receipt on hand (DROH), and a corrected action plan (CAP) must be attached to the final report.

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

12.12 Misdirected Claims

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

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

12.12.A For Claims that are not the financial responsibility of L.A. Care, within 10 working days of receipt, L.A. Care will either:

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

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

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

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

12.13 Financial Responsibility

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

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

Irrespective of who is at financial risk for the services rendered, Providers are still responsible for complying with and obtaining prior authorization for services, for timely and accurate claim submission, and coordination of care.

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

- Provider Authorization and Billing Reference Guide:
  https://www.lacare.org/sites/default/files/la3391_prior_auth_and_billing_reference_guide_202104.pdf
- Skilled Nursing Facility (SNF) Reference Guide:
  https://www.lacare.org/sites/default/files/universal/la2945_snf_reference_guide_202008-2.pdf

12.14 Coordination of Benefits

1. **Primary Payor**
   According to the Coordination of Benefits rule, another payor may be primarily or secondarily responsible for the payment of Covered Services rendered to Members. In those situations, Providers should submit claims in accordance with coordination of benefit rules as follows:-
   - Bill a payor that may be primary under applicable Coordination of Benefit rules for Provider Services provided to Members when information regarding such primary payor becomes available. When another payor besides L.A. Care is primary, Providers must follow the primary payor's billing rules.
   - If L.A. Care is determined to be the primary payor, L.A. Care will pay the Provider in accordance with the applicable contract, fee schedule, or Usual, Customary, and Reasonable (UCR) rate for services provided to Members without regard to the obligations of any secondary payors. Providers should not seek additional reimbursement from any secondary payors or from Members, except for deductibles, co-payments, or co-insurance amounts owed by Members under the terms of the Member's benefit plan.
   - For more information on CMS Coordination of Benefits, please visit: **https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits**
   - For more information on Medi-Cal Coordination of Benefits, please visit: **Medicare/Medi-Cal Crossover Claims Overview (medicare)**

2. **Secondary Payor**
   In the event that L.A. Care is not the primary payor, but rather the secondary payor because of Coordination of Benefits, Providers should submit a clean claim to L.A. Care within 180 calendar days from the date of the primary payor's determination. In the submission, Providers must include the primary payor's RA that includes the following:
   - Name of Primary payor (ex Noridian)
   - Date of Primary payor's payment
   - Amount paid by the primary payor
   - Primary payor's denial that includes denial rational

   L.A. Care, as a secondary payor, will coordinate benefits with the primary payor.
   L.A. Care may pay:
   - Deductibles
   - Co-insurance and
   - Co-payments for covered services up to the lower amount of its fee schedule or the Medicare/other insurance-allowed amount
   - Medicare Non-covered services – if covered under Medi-Cal and/or is included in a Provider's contract or the Members evidence of coverage (EOC)
   - Welfare and Institutions Code limits Medi-Cal's payment of the deductible and coinsurance to an amount which, when combined with the Medicare payment, does not exceed the Medi-Cal fee-for-service (FFS) rate

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

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

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

12.15 Fee-for-Service (FFS) Claims

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

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

Line of Business	Days
LACC/D	45 working days
MCLA	30 calendar days, up to 45 working days
PASC-SEIU	45 working days

12.16 Balance Billing

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

12.16.A Providers are prohibited from billing MCLA Members with the exception of share of cost (SOC). Providers can only bill LACC/LACCD/PASC-SEIU Members for authorized deductibles, co-payment, co-insurance, or non-covered services agreed to by a Member.

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

For more information on financial topics, please refer to Chapter 11 – Finance.

12.17 Share of Cost (SOC)

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

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

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

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

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

12.18 Fraud, Waste, and/or Abuse

L.A. Care is required to take affirmative steps to detect, investigate, and prevent fraud, waste, and/or abuse. The Payment Integrity team has designed their activities to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care, and preventing fraud, waste, and abuse from taking place.

To that end, the following initiatives were implemented to ensure that:

- Eligibility decisions are made correctly;
- Prospective and enrolled providers meet federal and state participation requirements;
- Services provided to enrollees are medically necessary and appropriate; and
- Provider payments are made in the correct amount and for appropriate services.

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

Please see the Chapter 15 – Compliance Program Integrity for additional guidance on Fraud, Waste, and/or Abuse.

12.18.A Overpayments To redress the overpayments itemized in the detailed notice, the Provider shall reply within 30 working days to acknowledge and reimburse the stated overpayments.

Failure to reply within the 30 working day response period shall, by applicable law:

- Constitute an acceptance of the overpayment details outlined in the Improper Payment Findings
- L.A. Care will deduct from future payments, and/or pursue any remedies to collect the overpayments, as permitted by law or the agreement between the parties.
- All such offset details will be included in every applicable Remittance Advice accompanying prospectively adjudicated claims

Providers who wish to avoid any such offsets against future claims, should reimburse the total overpayment amount noted in the detailed notice by mailing a refund check together with a copy of the detailed notice to:

- **By Mail:**
  L.A. Care Health Plan
  P.O. Box 740918
  Los Angeles, CA 90074-0918

Should a Provider agree to have the overpayment amounts deducted from future claims payments, they should sign and date the Improper Payments Findings notice and a copy of the letter should be faxed to L.A. Care at:

- **By Fax:**
  (213) 438-5057

If the Provider wishes to dispute the overpayments outlined in the Improper Payments Findings, a written dispute can be submitted along with a copy of the detailed notice and any supporting documentation to L.A. Care by fax or US mail at:

- **By Fax:**
  (213) 438-5057
- **By Mail:**
  L.A. Care Health Plan
  P.O. Box 740918
  Los Angeles, CA 90074

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

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

12.19 Provider Dispute Resolution (PDR)

A Provider dispute is a written notice challenging, appealing or requesting reconsideration of a claim's initial determination. Providers have a right to file a dispute in writing to L.A. Care within 365 calendar days of the health plan's last action. Providers can dispute a decision made by L.A. Care, or one of L.A. Care's delegated entities, regarding a claim submission. In addition, in cases of the health plan's inaction, Providers can file a dispute with L.A. Care within 365 calendar days after the time for contesting or denying claims has expired.

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

L.A. Care will consider the following Provider disputes:

- Adjusted claims
- Contested claims
- Denied claims
- Disputing a request for reimbursement of an overpayment to a claim
- Payment of a claim

- Seeking resolution of a payment determination
- Seeking resolution of other contract disputes relative to claims processing

Providers should not submit the following items as Provider disputes because they do not meet the L.A. Care definition of a Provider dispute and may result in the delay of processing your claim:

- Post-service/retrospective review requests occurring after medical care or services were performed.
    - For more information and for prior authorization forms, please visit: **https://www.lacare.org/providers/provider-resources/forms-manuals/prior-authorization-request-forms**.
- Initial claims submission
- Corrected claims submission
- Contract Language/Terms

Providers should submit a written notice to L.A. Care via US mail or another physical delivery for a dispute relating to the adjudication of a claim or a billing determination. Complete the Provider Dispute Resolution Request form that is located under "Claims Forms" on our website: **https://www.lacare.org/providers/provider-resources/forms-manuals**.

Disputes can be sent to the following address:

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

12.19.A Acknowledgment of Receipt of Dispute

Upon receipt, L.A. Care will review the claim dispute and provide a response via US mail within 15 working days of the date of receipt by L.A. Care. Electronically submitted claim disputes will be acknowledged within two (2) working days. A dispute submitted via fax will not be considered as an electronic dispute submission.

12.19.B Dispute Determinations

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

12.19.C Required Information for Provider Payment Dispute Notices

Should a Provider have a dispute with L.A. Care in connection with a claim payment, the Provider can first submit a written notice to L.A. Care's Provider Disputes.

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

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

1. Provider name, the tax identification number under which services were billed and contact information.
2. If the payment dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, using L.A. Care's original claim number, the date of service, and a clear explanation of the basis upon which the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is disputed.
3. If the payment dispute involves a Member or a group of Members, the name(s) and Member ID number(s), or Client Identification Number(s) (CIN) of the Member(s).
4. Second Level Disputes must state, "Second Level Dispute" and include a copy of the first level dispute filing and determination.

Providers should submit an amended Provider Payment Dispute Notice (including the missing information) within 30 business days after the date the Provider Payment Dispute Notice was received back from L.A. Care.

12.19.D Second Level Disputes

Second level disputes will be reviewed by L.A. Care. If L.A. Care's delegated entity performed the first level dispute, L.A. Care requires the delegated entity to forward all pertinent information to L.A. Care, using the process agreed upon between L.A. Care and the delegated entity. If L.A. Care performed the first level dispute, a different examiner will be assigned to review the second level dispute.

Second level disputes must be sent to the following address:

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

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

12.19.E Third Level Disputes

When the subject of the Provider dispute has been reviewed and upheld twice, the dispute will be denied, and the Provider is advised to seek relief with the DMHC. This does not apply to Medicare covered services under HMO D-SNP, which, due to requirements, if the original decision was upheld, would have already been sent to CMS's Independent Review Entity when first reviewed.

12.20 Capitation (Cap) Deduct Dispute Process

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

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

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

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

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

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

Cap Deduct Disputes must be sent to the following address:

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

12.21 Capitated Provider – Claims Dispute

The following section/sentence is only applicable to (as denoted between the asterisks): Participating Physician Group (PPG) and Capitated Hospitals.

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

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

12.22 Provider Dispute Resolution (PDR) Reporting Requirements for Delegated Entities

L.A. Care will be monitoring acknowledgement and resolution letters from the delegated entities who perform first level reviews.

L.A. Care will be monitoring how many claims are upheld by the delegated entity and will communicate to the delegated entity the expectation they will proactively forward that information to L.A. Care in anticipation of a possible second level dispute. The delegation oversight team will distribute the template to Providers.

12.23 Appeals and Grievance Process for Claims Dispute

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

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

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

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

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

12.24 Third Party Tort Liability (TPL) and Estate Recovery

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

Accidents or illnesses, which may result in TPL or estate recovery, should be reported by the Provider to L.A. Care within five (5) business days of the discovery being made.

12.24.A Should L.A. Care request details of the services provided, the Provider will submit the following information within 15 days of the date of the request and will include the following information:

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

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

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

- Name of requesting party
- Address
- Contact number

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

12.25 For More Information

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

Chapter 13 – Encounters

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

13.0 Introduction

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

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

13.1 FinThrive (formally TransUnion Healthcare)

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

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

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

13.2 Submitting Encounter Data

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

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

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

1. Submit Encounter Data to FinThrive within the parameters required by FinThrive
2. Submit their Encounter Data at least once a month
3. Submit data using the National Standard Codes; L.A. Care will only accept the National Standard Codes

Providers shall not:

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

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

- **Account Executive:**
  Doris Bermejo – Senior Consultant, Business Operations
- **By Phone:**
  (310) 337-8511
- **By Email:**
  Doris.Bermejo@finthrive.com
- **By Website:**
  https://finthrive.com/

13.3 Maximum Out-of-Pocket (MOOP)

The following section is only applicable to (as denoted in between the asterisks): L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), Homecare Workers Health Care Plan (PASC-SEIU).

* Department of Managed Health Care (DMHC) All Plan Letter (APL) 22-013 – Compliance with Senate Bill 368 - Deductible and Out-of-Pocket Accrual Balances Guidance requires health plans to provide commercial plan enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum (MOOP) until the accrual balances are met.

If the MOOP is met, the following will apply for the remainder of the calendar year unless there is a change in the Member's benefit plan and/or gap in coverage:

- Member will have no out-of-pocket responsibility.
- Providers will receive 100% of the contracted rate.

In order for L.A. Care to accurately track Member cost share accumulation and comply with APL 22-013, contracted entities (when applicable) are required to:

- Configure their systems according to the corresponding benefit plan prior to the start of the corresponding benefit year to accurately assign cost share for rendered services prior to encounters submission.
- Submit timely and complete encounters with applicable cost-share data (including copay, coinsurance, and deductible) based on the timeline requirements stated in the Provider contract.
- Modify and resubmit the medical encounters rejected and reported back to the contracted entity through L.A. Care based on the timeline requirements stated in the Provider contract.

L.A. Care will provide updates at least weekly to its contracted entities (as applicable) of accumulated out-of-pocket amounts for each of its Members. Contracted entities must:

- Utilize out-of-pocket data received from L.A. Care to properly calculate Member cost share for rendered benefits/services.
- Establish a trigger in their system once a Member meets the MOOP to prevent accruing further cost share.

13.4 Encounter Data & Member Cost Share

Encounter Data is the primary source of information about the delivery of services provided by practitioners and other Providers of care to LACC Members. Encounter Data is utilized by the Covered California and Center for Medicare and Medicaid Services (CMS) to validate the level of services provided to Members and will be used to determine current risk adjustment for Marketplace enrollees. That validation process will affect current and future reimbursement levels for our mutual Members. Therefore, accurate and timely Encounter Data from our contracted entities is extremely important. Moreover, Encounter Data that is timely, accurate, and complete is critical in being able to help consumers track their annual deductible and out-of-pocket maximum limits, while helping Providers determine whether co-payments need to be collected at the point of service. The same information provided in the Encounter Data is critical for monitoring and oversight functions, including HEDIS quality measures that L.A. Care must meet in order to continue participating in Covered California.

The Encounter Data elements required by Covered California can be found on the Covered California website here: **www.coveredca.com**.

Encounter Data should be submitted at least weekly or after each check run to ensure Member's cost-share and deductible amounts are accumulated towards the Member's MOOP timely. Services must be coded accurately, comply with national standards, and be at the code's highest specificity provided through L.A. Care's or its clearinghouse partner's operational and companion guides. Encounters rejected or denied must be corrected and resubmitted based on the timeline requirements stated in the Provider contract to meet timeliness and contractual requirements.

In order for L.A. Care to track out-of-pocket accruals, the contracted entity must populate and transmit Member cost share amounts (deductible, coinsurance, and copay when applicable) within the encounters 837 files or submit to L.A. Care directly via another agreed-upon type of file.*

13.5 For More Information

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

Chapter 14 – Marketing

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

14.0 Introduction

The L.A. Care Health Plan (L.A. Care) Business Units create, communicate, and deliver health information and/or interventions using Member-centered strategies to protect and promote the health of diverse populations.

L.A. Care Business Units develop and coordinate the distribution of educational materials focused on program benefits and improving Members' overall health status and disease management. These materials are written and designed to increase awareness about how to choose L.A. Care.

14.1 Marketing Activities and Standards

Contracted Providers that want to create and use marketing materials at marketing events or other marketing activities, must receive prior approval from the L.A. Care Compliance, Material Review (CMR) Unit before distributing to Members or prospective Members.

The Provider must submit materials to the L.A. Care CMR Unit at **MMCommunications@lacare.org**.

For information on the L.A. Care CMR Unit, internal reviewing timeframes and regulatory timeframes, inclusive of when a submission to a regulatory agency is required, please see section below.

14.1.A Marketing materials are considered and defined as when the intent is to perform one (1) or more of the following actions:

- Promote an organization
- Provide enrollment information for a health plan
- Explain the benefits of enrollment in a health plan
- Describe the rules that apply to enrollees in a health plan
- Explain benefits or other covered services, including conditions that apply to such coverage
- Communicate various membership operations policies, rules and procedures

Marketing materials also include materials that are produced in various mediums (e.g. print or digital), by or on behalf of L.A. Care, its employees, network Providers, agents or contractors that can reasonably be interpreted as intended to market L.A. Care to existing Members and/or potential enrollees. Marketing materials are generally distributed to L.A. Care's entire service area.

14.1.A.1 All marketing and/or Member outreach materials, developed by the Provider, requires submission to the L.A. Care CMR Unit or to their L.A. Care point of contact (e.g., Account or Contract Manager) for review and approval prior to use.

The marketing and/or Member outreach material submission requires the following:

1. Final/Clean content in Word format
2. Reading level assessment – material must be at a 6th grade reading level or below.

3. Please note: Requests without the readability results will not be processed until the assessment is provided.
4. For revised materials (previously approved material that require revisions) – submission must include a final/clean version and redline version that has the track changes to reflect revisions.

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

14.1.A.2 Review Process and Timeframes

- The assigned CMR Unit Compliance Advisor will process the material submission within seven (7) business days from the date of receipt from the Providers' point of contact.
  - For reference, the review and approval process may be delayed during the annual marketing season for the various LOBs. This season typically starts in May through October. Regulatory required member materials are high priority and deadlines established by the regulators must be met.
- CMR Unit, Compliance Advisor will determine if your material(s) require submission to regulatory agencies based on contract requirements and/or other applicable regulations.
- Please see table for the timeframes required by each regulator, when submission is required:

Organization	Days
Centers for Medicare & Medicaid Services (CMS)	45 calendar days
Department of Health Care Services (DHCS)	60 calendar days
Department of Managed Health Care (DMHC)	30 calendar days
L.A. Care Health Plan (L.A. Care)	07 business days

- Provider(s) will be notified via email from their point of contact when L.A. Care and/or the approving regulatory agencies approve materials.
- If L.A. Care or a regulatory agency does not approve materials, the Provider(s) will be required to address the issues (e.g., make revisions) and resubmit the materials following the process described above.

14.1.B L.A. Care reserves the right to review and ensure correct usage of the L.A. Care logo, including the contents of the material that contains the logo. Providers must co-brand Member outreach materials when communicating with LA. Care Members. The Provider shall submit a request to their L.A. Care business unit representative, contract, and/or account manager.

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

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

Upon receipt, the L.A. Care business unit representative or Provider Network Account Manager must submit the material for review and approval on behalf of the requesting Provider. Upon completion of review, the approval status will be sent to the Provider via email by their L.A. Care business unit representative or Provider Network Account Manager.

14.2 Marketing Guidelines for Providers

The purpose of this section is to ensure that all marketing materials used by L.A. Care's Providers have been approved by CMS, DHCS, and/or DMHC, as applicable.

The CMR Unit ensures all marketing materials are submitted to the appropriate regulatory agencies for approval. Once approved, L.A. Care contracted Providers may use these marketing materials to inform Members about their benefits, rights, and/or processes to navigate through the health plan and/or healthcare system.

14.2.A "Do's and Don'ts" marketing guidelines include the following:

Do's:	Don'ts:
Review and follow all of L.A. Care's marketing policies and procedures.	Don't engage in marketing activities or use materials without prior written approval from L.A. Care and the appropriate regulating agency.
Submit all potential marketing materials and planned activities to your L.A. Care business unit representative or Provider Network Account Manager to secure necessary approval prior to distribution.	Don't misrepresent your business, yourself, or L.A. Care or any health care agency or health plan through false statements or claims, or misrepresent or disparage the program or other health plans.
Ensure the language and information used in marketing materials is clear, simple (at 6th grade reading level or below) and communicates that enrollees have choices.	Don't mislead enrollees to entice them to select a specific doctor or medical facility. Don't make disparaging written/oral statements aimed at competitors – including the use of false performance data for comparison.
Ensure marketing efforts are done appropriately within outlined guidelines and do not violate governing regulations.	Don't make claims that a health plan or medical facility has been endorsed or recommended by L.A. Care, a governing agency or organization that has not certified its endorsement in writing.
Ensure that materials accurately describe the program and Provider involvement.	Don't offer monetary or incentives to prospects as an enticement to enroll with a contracted health plan or to become a patient at your medical facility. Don't engage in marketing activity on any unauthorized premises.
Ensure L.A. Care marketing materials are approved prior to making available or distributing to Members or prospective Members.	Don't coerce, intimidate, or threaten prospects into enrolling with a health plan or to choose your medical facility.
Ensure the L.A. Care business unit representative or Provider Network Account Manager involved in marketing material development and activities, on behalf of the requesting Provider, are trained and have a copy of the marketing policies and procedures, upon request made to the Marketing Department.	Don't allow staff or pay independent agents to engage in door-to-door marketing or solicit via phone or mail to enroll with a health plan or to select your facility. Don't use information that has derogatory language, comments or implications or that makes misleading comparisons. Also, do not use any satisfaction or "Best Plan" data that is not substantiated by a credible third party and/or that is solely based on the contracting plan's assessment of itself and competitors.
Ensure that staff who come in contact with L.A. Care Members have had appropriate marketing training and understand guidelines set forth by L.A. Care and regulatory agencies.	Don't engage in marketing practices that discriminate against prospective Members based on race, creed, color, marital status, religion, age, sex, national origin, sexual orientation, ancestry, pre-existing physical or mental disability or health status.

For detailed information regarding CMS and Covered California marketing guidelines, please visit:

- **https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines**
- **https://www.coveredca.com/agents/marketing-and-branding/**

14.3 Failure to Comply

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

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

For questions or concerns regarding marketing restrictions as they apply to the use of L.A. Care's name or logo, Providers can contact the L.A. Care CMR Unit via email at **MMCommunications@lacare.org.**

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

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

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

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

14.5 For More Information

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

Chapter 15 – Compliance Program Integrity

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

15.0 Introduction

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

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

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

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

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

15.1 Program Integrity Plan

L.A. Care is committed to protecting and preserving the integrity and availability of health care resources for our Members, stakeholders, and business partners by maintaining a comprehensive program integrity plan (i.e., Compliance Program). Additionally, L.A. Care recognizes the importance of preventing, detecting, and investigating Fraud, Waste, and Abuse (FWA). These responsibilities are delegated to the Program Integrity Department, which includes the Special Investigation Unit (SIU), whose mission is to maintain adherence to the L.A. Care Anti-Fraud Plan to ensure the integrity of publicly funded programs.

15.2 Special Investigation Unit (SIU) Role in Program Integrity

The SIU is a team of L.A. Care personnel charged with investigating allegations of FWA and facilitating all anti-fraud efforts at L.A. Care. The team consists of healthcare fraud investigators and subject matter experts who represent the following areas within the organization including, but not limited to, Legal Services, Compliance, Health Services, Finance, Claims, Member Services, Pharmacy and Formulary, and Credentialing. L.A. Care's SIU's goals are to organize and implement an anti-fraud strategy to identify and reduce costs to the plans, Providers, subscribers, enrollees, and others caused by fraudulent activities. The SIU also seeks to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. In addition to the SIU's efforts to protect and preserve the integrity and availability of health care resources for L.A. Care Members, stakeholders, and business partners, it also coordinates anti-fraud activities between L.A. Care and its Providers and the First Tier, Downstream, and Related Entities (FDRs) of its Providers.

15.3 Role of the Provider and Special Investigation Unit (SIU)

The SIU conducts audits of Providers, suppliers, or other healthcare service delivery entities to determine if services reimbursed are supported by documentation, which may include an assessment of clinical criteria and/or validating that appropriate coding was utilized. These audits typically involve either a medical records request or an unannounced on-site visit.

- **15.3.A** Medical Records Request
  When deemed necessary for vetting an allegation or complaint under investigation, the SIU will conduct Provider, supplier, or other healthcare delivery entity audits to determine if services reimbursed are supported by documentation, are medically necessary, or are correctly coded. The SIU will request medical records from health care Providers, suppliers, and other healthcare delivery entities to support this endeavor. The medical records should be sent to the SIU within seven (7) business days from the date of request.
  Medical records may include but are not limited to the following:
    - Diagnostic reports
    - Lab results
    - Office visit notes
    - Prescriptions
    - Prior authorization forms
    - Progress notes

- **15.3.B** Unannounced On-Site Inspection
  When deemed necessary for vetting an allegation or complaint under investigation, the SIU may conduct an unannounced on-site visit. The SIU investigator will present a valid L.A. Care identification badge and request access to the Provider's premises. The SIU investigator will specifically identify why they are present at the premises and what records they want to inspect.

- **15.3.C** Overpayment Recovery
  In the event L.A. Care overpays for Provider Services, L.A. Care shall notify the Provider in writing of the overpayment. The overpaid amount shall be reconciled and adjusted in the next payment due to the Provider, following the date of determination the Provider was overpaid.
    - If no such next payment is due to the Provider, then the Provider shall remit the amount of the overpayment to L.A. Care within 30 calendar days of the Notice of Action (NOA).
    - If Provider owes money to L.A. Care, then L.A. Care shall apply any overpayments due to the Provider towards and against payments due to L.A. Care.

For more detailed information on overpayment recoveries, please refer to Chapter 12 – Claims and Payment.

15.4 Fraud Waste and Abuse (FWA)

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste is defined as an overutilization of services or careless practices that result in unnecessary costs. Waste is generally not considered a criminally negligent action, but rather the misuse of resources.

Abuse is defined as actions that may directly or indirectly result in unnecessary costs to the Medicaid and Medicare programs or any other health care programs funded in whole or in part by the state, federal, and/or local governments; improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary. Abuse involves payment for items or services where there is no legal entitlement to that payment and the one receiving the payment has not knowingly and/or intentionally misrepresented facts to obtain payment.

15.4.A Examples of Fraud, Waste, and Abuse (FWA):

Member/Beneficiaries:

- Allowing someone else to use their identification card to get medical services
- Changing, forging, or altering a prescription
- Changing medical records
- Changing referral forms
- Identity theft
- Misrepresentation of eligibility status
- Prescription drug diversion and inappropriate use
- Prescription stockpiling
- Resale of medications on the black market

Provider/Prescriber:

- Billing a balance that is not allowed
- Billing for services that were not done
- Double billing, up-coding, and unbundling
- Forging a signature on a contract
- Intentionally submitting false claims
- Lying about credentials
- Pre- or post-dating a contract
- Underutilization – not ordering services that are medically necessary

15.5 Detection Efforts

L.A. Care uses various means to educate its Provider network and membership about its FWA detection efforts. Information about L.A. Care's FWA detection activities is communicated in some of the following ways:

- The L.A. Care Regional Community Advisory Committee (RCAC) Meetings
- Member newsletters
- New Member handbook
- Provider training

15.6 Reporting Potentially Fraudulent Activities to L.A. Care

Under the terms of the agreement between L.A. Care and the Provider, the Provider or its FDRs are required to report suspected cases of FWA. There are four (4) ways in which Providers and FDRs can report potential fraud:

1. **Compliance Helpline:**
   The Compliance Helpline is available 24 hours a day, seven (7) days a week and can be used by L.A. Care Board members, employees, contractors, Providers, Members, and other interested persons to report all violations or suspected violations of law and/or the compliance program and/or questionable or unethical conduct or practices including, without limitation, the following:
   - Incidents of FWA
   - Criminal activity (e.g., fraud, kickback, embezzlement, theft, etc.)
   - Conflict of interest issues
   - Code of conduct violations

   To file a report with the Ethics and Compliance Helpline:

   1. Phone: (800) 400-4889 or
   2. Online at **https://secure.ethicspoint.com/domain/media/en/gui/25457/index.html**

2. **In Writing:**
   A written letter regarding potentially fraudulent activities can be sent to L.A. Care at:
   L.A. Care Health Plan
   Attn: Compliance Officer c/o Special Investigation Unit (SIU)
   1055 West 7th Street, 10th Floor
   Los Angeles, CA 90017

3. **SIU (Compliance Officer):**
   The SIU is set up to receive and handle reports of all types of potentially fraudulent activities.
   To file a report with the SIU Compliance Officer:
   - Phone: (213) 694-1250, ext. 4292

4. **Provider Solution Center:**
   If unable to report a potential FWA case by calling the above phone numbers, please call the L.A. Care Provider Solution Center for guidance at (866) 522-2736.

15.7 Referral Requirements

Regardless of what method is used to report FWA to L.A. Care, the following should be included:

1. Name of person reporting fraud or abuse (optional, but highly recommended)
2. Name, address, license, or insurance identification of suspect (if known)
3. Nature of complaint
4. Supporting documentation (optional)

15.7.A If FWA is found, the fraudulent incident or activity will be reported to the appropriate outside law enforcement and/or regulatory agency.

To report Covered California FWA:
Please email: **StopFraud@covered.ca.gov** or visit: **https://www.coveredca.com/consumer-protection/**

To report Medicare FWA:
Please visit: **https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse**

To report Medi-Cal FWA:
Please email the Department of Health Care Services (DHCS), text 'STOP' to the Medi-Cal Fraud Hotline at (800) 822-6222 or visit: **https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx**

15.8 Non-Retaliation

Neither L.A. Care, nor any of its contracted entities, shall retaliate against any employee, temporary employee, contractor, or agent who, in good faith, reports suspected FWA or Code of Conduct violations to L.A. Care, the contracted entity, or a regulatory agency. Additionally, L.A. Care's contracted entities shall require that its subcontractors abide by this non-retaliation policy.

15.9 Annual Fraud, Waste, and Abuse (FWA) and General Compliance Training

All L.A. Care contracted Providers must ensure that all employees and contracted downstream and related entities participate and complete the Medicare Parts C and D of FWA and General Compliance Training within 90 calendar days of hire/contracting and annually thereafter.

All Medicare Providers must use the training materials provided by Centers for Medicare and Medicaid Services (CMS). The materials can be accessible through the CMS Medicare Learning Network here: **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.**

Providers that have met FWA certification standards through enrollment as a Medicare Provider are deemed to have met Medicare FWA training and educational requirements, but still must fulfill the General Compliance training requirements. All Providers are required to submit an executed FWA and General Compliance Awareness attestation confirming their organization's compliance with this requirement.

For more information on regulatory trainings, please refer to Chapter 20 – Provider Training.

15.10 Federal False Claims Act

The Federal False Claims Act is the government's primary weapon in the fight against health care fraud. The majority of funds recovered come from the False Claims Act suits or settlements. The Federal False Claims Act permits a person who learns of fraud against the United States Government, to file a lawsuit on behalf of the government against the person or business that committed the fraud. If the action is successful, the person filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery.

These persons are often referred to as "whistleblowers." Successful whistleblowers can receive anywhere from 15% to 50% of the total amount recovered. Any person may bring a lawsuit called a "qui tam action" regardless of whether he or she has direct or first-hand knowledge of the fraud. However, if substantially the same allegations or transactions alleged in the claim were publicly disclosed, the court may dismiss the claim.

15.10.A The False Claims Act provides protection to employees, agents, or contractors who are retaliated against by an employer because of the employee's, agent's, or contractor's participation in a qui tam action.

The protection is available to any employee, agent, or contractor who is:

- Demoted
- Fired
- Harassed
- Threatened ***or***
- Otherwise discriminated against by his or her employer because the employee, agent, or contractor investigates, files, or participates in a qui tam action

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against. California also has a state False Claims Act that is similar to the Federal False Claims Act.

15.11 Code of Conduct

L.A. Care is firmly committed to comply with its legal and ethical obligations under all state and federal laws and regulations, as well as its obligations with its state and federal contracts and grants. L.A. Care requires its Providers to operate in accordance with principles in the L.A. Care Code of Conduct.

The Code of Conduct is a guide to ensure compliance with the rules and regulations that govern our business. While the Code of Conduct is not designed to cover every possible situation, it does provide examples of everyday scenarios to assist Providers with proactively addressing issues.

To review the information on the L.A. Care Code of Conduct, please visit:
https://www.lacare.org/sites/default/files/universal/DES1804_Code_of_Conduct_0918.pdf.

15.12 Health Insurance Portability and Accountability Act (HIPAA)

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to specify privacy and security standards for Covered Entities (health plans, physicians, hospitals, and other health care providers). The HIPAA regulations improve the healthcare industry's efficiency, improve health insurance portability, protect the privacy of Members, and ensure health information is kept secure. It also ensures that we notify Members of breaches of their protected health information (PHI).

15.12.A Covered Entities

Three (3) types of entities fall within the oversight of HIPAA regulations:

1. Health plans: Include HMOs (i.e., L.A. Care), health insurance companies, and other organizations that finance and deliver healthcare.
2. Clearinghouses: Intermediaries between health plans and providers responsible for the translation of non-standard transactions to standard transactions.
3. Providers: The health care Providers are the people or organizations that provide health services (e.g., physicians, clinics, hospitals).

15.12.B Business Associates

Business Associates are individuals or organizations (e.g., lawyers, auditors, consultants, third-party administrators, healthcare clearinghouses, vendors, and contractors) performing certain functions/activities on behalf of Covered Entities. The Privacy Rule includes organizations or individuals contracted with Covered Entities, which perform specific functions that include accessing, using or disclosing PHI. However, employees or volunteers that work directly for a Covered Entity are not considered Business Associates, but have responsibility to comply with HIPAA on behalf of the Covered Entity. Business Associates must comply with all the provisions of HIPAA with respect to the PHI that they access, use, or disclose from or on behalf of the Covered Entity.

For more information and guidance on HIPAA, please visit: **https://www.hhs.gov/hipaa/index.html.**

15.12.C Privacy Rule

The Privacy Rule of HIPAA determines how Covered Entities and their Business Associates access use and disclose PHI. The Privacy Rule also requires that Covered Entities and their Business Associates limit (i.e., Minimum Necessary Standard) the amount of PHI that is used and disclosed to only the minimum amount necessary to do their job, and only to those who need the PHI to perform an allowable activity. It also specifies individual rights that allow Members to have control over the access to, and use and disclosure of PHI.

15.12.D Protected Health Information (PHI)

PHI is any information related to a Member's health condition, care, or payment for care that identifies the person or provides a reasonable likelihood that the information may result in identification. PHI includes any individually identifiable health information used or disclosed by a Covered Entity or transmitted in any form or medium, whether sent electronically, orally, or on paper.

15.12.D.1 The 18 identifiers that make health information PHI are:

1. Names
2. Dates, except year
3. Telephone numbers
4. Geographic data
5. FAX numbers
6. Social Security numbers
7. Email addresses
8. Medical record numbers
9. Account numbers
10. Health plan beneficiary numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Web URLs
14. Device identifiers and serial numbers
15. Internet protocol addresses
16. Full face photos and comparable images
17. Biometric identifiers (i.e. retinal scan, fingerprints)
18. Any unique identifying number or code

15.12.E Minimum Necessary Standard

HIPAA requires that Covered Entities access, use or disclose only the minimum amount of PHI necessary to fulfill the allowable intended purpose of the access, use or disclosure. This requirement is called the "Minimum Necessary" standard.

15.12.F Use and Disclosure of Protected Health Information (PHI)

The Privacy Rule includes specific rights and protections against the misuse or inappropriate disclosure of Members' PHI. Covered Entities and their Business Associates can use PHI for treatment, payment, and health care operations (TPO). In addition, there are other permissible disclosures that are for certain public interest and benefit activities (i.e., law enforcement, judicial and administrative proceedings, and health oversight activities). Outside of the permissible disclosures, authorization of the Member may be required.

15.12.G Member Rights

To empower individuals to have more control of decisions regarding their health and well-being, the Privacy Rule provides them with certain rights:

- Accessing PHI: Members have the right to access, review, and copy their PHI, request amendment of the information, and request an accounting of any disclosures made for purposes except TPO.
- Right to Amendment of PHI: Designated record set includes information that must be made available for access or amendment.
- Right to Accounts of Disclosure: Members have the right to request an accounting of non-routine disclosures a Covered Entity has made of their PHI.
- Right to Request Restrictions on Uses and Disclosures: Members may request restrictions on uses and disclosures of PHI except for TPO.
- Right to Request Confidential Communications: Members may request to receive communication of PHI at an alternative location or by alternative means.

For more information about HIPAA from the U.S. Department of Health and Human Services (HHS) and guidance, please visit: **https://www.hhs.gov/hipaa/index.html.**

15.12.H Security Rule

The Security Rule is a set of regulations intended to protect the security of electronic Protected Health Information (ePHI) and to maintain the confidentiality, integrity, and availability of ePHI. This is achievable by implementing proper administrative, physical, and technical safeguards.

While the Privacy Rule safeguards PHI, the Security Rule protects a subset of information covered by the Privacy Rule. The subset is all individually identifiable health information a Covered Entity creates, receives, maintains, or transmits in electronic form. The Security Rule does not apply to PHI transmitted orally or in writing.

It also requires Covered Entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated users or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce, such as employees and volunteers. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers, and other electronic devices.

15.12.H.1 The Security Rule is intended to be scalable; in other words, at this time it does not require specific technologies to be used. Covered Entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

There are three (3) safeguard levels of security:

1. **Administrative safeguards** are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect ePHI and to manage the conduct of the Covered Entity's workforce in relation to the protection of that information.
2. **Technical safeguards** are the technology and the policy and procedures for its use that protect ePHI and control access to it (i.e., access controls, audit controls, integrity, authentication, transmission security).
3. **Physical safeguards** deal with the protection of any electronic system, data, or equipment within the facility and organization. The risk analysis and risk management protocols for hardware, software, and transmission fall under this rule.

Organizational Requirements requires the implementation of business associate contracts or other arrangements be in place where appropriate, developing and enforcing policies and procedures, and documentation.

For more information about HIPAA from HHS and guidance, please visit: **https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html**.

15.12.I Breach Notification Rule

As a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act, Covered Entities and Business Associates are required to disclose a breach related to unsecured PHI. In addition, Business Associates are required to report incidents and breaches directly to the Covered Entity within the contractual timeframe. Please review the Provider's contractual requirements with L.A. Care for breach notification requirements.

Examples of accidental breaches include:

- A medical Provider sending or handing a Member the wrong file, allowing them to see another patient's personal information; this includes faxes, electronic communications, or mail inadvertently sent to the wrong recipient
- A third-party overhearing a private PHI-containing conversation
- When computers holding unsecured PHI are improperly disposed of
- A medical Provider leaving a file open and unattended where it can be inadvertently viewed
- A billing error providing Member PHI to unauthorized parties

Examples of intentional breaches include:

- A medical Provider or Business Associate accessing PHI out of curiosity
- A medical Provider accessing PHI to use against another person for profit or other gain
- Information thieves stealing or prohibiting access to PHI via ransomware or other electronic attacks
- Thieves retrieving Member PHI from unsecured physical hardware that they stole

Please notify L.A. Care's Privacy Officer of incidents/breaches directly to: **PrivacyOfficer@lacare.org**.

15.12.J Federal and State Guidance:

- Federal HIPAA Guidance: **https://www.hhs.gov/hipaa/index.html**
- California Privacy and Data Security Guidance: **https://oag.ca.gov/privacy/**

15.12.K Transaction and Code Sets Standards

According to CMS, electronic transactions are activities involving the transfer of health care information for specific purposes. The HIPAA regulations have identified certain standard transactions for Electronic Data Interchange (EDI) for the transmission of PHI.

These transactions include the following:

- Claims and encounter information
- Claims status
- Coordination of benefits
- Eligibility
- Enrollment and disenrollment
- Payment and remittance advice
- Premium payment
- Referrals and authorizations

15.12.K.1 If a Provider engages in one (1) of the identified transactions electronically, they must comply with the standard for that transaction.

For CMS guidance, please visit: **https://www.cms.gov/medicare/billing/electronicbillingeditrans.**

15.13 Health Insurance Portability and Accountability Act (HIPAA Violations)

The HIPAA act states that Covered Entities must keep personally identifiable information secure and private. This provision has made electronic health records safer for patients. HIPAA violations should be taken seriously. There are a few ways for Covered Entities and their Business Associate Agreement (BAAs) to avoid HIPAA violations.

To avoid the risk of violations, Covered Entities and BAAs should routinely:

- Conduct risk analysis
- Control device and media access
- Encrypt ePHI
- Have Policies and procedures in place to safeguard PHI
- Offer security awareness training to employees and workforce

15.13.A The penalties for violations of HIPAA Rules from a regulatory agency can be severe. The State Attorney General can issue fines up to a maximum of $25,000 per violation category. Providers who do not implement safeguards will increase their risk of right of access and HIPAA violations. A Provider is required to comply with all CMS Compliance Program Effectiveness requirements.

15.14 Resources and Websites

For privacy and health information guidance and resources, please see the list below:

Name of Entity	Resource
California Department of Health Care Services	**https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx**
California Department of Justice, Office of the Attorney General	**https://oag.ca.gov/**
California Department of Technology	**https://www.ca.gov/privacy-policy/**
Centers for Medicare and Medicaid Services (CMS)	**https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Data_Use_Agreement**
L.A. Care Health Plan – Provider Policies and Compliance	**https://www.lacare.org/providers/provider-resources/policies-compliance**
National Committee on Vital and Health Statistics	**https://ncvhs.hhs.gov/**
National Institutes of Health	**https://privacyruleandresearch.nih.gov/**
National Institute of Standards and Technology	**https://www.nist.gov/**
U.S. Department of Health and Human Services	**https://www.hhs.gov/hipaa/index.html**

15.14.A In addition to the federal privacy rules, providers in California must also comply with the Confidentiality of Medical Information Act (CMIA) as well as DHCS requirements.

15.15 For More Information

For questions regarding the information provided in this chapter, please contact the Compliance Department via email at **LACareComplianceOfficer@lacare.org.**

Chapter 16 – Pharmacy and Formulary

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

16.0 Introduction

The L.A. Care Health Plan (L.A. Care) Pharmacy and Formulary Department offers several resources and guidelines to assist Providers with prescribing medications to Members.

The Pharmacy and Formulary Department is responsible for helping L.A. Care contain the cost of prescription drugs while maintaining care quality.

Key responsibilities include:

- Managing the formulary of approved medications
- Updating the formulary with new recommendations and clinical guidelines
- Working with pharmacies and Providers

L.A. Care's prescription drug formulary is designed to support positive Member health outcomes through the administration of pharmacy benefits, including high quality, cost-effective pharmaceuticals and supplies. The goal of the formulary is to provide a comprehensive list of covered pharmaceutical benefits that enhances the prescribing practitioner's and pharmacist's ability to deliver optimal drug therapy to L.A. Care Members.

For additional pharmacy, information and resources please visit:
https://www.lacare.org/providers/provider-resources/pharmacy-services

16.1 Formulary (Drug List)

The formulary is a tool to promote cost-effective prescription drug use. Drugs and supplies on the L.A. Care formulary have been approved by the Pharmacy and Therapeutics Committee. The formulary is designed to represent a variety of clinically and economical pharmacotherapeutic options for Members.

Coverage of medications can vary from plan to plan and the drug list can change during the year. While most changes happen at the beginning of the year (January 1st), the formulary is subject to changes throughout the year as well, at which point it will be updated.

To view the complete list of formularies by line of business (LOB), please visit:
https://www.lacare.org/providers/provider-resources/pharmacy-services/medication-adherence/list-covered-drugs.

16.2 Drug Recalls and Withdrawals

Recalls are actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by the United States Food and Drug Administration (FDA) request, or by FDA order under statutory authority. L.A. Care works closely with pharmacies and Providers to make sure the medications Members take are safe. When L.A. Care is notified that a medication has been recalled or withdrawn from the market, L.A. Care will notify the member and prescriber.

For more information on drug recalls and access to specific drug recall notifications, please visit: **https://www.lacare.org/members/getting-care/pharmacy-services/drug-recalls-withdrawals**.

16.3 Medi-Cal Rx – Pharmacy Benefit Carve-Out

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

*The Medi-Cal Pharmacy Benefits is carved out to the Department of Health Care Services (DHCS) through Medi-Cal Rx and will be managed by DHCS Pharmacy Benefit Manager (PBM), Magellan Medicaid Administration, Inc. (Magellan). Please note, Magellan is not a contracted vendor of the L.A. Care Provider Network.

This change will improve access to pharmacy services and standardize the Medi-Cal Pharmacy Benefit statewide. Medi-Cal Pharmacy Benefits will be administered through the fee-for-service (FFS) delivery system.

16.3.A Medi-Cal Rx Overview

Medi-Cal Rx includes pharmacy services billed as a pharmacy claim, including but not limited to:

- Outpatient drugs (prescription and over-the-counter), including Physician Administered Drugs (PADs)
- Enteral nutrition products
- Medical supplies

Providers should visit the DHCS website regularly for additional resources, implementation dates, and training opportunities, please visit:
https://medi-calrx.dhcs.ca.gov/home/.

For questions about this information, please email DHCS Medi-Cal Rx Project Team at **medicalrxeducationoutreach@magellanhealth.com**.

For assistance by phone, call the Medi-Cal Rx Customer Service Center at (800) 977-2273.*

16.4 Prescription Drug Prior Authorizations (PA)

Certain formulary medications and all non-formulary medications require a Prior Authorization (PA) request to be submitted by the prescribing Provider for L.A. Care Members. Each PA request will be reviewed based on the individual Member's need. Determination will be based on documentation of existing medical need. The PA criteria and the length of PA approval follow Centers for Medicare and Medicaid Services (CMS) regulations.

16.4.A Instructions on how to submit PA requests are located on the Prescription Drug Prior Authorization forms, which can be found at:
https://www.lacare.org/providers/provider-resources/pharmacy-services/prior-authorizations.

Prescribers may also access additional information regarding the formulary and the specific PA criteria on the coverage determination process from L.A. Care's contracted Pharmacy Benefit Manager (PBM) and from Medi-Cal Rx – Magellan.

16.4.B Below are the PBM vendors that handle the processing of the pharmacy benefits and PAs by LOB:

- **Navitus Health Solutions**
  LOB: LACC/D, PASC-SEIU
  Phone: (844) 268-9785
  Fax: (855) 878-9210
  Website: **https://www.navitus.com/**

- **Medi-Cal Rx – Magellan**
  LOB: MCLA
  Phone: (800) 977-2273
  Website: **https://medi-calrx.dhcs.ca.gov/home/**

For more information on generic substitution, step-therapy, quantity limits, and more, please visit: **https://www.lacare.org/members/getting-care/pharmacy-services**.

16.5 Pharmacy Appeals and Grievances

If a prescribing Provider would like to discuss a decision for a prior authorization/coverage determination denial with a clinical reviewer, or if the Provider does not believe the determination is correct, they have the right to appeal the decision on behalf of the Member. The prescriber must provide information to support the appeal on the basis of medical necessity.

16.5.A Pharmacy appeals for MCLA are handled through Medi-Cal Rx by Magellan.

- **Medi-Cal Rx – Magellan**
  LOB: MCLA
  Phone: (800) 977-2273
  Website: **https://medi-calrx.dhcs.ca.gov/home/**

For questions related to the formulary, prior authorizations, step-therapy, quantity limits, or therapeutic interchange, please call the appropriate PBM.

16.5.B For all other appeals that are not MCLA, Providers may also submit a copy of the denial notice and a brief explanation of the concern with any other relevant information to the address below:

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

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

16.6 Mail Order Prescriptions

L.A. Care offers Members the option of getting up to a 90-day supply of select maintenance medications mailed to their home or alternate address through our prescription mail order program.

16.6.A Providers can call, mail, e-prescribe, or fax prescriptions to Quality Drug Clinical Care. Fax:

- **By Mail:**
  Mail prescription(s) to:
  Quality Drug Clinical Care
  National Provider Identifier (NPI): 1417453226
  18 Technology Drive, Suite 104
  Irvine, CA 92618

- **By Fax:**
  (949) 404-3760
- **By Phone:**
  (949) 471-0223

16.6.B Quality Drug Clinical Care will begin working on the Member's order once the prescription is received. Once the prescription is processed, the medication will be delivered to the Member within one (1) – three (3) days.

16.7 Pharmacy Network

A large number of pharmacies are available to Members across Los Angeles County. The network includes most major chain drug stores, retailers, and community pharmacies. Members should fill prescriptions at network pharmacies. The pharmacy list is updated monthly.

To locate a network pharmacy near a Member or Provider site, please visit the L.A. Care online pharmacy search tool here: **https://www.lacare.org/members/getting-care/pharmacy-services/find-pharmacy**.

16.8 Specialty Pharmacy

L.A. Care has specific policies for use of specialty drugs. Specialty drugs are often high cost pharmaceuticals, which may require special handling by the manufacturer and/or the FDA, and their effectiveness is driven by coordinated clinical support for the Member. Most of these therapies require prior authorization, and for LACC/D and PASC-SEIU, most of these therapies must be dispensed by L.A. Care's preferred specialty pharmacies. This is to ensure the patient achieves the optimal clinical benefit from the prescribed therapy.

16.8.A To learn more about specialty drug access and coverage determination for these drugs and therapies, prescribing Providers and pharmacies may call:

- **Navitus Health Solutions**
  LOB: LACC/D, PASC-SEIU
  Phone: (844) 268-9785
  Fax: (855) 878-9207
  Website: **https://www.navitus.com/**
- **Medi-Cal Rx – Magellan**
  LOB: MCLA
  Phone: (800) 977-2273
  Website: **https://medi-calrx.dhcs.ca.gov/home/**

16.9 Opioid Overutilization

Opioid utilization is monitored by L.A. Care and Navitus to reduce potentially inappropriate and unsafe use of opioids. Member specific reports are generated when pre-established overutilization criteria are met during a defined time period, and the reports are supplied to the appropriate Providers. The information is shared with Providers to increase awareness and facilitate next steps to address opioid overutilization. The program also improves Drug Utilization Review (DUR) controls at the point-of-sale, formulary management, case management, and overall utilization reviews.

16.9.A Please remember to refer to the Controlled Substance Utilization Review and Evaluation System (CURES) before prescribing opioids.

The following section/sentence is only applicable to (as denoted between the asterisks): L.A. Care Covered (LACC/D), and Homecare Workers Health Care Plan (PASC-SEIU).

*L.A. Care also has an opioid overutilization program (also known as a Drug Management Program) that can help Members safely use their prescription opioid medications or other medications that are frequently abused. MCLA Members are excluded.

If the Member uses opioid medications from several Providers or pharmacies, we may talk to the prescribing physician(s) and other Providers to make sure the use is appropriate and medically necessary. If L.A. Care decides that the Member is at risk for misusing or abusing the opioid or benzodiazepine medications, L.A. Care may limit how the Member can get those medications.

16.9.A.1 Limitations may include the following:

- Requiring the Member to get all prescriptions for those medications from one (1) pharmacy and/or from one (1) doctor
- Limiting the amount of those medications we will cover for the Member

16.9.B If L.A. Care decides that one (1) or more limitations should apply to the Member, a letter will be sent in advance to the Member. The letter will explain the limitations that should apply. The Member will have a chance to tell us which Providers or pharmacies they prefer to use. If a Provider thinks L.A. Care made a mistake, disagrees that the Member is at risk for prescription drug abuse, or disagrees with the limitation, Providers and the Member can file an appeal.

16.9.C Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization are a priority for all of us in healthcare. L.A. Care requires Providers to adhere to L.A. Care's drug formularies and prescription policies, which are designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.

L.A. Care is dedicated to ensuring Providers are equipped with additional resources, which can be found on the L.A. Care Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at **https://www.lacare.org/Providers/Provider-resources/tools-toolkits/toolkits** under the Health Resource tab. Please consult with your Provider Services Representative or reference the medication formulary for more information on L.A. Care's Pain Safety Initiatives. Additionally, Members have other pain management options such as Chiropractic Care.

For more information, please call the Provider Solution Center at (866) LACARE6 or (866) 522-2736, 24 hours a day, seven (7) days a week, including holidays. *

16.10 For More Information

For questions regarding the information provided in this chapter, please contact L.A. Care's Provider Solution Center at (866) 522-2736.

Chapter 17 – Managed Long Term Services and Supports (MLTSS)

This chapter applies to L.A. Care Medi-Cal (MCLA), unless otherwise noted.

For L.A. Care Medicare Plus (HMO D-SNP) specifications please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

17.0 Introduction

The L.A. Care Health Plan (L.A. Care) Managed Long Term Services and Supports (MLTSS) Department works with internal staff and external stakeholders to improve the way health care is provided to seniors, people with disabilities, people with chronic illness, people with other health conditions, and other at-risk Members.

MLTSS refers to a wide range of services that support people to live independently in the community.

17.1 Managed Long Term Services and Supports (MLTSS) Programs

There are four (4) programs under MLTSS. In addition, the MLTSS department manages the L.A. Care Palliative Care program:

1. **Community Based Adult Services (CBAS)**
   A program where Members can go to a center during the day for assistance with their daily needs.
2. **In-Home Supportive Services (IHSS)**
   A California state program that provides homecare services to low-income seniors and persons with disabilities, allowing them to remain safely in their home.
3. **Long Term Care (LTC)**
   Service that provides medical, social, and personal care in either a facility or home for Members with medical or mental conditions who need constant, continuous care.
4. **Multipurpose Senior Services Program (MSSP)**
   An intensive case management program for seniors who are certified for nursing home placement, but wish to remain at home. The program provides both social and health care management services.

17.2 Care Coordination

Entities with appropriate identification and authorization issued by L.A. Care such as appropriate L.A. Care staff, a Member's Primary Care Physician (PCP), and other Providers or vendors contracted with L.A. Care, should have access at any time upon request to the following:

- Provide oversight and facilitate coordination of care
- Conduct initial and ongoing assessments to ensure appropriate care delivery
- Provide coordination referrals and services in a culturally and linguistically appropriate matter
- Part of Care Management's Interdisciplinary Care Team (ICT) to contribute to a multidisciplinary care plan that aligns with the needs expressed by the Member
- Facilitate and support connections with local community care services Providers

17.3 Long Term Care (LTC)

Long Term Care (LTC) is the provision of medical, social and personal care services in either an institution or private home. Most LTC services are provided in a Skilled Nursing Facility (SNF). The primary purpose of LTC is to assist the Member in the activities of daily living (ADLs), such as:

- Assistance with mobility
- Bathing, grooming and toileting
- Getting in and out of bed
- Feeding and/or preparing special diets
- Supervision of medication

17.3.A Referrals for LTC can come from various sources such as a PCP, Discharge Planner, Family Caregiver or ICT. LTC covers room and board at a SNF. SNF Providers are responsible for coordinating specialty services for LTC Members who need specialty care.

The L.A. Care MLTSS Department will assist LTC Members with transitions from LTC back to the community and coordinating other health plan benefits or community resources.

17.4 Skilled Nursing Facility (SNF)

A Skilled Nursing Facility (SNF) is an inpatient rehabilitation and medical treatment center staffed with trained medical professionals. They provide the Medically Necessary services of licensed nurses, physical, occupational and speech therapists. SNFs provide 24-hour care to residents whose primary need is for availability of skilled nursing care on an extended basis.

17.4.A Skilled Nursing Facility (SNF) Requirements

All contracted SNFs must do the following:

- Coordinate and cooperate with Participating Physician Group (PPG), Utilization Management (UM) and care coordinators regarding the Member's care and treatment
- Participate and comply with UM programs assisting in the maintenance of statistical data, records, and reporting requirements regarding the care and treatment provided to the Member
- Be fully licensed and accredited by National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), programs or any other applicable regulatory or accrediting agencies and bodies
- Not operate outside of established bed capacity and appropriate staffing
- Provide short and long-term services in a compassionate and caring manner

17.4.B Additionally, the SNF's quality management requirements, including peer review, in accordance with federal state law should be enforced and adhered to at all times including the following:

- SNF shall permit the L.A. Care Quality Management and UM personnel direct and reasonable access to Members while institutionalized and to the medical and SNF's records for those Members on a daily basis, or as required, so long as such access does not interfere with the Member's medical treatment. Notwithstanding the foregoing, L.A. Care shall, in its sole discretion, retain the ability to prohibit any health professional or general service Provider from providing services to a Member, upon written notice to SNF.

- SNF shall cooperate and comply with L.A. Care Quality Management Program. L.A. Care shall have the right to attend SNF's quality management meetings for that portion of the meeting relating to L.A. Care Members only. The SNF shall use reasonable efforts to provide L.A. Care with five (5) calendar days' prior notice of such meetings.
- If the SNF is delegated quality improvement functions, the SNF shall be required to submit quarterly reports to L.A. Care outlining all quality improvement activities in a mutually agreed upon format, as applicable.
- There shall be collaboration to provide the best care possible for Members and to improve outcomes by the SNF to achieve their mission, vision, and goals. Licensed nursing care on a 24-hour basis, restorative, rehabilitative care, and assistance in meeting daily living needs along with appropriate referrals and/or transfer when the SNFs cannot meet Member needs shall also be provided to attain the best possible care and outcomes.

17.5 Palliative Care Program

Palliative Care is designed to provide pain and symptom management as well as other support services for advanced illness Members.

Palliative Care is a multidisciplinary approach to specialized social and medical care for people with serious and advanced illnesses. It focuses on providing Members with social services and mental health support and relief from the symptoms, pain, physical stress, and mental stress of a serious illness--whatever the diagnosis. The goal of Palliative Care is to improve the quality of life for both the Member and the family.

17.5.A Palliative Care Services

Palliative Care must include, at a minimum, the following six (6) services when Medically Necessary and reasonable for the palliation or management of a qualified serious illness and related condition:

1. Advance Care Planning
2. Care Coordination
3. Mental Health and Medical Social Services
4. Pain and Symptom Management
5. Palliative Care Assessment and Consultation
6. Palliative Care Team of doctors, nurses, social workers, chaplain, and other specialists

17.5.B Eligibility

The benefit applies to Medi-Cal managed care Members who are not dually eligible for Medicare and Medi-Cal.

17.6 Managed Long Term Services and Supports (MLTSS) Referral Forms

Providers can find important MLTSS referral forms on the L.A. Care website here:

- CBAS Face-to-Face Assessment Request Form:
  https://www.lacare.org/sites/default/files/la2903_cbas_form_202012.pdf
- MLTSS Referral Form:
  https://www.lacare.org/sites/default/files/la2562_mltss_referral_form_202005.pdf
- Palliative Care Referral and Screening Tool:
  https://www.lacare.org/sites/default/files/la3002_universal_pc_referral_form_202008.pdf

17.7 Member Transfers

Contracted SNFs shall facilitate transfers of the Members to or from a hospital when there is a change of level of care and take actions to notify L.A. Care, Member's attending physician, and Member's guardian or family members, within the timeframes established by CMS' Structure and Process Measures and the agreement. Also, the SNF shall ensure that a copy of the hospital Discharge Summary is provided to the receiving facility, as well as the L.A. Care UM Department.

17.7.A Should a Provider fail to send L.A. Care a written discharge plan in a timely manner, it may result in termination from L.A. Care.

For questions or to submit discharge plans, please contact:

- **By Phone:**
  UM at (877) 431-2273
- **By Fax:**
  UM at (213) 438-5096

17.8 Discharging Members from Long Term Care

Contracted SNFs shall develop a discharge plan when the Member is no longer eligible for LTC services. L.A. Care must be informed by the SNF in writing using **DHCS Medi-Cal Long Term Facility Admission and Discharge form (MC171)** immediately, but no later than 72 hours from discharge. Should a Provider fail to notify L.A. Care timely, it may result in termination from L.A. Care.

17.8.A In the event a Member receiving LTC under this agreement expires, the SNF is required to notify L.A. Care using DHCS Medi-Cal Long Term Facility Admission and Discharge form (MC171) within two (2) hours of passing. Additionally, the SNF must assemble inventory and safeguard the Member's personal effects during that time. Should a Provider fail to notify L.A. Care within two (2) hours of a Member's death it may result in termination from L.A. Care.

17.8.B The written discharge plan (MC171) can be faxed to the UM MLTSS fax number below. Should a Provider fail to send L.A. Care a written discharge plan in a timely manner, per the specified timeframe(s) above, it may result in termination from L.A. Care.

For questions or to submit discharge plans, please contact:

- **By Phone:**
  UM at (877) 431-2273
- **By Fax:**
  UM at (213) 438-5096

17.9 For More Information

For questions regarding the information provided in this chapter, please contact the MLTSS Department via email at **MLTSS@lacare.org**.

Chapter 18 – Appeals and Grievances

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

18.0 Introduction

The L.A. Care Appeals and Grievances Department is dedicated to evaluating Member grievances and providing support related to complaints, disputes, or dissatisfactions with the level of service or care a Member has received.

In addition to grievances, the Appeals and Grievances Department also reviews appeals made by a Member, a Provider on behalf of the Member, or an appointed representative on behalf of the Member. A Member or a Provider acting on behalf of a Member can file an appeal when a Member has a dispute with the authorization of a service or the determination of coverage.

18.1 Member Grievances

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Health Plan, or its Providers, regardless of whether remedial action is requested. If a Member is dissatisfied or has problems or questions with the services or care given by their Provider and cannot resolve them with the Provider, they have a right to file a grievance or complaint.

Examples of common Member grievances:

- Problems booking an appointment or having to wait a long time for an appointment
  - For more information on timely access standards, please refer to Chapter 3 – Access to Care
- Disrespectful or rude behavior by Providers, Provider's office, or other clinical staff
- Service or care received from L.A. Care

18.1.A Members also have the right to file an urgent grievance with the Department of Managed Health Care (DMHC) without filing a grievance with L.A. Care.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb, or major bodily function
- Immediate and serious deterioration of health

18.2 How to File a Member Grievance

Members and Providers acting on behalf of a Member have many ways to file a grievance with L.A. Care. Members needing assistance with filing a grievance can call the L.A. Care Customer Solution Center at the number located on the back of their Member identification card (ID), 24 hours a day, 7 days a week, including holidays.

Members and Providers can use the following methods to file a grievance:

- **By Mail:**
  L.A. Care Health Plan
  Attn: Appeals and Grievances Department
  1055 W. 7th Street
  Los Angeles, CA 90017
- **By Phone:**
  For (LACC/D) Members:
  Customer Solution Center at (855) 270-2327 (TTY 711)

  For (MCLA) Members:
  Customer Solution Center at (888) 839-9909 (TTY 711)

  For (PASC-SEIU) Members:
  Customer Solution Center at (844) 854-7272 (TTY 711)
- **By Fax:**
  L.A. Care Appeals and Grievances Department at (213) 438-5748
- **By Online Grievance and Appeal Form:**
  https://www.lacare.org/members/member-support/file-grievance/grievance-form

18.2.A Should a Member express any form of dissatisfaction for any reason, whether orally or written, Providers must forward the complaint to L.A. Care within 24 hours of receipt to the following email addresses:

- Urgent Request: **Agexpedited@lacare.org**
- Non-Urgent Request: **A&G_Intake@lacare.org**

18.3 State Hearing

A State Hearing is another way a Member can file a grievance. The Member may present their case directly to the State of California or a Member may ask someone to present their case such as legal counsel, relative, friend, or any other person. MCLA Members have the right to ask for a State Hearing at any time within 120 days of the date on L.A. Care's Notice of Appeal Resolution (NAR) letter.

Members must first go through the L.A. Care grievance process before applying for a State Hearing. Sometimes a Member can ask for a State Hearing without completing L.A. Care's appeal process. For example, a State Hearing can be requested without having to complete our appeal process, if we did not notify you correctly or on time about your service(s). This is called Deemed Exhaustion.

The following are some examples of Deemed Exhaustion:

- L.A. Care did not make a NOA letter available to you in your preferred language.
- L.A. Care made a mistake that affects any of your rights.
- L.A. Care did not give you a NOA letter.
- L.A. Care made a mistake in our NAR letter.
- L.A. Care did not decide your appeal within 30 days. We decided your case was urgent, but did not respond to your appeal within 72 hours.

For more information about a State Hearing request, please call the California Department of Public Social Services (DPSS) at (800) 952-5253 or TTY 711.

18.4 Expedited State Hearing

In cases of health services denials, a Member or Provider may request a faster decision through an Expedited State Hearing if a Member's life, or health, or ability to attain, maintain, or regain maximum function could be seriously risked by going through a standard State Hearing.

Requests for Expedited State Hearings should be directed to:

- **By Mail:**
  Expedited Hearings Unit
  California Department of Social Services State Hearings Division
  744 P Street, MS 19-65
  Sacramento, CA 95814

- **By Fax:**
  (916) 229-4267

For more information on DPSS State Hearings, please visit:
https://dpss.lacounty.gov/en/rights/ash/request-hearing.html.

18.5 How to File a Member Appeal

An appeal is different from a complaint. An appeal is a request for L.A. Care to review and change a decision that was made about coverage for a requested service for a Member. With written permission from a Member, a Provider can assist the Member and file an appeal. Members needing assistance in filing an appeal can call the Member Services number located on the back of their ID card, 24 hours a day, 7 days a week including holidays.

18.5.A Appeals must be filed within 60 calendar days from the date on the Notice of Action (NOA) that was delivered to the Member or before the date L.A. Care states services will discontinue. Within five (5) calendar days of receiving the appeal, L.A. Care will send a letter acknowledging they received it. Within 30 calendar days, L.A. Care will issue a decision on the appeal.

Members and Providers acting on behalf of a Member can use the following methods to file an appeal with L.A. Care:

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

- **By Phone:**
  For (LACC/D) Members:
  Customer Solution Center at (855) 270-2327 (TTY 711)

  For (MCLA) Members:
  Customer Solution Center at (888) 839-9909 (TTY 711)

  For (PASC-SEIU) Members:
  Customer Solution Center at (844) 854-7272 (TTY 711)

- **By Fax:**
  L.A. Care Appeals and Grievances Department at (213) 438-5748
- **By Online Grievance and Appeal Form:**
  https://www.lacare.org/members/file-grievance/grievance-appeal-form -

18.5.B If a Provider needs an expedited decision to be made because the time it takes to resolve the appeal would put the Member's life, health, or ability to function in danger, Providers can call L.A. Care and request an expedited review. L.A. Care will make a decision within 72 hours of receiving the appeal.

- **By Phone:**
  For (LACC/D) Members:
  Customer Solution Center at (855) 270-2327 (TTY 711)
- **For (MCLA) Members:**
  Customer Solution Center at (888) 839-9909 (TTY 711)
- **(PASC-SEIU) Members:**
  Customer Solution Center at (844) 854-7272 (TTY 711)

18.6 Independent Medical Review (IMR)

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

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

Members or Providers filing on behalf of a Member have up to six (6) months from the date of the denial to file an IMR with DMHC. However, the Members or Providers filing on behalf of the Member only have 120 days to request a State Hearing so if a Provider would like to file an IMR and a State Hearing it must be filed as soon as possible. Please remember that if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say. Providers will need to provide information to support the request for an IMR.

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

18.6.A When to File an Independent Medical Review (IMR)

Members, or Providers submitting on behalf of the Member, may file an IMR if they meet the following requirements:

- Member's Primary Care Physician (PCP) says a health care service is medically necessary and it is denied; ***or***
- Member received urgent or emergency services determined to be necessary and they were denied; ***or***
- Member continues to see a network Provider for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- Disputed health care service is denied, changed or delayed by L.A. Care based in whole or in part on a decision that the health care service is not medically necessary, ***and/or***
- Member filed a grievance with L.A. Care and the health care service is still denied, changed, delayed, or the grievance remains unresolved after 30 calendar days.

18.6.B Members must first go through the L.A. Care grievance process before applying for an IMR. In special cases, DMHC may not require Member to file an L.A. Care grievance before filing an IMR in cases where there is a serious threat to a Member's health. The dispute will be submitted to a DHMC medical specialist if it is eligible for an IMR. The specialist will make an independent decision to determine whether or not the care is medically necessary. The copy of the IMR decision will come from DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

18.7 Non-Urgent Cases

For non-urgent cases, the IMR decision must be made within 30 calendar days. The 30-day period starts when a Member's application and all documents are received by DMHC.

18.8 Urgent Cases

If the Member's grievance is urgent and requires a fast review, a Memberor a Provider acting on the behalf of a Member, may bring it to DMHC's attention right away. A Member will not be required to participate in the L.A. Care grievance process.

18.8.A For urgent cases, the IMR decision must be made within seven (7) calendar days from the time the information is received.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb, or major bodily function
- Immediate and serious deterioration of a Member's health

For more information on the DMHC IMR process, please visit:
https://dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx

18.9 Provider Information Request Notification

Often and at the investigatory stage of a Member grievance or appeal, a regulatory agency may request additional information from L.A. Care and its Providers. Once notified by the regulatory agency, the L.A. Care Appeals and Grievances Department will email or fax a Provider Information Request to the Provider requesting additional information on the Member's grievance or appeal.

Examples of documents or evidence L.A. Care may request from Providers include, but are not limited to the following:

- Authorizations
- Claims
- Denial Packets
- Medical Director Review
- Medical Records
- Notice of Action
- Provider Response

18.9.A Please note: requests for documents or evidence will vary and no two (2) cases are alike. It is the Provider's responsibility to reply to the requests made by L.A. Care in the manner instructed on the Information Request Notification form.

18.9.B Steps to Ensure a Complete and Timely Response include the following:

1. Review the Provider Information Request form from L.A. Care and any accompanying list of requested documents or actions.
2. Acknowledge receipt of request within 30 minutes via email at **CSC_RFI@lacare.org**, of receiving the request and include the following:
    - Acknowledgement of the due date and time
    - Name of person assigned to the case
    - Contact information for the person assigned to assist with the investigation
3. Contact the assigned L.A. Care Appeals and Grievance Specialist with any additional questions or concerns. The assigned Specialist's contact information will be on the Provider Information Request form.
4. Review the Provider Information Request form's list of issues and ensure the documents required are complete and all issues have been addressed.
5. Ensure the Provider response, including documents or evidence, is sent by the deadline noted on the Provider Information Request form.
6. Providers should send all responses to the email address noted on the Provider Information Request form and copy the following email: **CSC_RFI@lacare.org**.

18.9.C Providers are responsible for submitting all requested information made by L.A. Care within the timeframe specified for each request to support an appeal and grievance investigation.

18.10 Pharmacy Appeals

If a prescribing Provider would like to discuss a decision for a coverage determination denial with a clinical reviewer, or if the Provider does not believe the determination is corrector with the Department of Health Care Services (DHCS) Medi-Cal Rx Magellan. The Provider must provide information to support the appeal on the basis of medical necessity.

18.10.A Below is the PBM information that handles the determinations by line of business (LOB):

- **Navitus Health Solutions** (LOB: LACC/D, PASC)
  Phone: (844) 268-9785
  Fax: (855) 878-9207
  Website: **https://www.navitus.com/**

- **Medi-Cal RX – Magellan** (LOB: MCLA)
  Phone: (800) 977-2273
  Website: **https://medi-calrx.dhcs.ca.gov/home/**

For questions related to the formulary, prior authorizations, step-therapy, quantity limits, or therapeutic interchange, please call the related PBM.

18.10.B Providers may also submit a copy of the denial notice and a brief explanation of the concern with any other relevant information to the address below:

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

For more information on pharmacy, please visit Chapter 16 – Pharmacy and Formulary.

18.11 Provider Claim Disputes

A Provider dispute is a written notice challenging, appealing, or requesting consideration of a claim. Providers have a right to file a dispute in writing to L.A. Care within 365 days of the most recent action date if there are multiple actions.

For more information on how to dispute a claim, please refer to Chapter 12 – Claims and Payments.

18.12 For More Information

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

Chapter 19 – Behavioral Health

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

19.0 Introduction

The L.A. Care Health Plan (L.A. Care) Behavioral Health Department provides Mental Health and Substance Use Disorder Services through Primary Care Physicians (PCPs), Behavioral Health Specialty Providers through L.A. Care's behavioral health vendor, Carelon Behavioral Health (Carelon) (formerly known as Beacon Health Options), Los Angeles County Department of Mental Health (DMH), and Los Angeles County Department of Public Health (DPH). For Members enrolled in Medi-Cal, including MCLA line of business (LOB), the delivery system in which Members can access care is based on the type and severity of symptoms and impairment. For commercial LOBs, all services other than PCP screenings are provided by Carelon. The goal is to ensure and facilitate the provision of appropriate behavioral health services to L.A. Care Members.

Please note, it is the responsibility of the Provider to check and verify Member eligibility in order to identify the system of care to which the Member should be referred for services.

No prior authorization is required for an initial mental health assessment.

19.1 Behavioral Health Treatment (BHT)

L.A. Care covers BHT for all Medi-Cal members under 21 years of age with a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary. This includes Applied Behavior Analysis (ABA) and similar evidence-based treatments. A diagnosis of Autism Spectrum Disorder is no longer required for authorization of these services.

19.1.A For Members in the MCLA LOB, the BHT Provider Network is contracted directly through L.A. Care.

For questions or concerns regarding Behavioral Health Treatment (BHT) for Medi-Cal Members, please call or email:

- **By Phone:**
  L.A. Care ABA/BHT Services at (888) 347-2264
- **By Email:**
  ASDbenefit@lacare.org

19.1.B For Members in all other LOBs, please contact Carelon Behavioral Health (information below).

- **By Phone:**
  Carelon Behavioral Health at (877) 344-2858

19.2 Non-Specialty Mental Health Services (NSMHS)

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

*Mental Health Services may include treatment for anxiety, depression, and/or other related mental health conditions. PCPs may provide Members with outpatient mental health services that are within the PCP's scope. L.A. Care is responsible for outpatient mental health services for Medi-Cal Members with mild to moderate impairment(s) resulting from a mental disorder, referred to as Non-Specialty Mental Health Services (NSMHS).

These services include, but are not limited to:

- Mental health evaluation and treatment, including individual, group, and family psychotherapy
- Outpatient services that include lab work, drugs, and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Psychological testing to evaluate a mental health condition
- Maternal mental health services

Both Members and Providers can call Carelon Behavioral Health to coordinate triage and access care.

To contact Carelon Behavioral Health:

- **By Phone:**
  Carelon Behavioral Health at (877) 344-2858

To learn more about Carelon Behavioral Health services, please visit:
https://www.carelonbehavioralhealth.com/

To locate a Carelon Behavioral Health Provider, Providers can search here:
https://plan.carelonbehavioralhealth.com/find-a-provider/

19.3 Specialty Mental Health Services (SMHS)

L.A. Care Medi-Cal Members who meet criteria for SMHS may access services through DMH. SMHS, including inpatient psychiatric hospitalization for MCLA, is the responsibility of the DMH.

19.3.A These services include, but are not limited to:

- Outpatient Mental Health Services (assessment and treatment for Serious Mental Illness in adults and Serious Emotional Disturbance in children and adolescents)
- Medication Support
- Crisis Intervention and stabilization
- Day Treatment Services & Day Rehabilitation Services
- Therapeutic Behavior Services
- Residential Treatment Services
- Inpatient Psychiatric Hospitalization

To contact the DMH Helpline:

- **By Phone:**
  (800) 854-7771

For more information regarding the DMH, please visit: **https://dmh.lacounty.gov/***

19.4 Substance Use Disorder (SUD) – Preventive Services

L.A. Care covers Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) services in the primary care setting for all Members ages 11 years and older, including pregnant women. For more information and a list of validated screening tools, please visit: **https://samhsa.gov/sbirt** or refer to the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014.

19.4.A Medi-Cal Members may seek and obtain higher levels of outpatient SUD Treatment from the Department of Public Health, Substance Abuse Prevention and Control (DPH SAPC).

These services include, but are not limited to:

- Outpatient Treatment
- Intensive Outpatient Treatment
- Case Management
- Medications for Addiction Treatment
- Withdrawal Management (detox)
- Residential Treatment
- Recovery and Support

To contact DPH/SAPC:

- **By Phone:**
  (844) 804-7500

For more information on substance abuse treatment services, please access the links below:
http://publichealth.lacounty.gov/sapc/PatientPublic/Brochure.pdf
https://sapccis.ph.lacounty.gov/sbat/

19.4.B All Behavioral Health Services (mental health and substance use) for LACC, LACCD, and PASC-SEIU Members are offered by Carelon Behavioral Health. Both Members and Providers can call Carelon Behavioral Health to coordinate triage and access care.

To contact Carelon Behavioral Health:

- **By Phone:**
  Carelon Behavioral Health at (877) 344-2858

To learn more about Carelon Behavioral Health's services, please visit:
https://www.carelonbehavioralhealth.com/

To locate a Carelon Behavioral Health Provider, Providers can search here:
https://plan.carelonbehavioralhealth.com/find-a-provider/

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

L.A. Care adheres to a No Wrong Door policy to help ensure Members receive timely behavioral health services without delay, regardless of the delivery system in which they seek care. Members will be screened and transferred to the appropriate delivery system. For the Medi-Cal LOB, the No Wrong Door protocol is described in the DHCS APL 22-005.

19.5 Transgender Health

L.A. Care provides medically necessary Transgender Health Services (gender-affirming services) to our Members when they meet criteria for services, per APL 20-018 and pursuant to the clinical guidance of The World Professional Association for Transgender Health (WPATH) standards of care.

19.5.A Transgender services include the following:

- Behavioral health assessments for transgender services
- Medically Necessary hormone therapy
- Medically Necessary gender affirming surgery and procedures
- Preventive screenings (delegated to Member's PPG/IPA)

For questions regarding the L.A. Care Transgender Health Program, please contact: **transgenderhealthprogram@lacare.org**.

19.6 Behavioral Health Services Contact Information:

Organization	Services	Phone Number and Website Information
Carelon Behavioral Health	Medi-Cal Members (MCLA): Mental Health Services for mild to moderate (NSMS) only LACC, LACCD, and PASC: Mental health services and substance use disorder benefits (MH/SUD)	Carelon Behavioral Health: (877) 344-2858 Website: **https://www.carelonbehavioralhealth.com/**
MCLA- Behavioral Health Treatment (BHT)	MCLA only: BHT for individuals under 21 years of age	BHT: (888) 347-2264 Email: **ASDBenefit@lacare.org**
Los Angeles County Department of Mental Health (DMH)	Medi-Cal Members (MCLA): Specialty mental health services (SMHS) for assessment and treatment of serious mental illness (SMI) and serious emotional disturbance (SED).	DMH: (800) 854-7771 Website: **https://dmh.lacounty.gov/**
Los Angeles County Department of Public Health/Substance Abuse Prevention and Control (DPH/SAPC)	Medi-Cal Members (MCLA): Treatment for alcohol and/or substance use disorders.	DPH/SAPC: (844) 804-7500 Website: **http://publichealth.lacounty.gov/sapc/** Pamphlet: **http://publichealth.lacounty.gov/sapc/PatientPublic/Brochure.pdf**

19.7 For More Information

For questions regarding the information provided in this chapter, please contact the Behavioral Health Department at (844) 858-9940 or by email at **BehavioralHealth@lacare.org**.

Chapter 20 – Provider Training

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

For L.A. Care Medicare Plus (HMO D-SNP) specifications, please see HMO D-SNP Chapter starting on page 156.
*For information tailored to our Direct Network Providers, please refer to the **Direct Network Contracted Provider Reference Guide**.*

20.0 Introduction

The L.A. Care Health Plan (L.A. Care) Learning and Development Department offers no-cost workshops, online courses, and webinar trainings on several topics, as determined in L.A. Care's sole discretion, including those that are required and/or requested by certain regulators, and on other generic training topics; some trainings offer continuing education credits to network Providers and certain staff. The trainings are provided as either instructor-led classroom training or online in a virtual setting. Provider training and education (goals, objectives, curricula, and implementation guidelines) are established by L.A. Care based on regulatory requirements.

The goal of Provider training and education is to improve the delivery of services to L.A. Care Members by providing appropriate forums for Providers to:

- Be better informed about products offered by L.A. Care
- Comply with regulatory requirements
- Improve clinical/patient interaction
- Understand the needs of L.A. Care Members
- Updates to L.A. Care Policy and Procedures

In most cases, L.A. Care will notify Providers of the training and education sessions, including required regulatory training. Providers will be informed of how to register and participate in these training sessions before the event. It is the responsibility of the Provider to register, attend, and make any appropriate staff aware of these training sessions.

20.1 Provider Training and Education

The following section/sentence is only applicable to (as denoted between the asterisks): delegated Participating Physician Group (PPG), their Management Services Organizations (MSO), and affiliated Providers, as applicable.

* It is the responsibility of the PPG, per the PPG's contract between L.A. Care and the PPG, that the PPG ensure that its staff, as applicable, complete certain training and education as required by applicable laws, regulatory agencies, and L.A. Care. It is the obligation of the PPG to provide or "downstream" the information about the training requirements and the availability of certain training from L.A. Care to its affiliated Providers and staff.

20.1.A New Provider Onboarding (Orientation)
PPGs are responsible for ensuring that all of their Primary Care Physicians (PCPs), Specialists (SPC), and applicable staff receive onboarding training and education, including those required by applicable regulatory bodies and the National Committee for Quality Assurance (NCQA).

In order to ensure that PPGs are conducting onboarding training for their newly contracted Providers, which is compliant with contractual requirements and regulatory guidelines, L.A. Care will require the PPG, or its MSO on behalf of the PPG, to submit monthly reports.

- **20.1.A.1 Monthly Training Reporting Instructions:**
  1. Conduct onboarding and annual training to downstream to the providers and staff
  2. Document all trainings completed by each staff and/or downstream Providers, as applicable
     - Documentation must be kept on file and include, but are not limited to, sign-in sheets, attestations, and training materials, and policies and procedures
     - Onboarding training is considered valid for one (1) year of time; thereafter the Provider and/or staff, as applicable, must be trained on an ongoing basis
  3. Submit a report of newly contracted and trained PCPs, SPCs, and Mid-Level Providers to L.A. Care on the last business day of each month using the L.A. Care Monthly Training Report templates
     - Do not include: Office staff. Their training does not need to be submitted in the report, but must be tracked in order to provide evidence upon request by L.A. Care
     - Include: Per Diem "Locum Providers," if they are physicians who treat patients
     - Include: Contracted affiliated Providers (i.e. hospitalists)
  4. Important timeframes:
     - Trainings MUST take place within 10 business days of active status
       - Active or "effective" status dates are driven by the Provider Onboarding policy of the PPG/MSO
  5. Failure to submit timely, accurate, and complete, monthly reports will be identified as non-compliant and may result in the PPG being placed on a Corrective Action Plan (CAP)
  6. Submit the Monthly Training Report to L.A. Care via email at: **PNMTraining@lacare.org**
  7. To inquire or request the L.A. Care Monthly Training Report template, L.A. Care Sign-in Sheet, and/or L.A. Care Attestation, please email: **PNMTraining@lacare.org**

L.A. Care will conduct quarterly, ad hoc, and annual audits of PPG's records as necessary. These audits may include training reports, signed attendance sheets, attestations, training materials, policies and procedures, and may sample Provider records. *

- **20.1.A.2 Provider Education**

  L.A. Care's delegated PPGs are responsible for educating their network of downstream providers and staff on health education requirements and available L.A. Care health education services.

  Methods for educating may include, but are not limited to:
  - Fax blasts
  - Meetings
  - Newsletters
  - On-site visits
  - Provider mailings
  - Seminars or other trainings
  - Website postings
  - Zoom or other platform

  For more information on Provider education and the available resources, please refer to Chapter 9 – Health Education.

20.1.B Annual Regulatory Required Courses

The completion of annual regulatory required training courses (e.g. Fraud, Waste, and Abuse, General Compliance) are the responsibility of all Providers as well as their affiliated providers and staff, including those who provide health or administrative services (e.g. Provider, office staff, and medical staff). All required trainings must be completed within ninety days of contracting/hiring and annually thereafter.

- **20.1.B.1 L.A. Care University**
  To extend accessibility of certain learning and training courses to our contracted Providers and their staff, with the help of the online Learning Management System (LMS), L.A. Care has established the L.A. Care University. Inside of the L.A. Care University, Providers and their staff will find many of the required trainings and continuing education in a self-serve virtual environment.

In order to enter L.A. Care University and to complete training, learners must do the following:

- **20.1.B.2 Steps to Complete Training:**
  1. Use the registration code provided by L.A. Care to gain access to the website
     - To request a new or lost registration code, email: **lacareuniversity@lacare.org.**
  2. After obtaining a registration code, the Provider and its staff can the access L.A. Care University at: **https://lacarehea.plateau.com/learning/user/portal.do?siteID=LACareUniversity&landingPage=login.**
  3. Register as a New User on the L.A. Care University website
     - If already registered with L.A. Care University, DO NOT register again, simply log into the system for access to the L.A. Care learning catalog.
  4. Once inside L.A. Care University, to locate the curriculum or course needed, enter the course name in the Find Learning tile, and click Go.
     - For Providers who need to submit an attestation, enter "Attestation" in the Find Learning tile, and continue with the steps below.
  5. Select the course(s) or attestation to self-assign the session.
  6. The course content or attestation will open a new window to begin the session.
  7. Follow all instructions on the screen for completing the course(s) or submitting the electronic attestation.
  8. Complete the course(s) and receive an electronic certificate of completion with the option to print a certificate. Please keep a copy of the certificate.
  9. To view a list of completed courses or to retake a course, select the Learning History tile on the homepage and click View All.
  10. A Quick Reference Guide can be accessed via the My Learning Assignments tile on the homepage.
  11. The Provider is responsible for the code, as well as the user credentials and passwords and not share or disclose to anyone else. The Provider must ensure that only authorized staff use L.A. Care University. The Provider and its staff must comply with the terms and conditions of use for L.A. Care University, and L.A. Care's security requirements. If the Provider does not comply with L.A. Care's requirements, and/or its staff misuse or disclose the code to individuals who are not authorized, then L.A. Care may remove the Provider's access to L.A. Care University.

For questions regarding the L.A. Care University or the required courses, please email: **lacareuniversity@lacare.org.**

20.2 Provider Programs

L.A. Care offers Providers a wide range of Provider training opportunities and continuing medical education (CME) for some courses. These include:

20.2.A Provider Continuing Education (PCE) Program

The Provider Continuing Education (PCE) Program is an accredited educational program that consists of Continuing Education (CE) activities for physicians and CE activities for other healthcare professionals. PCE Program's ultimate goals are to share best practices to improve quality of Member care and patient outcomes, as well as partnerships and collaborations with other healthcare organizations.

For more information on the PCE Program, please visit:
https://www.lacare.org/providers/training/provider-continuing-education-program.

20.2.B Cultural and Linguistic Provider Training Series

The Cultural Competency and Disability Sensitivity trainings are designed to assist network Providers and office staff in delivering Member-centered care to diverse populations. The *Communicating through Health Care Interpreters* training offers CME credits.

For more information on Cultural and Linguistic Provider Training, please visit:
https://www.lacare.org/providers/training/cultural-and-linguistic-training.

For further information on the Cultural and Linguistic Department, please refer to Chapter 10 – Cultural and Linguistics (C&L).

20.2.C Quality Improvement Provider Training Series

An ongoing series of webinars, which cover a wide range of topics, related to quality improvement, including Healthcare Effectiveness Data and Information Set (HEDIS), Member satisfaction, data, and improving clinical outcomes. Some sessions provide the opportunity to earn CME or CE credits.

For more information on Quality Improvement Provider Trainings, please visit:
https://www.lacare.org/providers/training/webinars-for-ipas-and-providers.

For further information on the Quality Improvement Department, please refer to Chapter 6 – Quality Improvement.

20.3 For More Information

For questions regarding the information provided in this chapter, please contact the Learning and Development Department via email at **PNMTraining@lacare.org**.

L.A. Care HEALTH PLAN®

For A Healthy Life

L.A. Care Medicare Plus (HMO D-SNP) Chapter

Version 1.2

Table of Contents

Chapter 1 – Introduction

This Provider Manual is a subpart to the L.A. Care Universal Provider Manual (UPM) that contains information applicable only to L.A. Care Providers that are contracted to provide services for Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) enrollees ("Members") in L.A. Care's D-SNP program called L.A. Care Medicare Plus (HMO D-SNP). It includes a general overview of the L.A. Care HMO-D-SNP, provider functions and administrative activities that L.A. Care has delegated.

For the purpose of this HMO D-SNP section, L.A. Care's contracted network of providers and their Affiliated Providers are collectively known as "Providers". "Affiliated Providers" as used in this HMO D-SNP section refers to downstream providers employed or sub-contracted with the contracted Provider, such as physicians, hospitals, and other health care providers, per their applicable independent contractual agreement with such provider, under which they provide covered services to HMO D-SNP Members on behalf of the Provider or per the terms and conditions of the contracted Provider's agreement with L.A. Care. "Delegated Entities" as used in this HMO D-SNP section refers to L.A. Care contracted Providers who are delegated to render certain administrative services, e.g. UM or claims processing, associated with the covered services rendered to HMO D-SNP Members ("Delegated Activities") per the contracted Provider's applicable agreement with L.A. Care.

Chapter 2 – L.A. Care Medicare Advantage Prescription Drug Program Overview

The Medicare Prescription Drug Improvement and Modernization Act (MMA) introduced the Medicare Advantage Program and the Prescription Drug Benefit. The prescription drug benefit referred to as Medicare Part D. Coverage for the drug benefit provided through Medicare Advantage plans that offer both prescription drug and health care coverage.

The Bipartisan Budget Act (BBA) of 2018 permanently authorized D-SNP and strengthened Medicare-Medicaid integration requirements. Under the BBA, new terms introduced to describe the D-SNP level of Medicare and Medicaid known in California as ("Medi-Cal") integration.

Dual Eligible Special Needs Plan in California (Coordinated D-SNP): A MA plan that provides specialized care to beneficiaries dually eligible for Medicare and Medi-Cal, and offers care coordination and wrap-around services.

Exclusively Aligned Enrollment Dual Special Needs Plan (EAE D-SNP): A MA plan where the State's Department of Health Care Services (DHCS) limits enrollment in a D-SNP to full-benefit dual eligible individuals who are enrolled in a D-SNP for their Medicare benefits and a Medi-Cal Managed Care Health Plan (MCP) for their Medi-Cal benefits, and the D-SNP and MCP are both owned and controlled by the same parent organization. EAE D-SNPs are subject to the integrated appeals and grievances procedures provided under Federal law and rules.

Applicable Integrated Plans (AIP): The integrated appeals and grievances processes apply only to D-SNPs that qualify as "applicable integrated plans." D-SNPs qualify as applicable integrated plans if they operate with exclusively aligned enrollment and cover at least certain Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan. Centers for Medicare and Medicaid Services (CMS) designates applicable integrated plans at the plan benefit package level.

Chapter 3 – Medicare Advantage Prescription Drug Product

3.1 L.A. Care Medicare Plus (HMO D-SNP)

L.A. Care Medicare Plus (HMO D-SNP) is the name of the L.A. Care D-SNP plan available to Los Angeles County beneficiaries who are eligible for both Medicare and Medi-Cal (dual eligible) and are at least 21 years of age. This HMO D-SNP plan offers all services covered by Original Medicare Fee-For-Service (FFS) Parts A and B, Medicare Part D prescription drug coverage, and additional supplemental benefits that may be helpful to Members which are detailed in the D-SNP benefit materials. This plan coordinates benefits of Medicare and Medi-Cal services to Members through an established and robust provider network.

Chapter 4 – Contact Information

Department	Contact Information
Capitation	(213) 694-1250 ext. 5265
Care Management	(844) 200-0104
Claims	(866) 522-2736 For all L.A. Care responsible claims please submit by the following: By Mail: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081 Electronic Submissions: **www.changehealthcare.com** Electronic Payments: **www.payspanhealth.com**
Cultural and Linguistic Services	(855) 856-6943
Eligibility Verification	(866) 522-2736
Encounter Data	L.A. Care Provider Solutions Center: (866) 522-2736 Email: **ProviderRelations@lacare.org** FinThrive (formally TransUnion): Website: **https://finthrive.com**
Health Education Disease Prevention and Management	(855) 856-6943 Email: **HealthEd_Info_Mailbox@lacare.org**
Managed Long Term Services and Supports (MLTSS)	(855) 427-1223 Email: **mltss@lacare.org**

Department	Contact Information
Marketing/Sales	Marketing (213) 694-1250 ext. 4128 (213) 392-7785 Email: **L.A.CareMarketing@lacare.org** Sales (213) 330-6648 **HealthPlanFieldRepresentative@lacare.org**
Customer Solution Center	(833) 522-3767
Pharmacy	(800) 633-4227
Utilization Management Prior Authorizations/Hospital Admissions	L.A. Care's UM Department must be notified within 24 hours or the next business day following the admission. To obtain an Authorization: Call Toll-Free: (877) 431-2273 Inpatient Fax: (877) 314-4957 Outpatient Fax: (213) 438-5777 Written Requests: L.A. Care Health Plan Attn: Authorization 1055 W. 7th Street, 10th Floor Los Angeles, CA 90017
Provider Credentialing, Performance, and Certification	(844) 530-7596 E-mail: **credinfo@lacare.org**
Provider Information/Data Issues	Provider Solutions Center (866) 522-2736
Provider Network	L.A. Care Health Plan Attn: PNM/Contracts and Relationship Management 1055 W. 7th Street, 10th Floor Los Angeles, CA 90017 E-mail: **ProviderRelations@lacare.org**
Quality Improvement, Senior Director	(213) 694-1250 ext. 4312 Email: **quality@lacare.org**
Provider Fraud Waste Abuse	Compliance Officer at (213) 694-1250 ext. 4292 Compliance Helpline at (800) 400-4889 Email: **LACareComplianceOfficer@lacare.org** Fraud, Waste and Abuse Website: **www.lacare.ethicspoint.com**

Chapter 5 – Member Rights and Responsibilities

5.1 General Information

Providers must comply with the Members rights and responsibilities as outlined in the L.A. Care Medicare Plus (HMO D-SNP) Member Handbook. The Member Handbook for the applicable benefit year provided to Members annually is incorporated into this Provider Manual. The most current Member Handbook can be found on L.A. Care's Medicare website under the Member Materials section at **https://medicare.lacare.org**.

State and federal Law require that healthcare Providers and healthcare facilities recognize Member rights while the Members are receiving medical care. State and federal Law also require that Members respect the Provider's right to expect certain behavior on the part of the Members.

For additional information, please contact the L.A. Care Provider Solutions Center at (866) 522-2736. Available 24 hours/7 days a week. TTY/TDD users, please call 711.

Chapter 6 – Eligibility and Enrollment in L.A. Care's Medicare Plan

6.1 L.A. Care Medicare Plus (HMO D-SNP)

Dual Eligible beneficiaries' eligible to enroll into D-SNP:

- Must have both Medicare Part A and be enrolled in Medicare Part B;
- Eligible to enroll in a Medicare Part D Plan;
- Must be 21 years of age or older;
- Permanently reside in Los Angeles County;
- Must be a U.S. citizen or lawfully present in the United States;
- Beneficiary makes a valid enrollment request that is received by D-SNP during an election period; and
- Beneficiary or their legal representative completes an enrollment election form completely and accurately;
- Is fully informed and agrees to abide by the rules of D-SNP;
- Eligible to receive Full Medi-Cal benefits as defined by and determined by the State of California under one (1) of the following categories:
  - Dual Eligible Qualified Medicare Beneficiary (QMB) Plus Individuals;
  - Dual Eligible Specified Low-Income Medicare Beneficiary (SLMB) Plus Individuals;
  - Full Benefit Dual Eligible (FBDE) Individuals.
- Enrolled in the L.A. Care's Medi-Cal Managed Care Plan

6.2 Effective Date of Coverage

Members typically become enrolled, as determined by CMS, effective on the first (1st) day of the month after completing an enrollment application (paper, online, telephonic). Upon receipt of enrollment confirmation from CMS, L.A. Care will send a confirmation enrollment letter and a welcome packet to the Member that includes the L.A. Care Medicare Plus (HMO D-SNP) Member Handbook, identification (ID) card, and access to the Provider Directory.

6.3 Primary Care Physician

6.3.1 Selection and Assignment

At the time of enrollment, Members must select a PCP with an open panel from the HMO D-SNP Provider Directory. New plan Members may request assignment to a PCP with a closed panel as long as the Member is an established patient with the selected PCP. The Provider Directory also has helpful information about each PCP, PPG, clinic, and other Providers in the network. Members who do not select a PCP at the time of enrollment will be assigned one (1) by L.A. Care per applicable federal and state laws, and rules.

Members may change their PCP and/or PPG on a monthly basis online or by calling the L.A. Care Customer Solution Center at (833) 522-3767 (TTY: 711). In general, the change will occur on the first (1st) of the following month, provided the request is received by Customer Solution Center by the 20th of the month.

6.4 Disenrollment

L.A. Care will process Member disenrollment only as allowed by CMS and/or DHCS regulations. L.A. Care will only disenroll a Member under the following circumstances or as allowable under applicable Laws, rules and regulations:

- Member requests disenrollment (during a valid election period);
- Member enrolls in another health plan (during a valid enrollment period);
- Member leaves the L.A. County service area for more than six (6) months or directly notifies L.A. Care of the permanent change of residence;
- Member loses eligibility for Medicare Part A and/or Part B benefits;
- Member loses Medi-Cal eligibility for more than three (3) months;
- L.A. Care's contract with CMS terminates. In the event of termination, L.A. Care will send CMS-approved notices and a description of alternatives for obtaining services. The notice will be sent timely, before the termination of the plan; and/or,
- L.A. Care discontinues offering services in specific service areas where the Member resides

Providers or its staff may never verbally, in writing, or by any other action or inaction, request or encourage a Member to voluntarily disenroll.

6.4.1 Loss of Medi-Cal (Deeming Period)

Members that lose their dual eligibility status may remain enrolled in D-SNP for up to three (3) months in attempt to regain their Medi-Cal eligibility ("Deeming Period"). During this time, DHCS policy requires Members to be placed on Medi-Cal FFS and Providers must coordinate all covered Medi-Cal services through the state. During the Deeming Period, for services that are covered by Medicare and MediCal, Providers should not balance bill Members as the share of cost covered by Medi-Cal FFS will be covered by the Member's D-SNP Plan. If the Member regains their Medi-Cal eligibility within the Deeming Period, the Member may be re-enrolled in the D-SNP and re-enrolled in L.A. Care's Medi-Cal Managed Care plan. Members unable to regain their Medi-Cal eligibility prior to the end of the Deeming Period will be disenrolled from the D-SNP effective the last day of the Deeming Period month.

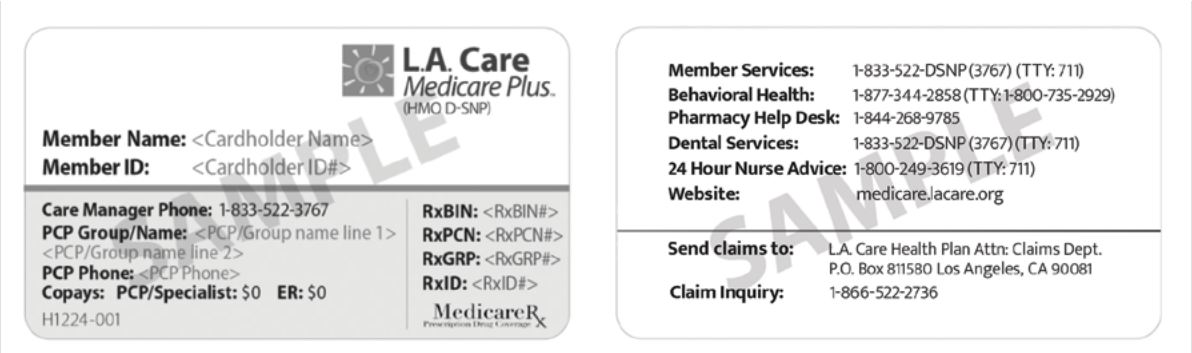
6.4.2 Out-of-Service-Area

Members will be disenrolled from HMO D-SNP if any of the following occur:

- Temporarily absent from Los Angeles County service area for over six (6) consecutive months, or
- Member confirms permanent residence outside of Los Angeles County service area for which disenrollment is effective the beginning of the following month.

6.5 Member Identification Card Example – Medical Services

Newly enrolled Members are issued a L.A. Care Member ID card like the example below. This card contains their Member ID number, their PPG/PCP's name, and telephone number. The cardalso provides important L.A. Care telephone numbers to assist Members and Providers to access services.



6.6 Verifying Eligibility

To ensure payment, L.A. Care strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility, coverage or payment. It is the responsibility of the Provider to verify the eligibility of the Member.

Providers who contract with L.A. Care or Delegated Entities may verify a Member's eligibility by checking the following:

- Provider Portal at **https://www.lacare.org/Providers/Provider-central/la-care-Provider-central**
- Provider Services automated Interactive Voice Response (IVR) system at (866) 522-2736

6.7 HMO D-SNP Members and Cost-Share

Members are eligible to receive benefits and services from both Medicare and Medi-Cal programs. Additionally, for covered services, Members will have their Medicare premiums, deductibles, and cost sharing covered by Medi-Cal until the annual maximum out-of-pocket (MOOP) is met.

Members may not be charged out-of-pocket costs or cost sharing for covered Medicare Part A and Part B services, including Part D prescription drugs. Providers may not impose cost sharing on Members for any Medicare covered services. All services covered by Medi-Cal must be provided with no copay.

HMO D-SNP has a yearly MOOP threshold amount set by L.A. Care for all accumulated payments covered under Medicare Part A and Part B. Once met, all covered Medicare benefits are covered at 100%. See the MOOP section within this document for more details.

For more information on HMO D-SNP benefits, please see the most current L.A. Care Medicare Plus (HMO D-SNP) Member Handbook found on L.A. Care's Medicare website under the Member Materials section.

Website: **https://medicare.lacare.org**.

Chapter 7 – Member Notice of Network Termination

Members must be notified in advanced when a Provider to whom they are assigned or receiving treatment from terminates from the network in accordance with § 422.111 and 422.2267. If that happens, L.A. Care or Delegated Entity will notify Members as provided below, and using L.A. Care approved materials. Additionally, Member's must be given the choice to select a different provider in the network, if available, by providing alternate options and assistance in selection of a different contracted provider.

Primary Care Provider or Participating Provider Group Terminations

For PCP or PPG terminations, L.A. Care must notify Members 45 calendar days in advance of effective date by letter and 1 call attempt (excluding members on the provider's "Do not call list"). In compliance with timely member notifications, PPGs must notify L.A. Care at least 60 calendar days in advance of any known PCP terminations in their network as required under the notice provisions of their provider agreement. The minimum elements that must be in the notice letter are listed below.

Behavioral Health (BH) Terminations

L.A. Care uses a vendor to manage the BH provider network, and this Delegated Entity is responsible for notifying Members 45 calendar days in advance of the effective date of the of a provider termination. Notice must be given by letter sent to the Member and 1 call attempt (excluding Members who are on the provider's "Do not call list"). The minimum elements that must be in the notice letter are listed below.

Specialist Terminations

L.A. Care generally delegates the management of specialist and certain facility providers in its network. For any specialist or facility subcontracted with a Provider, the Delegated Entity, as applicable, must notify the Member of the termination of their network specialist or facility, seen by a Member within the past 3 months, by letter, 30 calendar days in advance of effective date of the termination of such specialist or facility provider. The minimum elements that must be in the notice letter are listed below.

Summary

Provider Type	Timing	Notification Method	Responsibility	Letter Elements
Primary Care Provider (PCP)	45 calendar days	Letter and 1 call attempt	L.A. Care	Must be in the following order: Inform Member provider is no longer in network and effective date of termination
Behavioral Health (BH)	45 calendar days	Letter and 1 call attempt	Delegated Entity	Provide alternate list of in-network providers
Other provider or facility seen by the Member within the past 3 months	30 calendar days	Letter	Delegated Entity	How Member can request continuity of care from terminating provider Medicare enrollment periods L.A. Care contact info and hours of operations

Chapter 8 – Benefit Overview

8.1 Benefit Materials

The most current L.A. Care Medicare Plus (HMO D-SNP) Member Handbook can be found on the L.A. Care Medicare website under the Member Materials section.

Website: **https://medicare.lacare.org**.

8.2 Obtaining Access to Certain Covered Services Preventive Services

8.2.1 Preventive Services

Medicare covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. In addition, Medicare-covered preventive services are available at no cost to the Member.

For a complete list of HMO D-SNP covered preventive services, please see the most current L.A. Care Medicare Plus (HMO D-SNP) Member Handbook found on L.A. Care's Medicare website under the Member Materials section.

Website: **https://medicare.lacare.org**.

8.2.2 Telehealth and Telemedicine Services

Members may obtain covered services through the telehealth and telemedicine services if the capability is available. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are not permitted when the Member and participating Provider are in the same physical location
- Services do not include texting, facsimile or email only communications
- Services include preventive and/or other routine or consultative visits during a public health emergency
- Covered services provided through store-and-forward technology must include an in-person office visit to determine diagnosis or treatment
- The use of telehealth modalities also satisfies the federal requirements for the annual Member face-to-face encounters

L.A. Care shall inform Providers offering Telehealth services at least 10 days in advance to conduct testing of their platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for Telehealth capabilities and according to the preference of L.A. Care. Provider shall make its personnel reasonably available to answer questions from L.A. Care regarding Telehealth operations.

For additional information on Telehealth and Telemedicine claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

8.3 Supplemental Services

L.A. Care offers supplemental benefits not covered by Original Medicare, as approved by CMS. Supplemental benefits may include an allowance for some over-the-counter (OTC) health items, dental, vision services, access to fitness facilities, and other benefits available to all Members eligible for it. The supplemental benefits offered are subject to CMS approval and may change for each benefit year.

Supplemental Dental Benefits

Supplemental dental benefits are offered to Members through the HMO D-SNP and must be exhausted prior to or concurrent with authorization of or referral for Medi-Cal Dental benefits.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

HMO D-SNP offers some supplemental benefits for Members with certain chronic conditions called Special Supplemental Benefits for the Chronically Ill as allowed by CMS. SSBCI benefits may include an allowance towards heathy foods/groceries, utilities, and gasoline at the pump. SSBCI offered are subject to CMS approval and may change for each benefit year.

L.A. Care determines a Member's SSBCI eligibility by the criteria listed below:

- Completed Initial Health Risk Assessment (HRA) if Member is new to L.A. Care, or
- Completed Annual Health Risk Reassessment within 365 days of new benefit year if Member is an existing , and
- Have one (1) or more of the following qualifying chronic conditions and meet the eligibility criteria determined by CMS:
    - Autoimmune Disorder
    - Cancer
    - Cardiovascular Disorders
    - Chronic Alcohol and Other Drug Dependence
    - Chronic and Disabling Mental Health Conditions
    - Chronic Heart Failure
    - Dementia
    - Diabetes
    - End-Stage Liver Disease
    - End-Stage Renal Disease (ESRD)
    - HIV/AIDS
    - Chronic Lung Disorders
    - Neurologic Disorders
    - Severe Hematologic Disorders
    - Stroke
- Have a high risk of hospitalization or other adverse health outcomes
- Require intensive care coordination

Providers can help Members obtain SSBCI benefits by reminding Members to complete an initial or annual HRA, as applicable, and ensure that the applicable above qualifying conditions are documented in the Member's annual wellness exams (AWE) performed.

Please visit L.A. Care's website to access the L.A. Care Medicare Plus (HMO D-SNP) Member Handbook for details on supplemental benefits as well as the Provider Directory for supplemental benefit Provider contact information at **https://medicare.lacare.org/**.

8.4 Provider Education on Covered Benefits and Member Access to Care

L.A. Care provides the necessary tools, information, and education to Providers to ensure Members understand their benefits and how to access care. This includes, but is not limited to, the following:

- How to identify HMO D-SNP and L.A. Care Medi-Cal covered benefits

- How to access Medi-Cal carved-out services, including waiver services such as Long Term Support Services (LTSS), In-Home Support Services (IHSS), or certain Behavioral Health Services. See the list of agencies and contact information under section 8.6 Medi-Cal Carved Out Covered Benefits below
- How to access care virtually through digital health education
- Please visit L.A. Care's website for Provider tools and resources at **https://www.lacare.org/providers/provider-resources/tools-toolkits**

8.5 Access to Care Standards

Access to timely, comprehensive, equitable, and quality health care services is important for promoting and maintaining health, preventing and managing disease, and reducing unnecessary disability and premature death. Providers must ensure their hours of operation are convenient to, and do not discriminate against, Members. L.A. Care requires Providers to have adequate coverage or backup to ensure medically necessary services are available 24 hours a day, 7 days a week. The standards provided by L.A. Care considers the Member's need and common waiting times for comparable services in the community. (Examples of reasonable standards for primary care services are: (1) urgently needed services or emergency - immediately; (2) services that are not emergency or urgently needed, but in need of medical attention - within one week; and (3) routine and preventive care - within 30 days).

Access to Care Quick Tips can be found here:

https://www.lacare.org/sites/default/files/la2573_access_to_care_tips_202301rev.pdf

8.6 Medi-Cal Carved Out Covered Benefits

For Medi-Cal covered services not covered under HMO D-SNP, Providers, including Delegated Entities, will need to coordinate services with L.A. Care's Medi-Cal Plan, Medi-Cal FFS, and/or any of the following agencies, as applicable:

- **Behavioral Health Services**
  County Mental Health Plans (CMHP)
  Contact information can be found at:
  Department of Mental Health - hope. recovery. wellbeing. (lacounty.gov)

- **In-Home Support Services (IHSS)**
  County IHSS Office
  Contact information can be found at:
  https://www.cdss.ca.gov/inforesources/county-ihss-offices

- **Medi-Cal Dental Benefits**
  Contact information can be found at:
  https://smilecalifornia.org/contact-us/

- **Medi-Cal Dental Managed Care**
  Contact information can be found at:
  https://dental.dhcs.ca.gov/Dental_Providers/Dental_Managed_Care

- **Medi-Cal Pharmacy Benefits**
  Medi-Cal Rx
  Contact Information can be found at:
  https://medi-calrx.dhcs.ca.gov/home/contact

Chapter 9 – Health Care Benefits

Providers are required to cooperate and comply with L.A. Care's utilization management and care management programs, including HMO D-SNP Model of Care requirements, policies and procedures for facility admission, prior authorization, medical necessity review determination, interdisciplinary care team, and applicable federal and state requirements. Providers must also cooperate with L.A. Care in audits to identify, confirm, and/or assess utilization levels of covered services.

9.1 Model of Care

L.A. Care's Model of Care (MOC) is a structured framework and care management approach that enables the delivery of coordinated and comprehensive services to beneficiaries. It outlines the organization's strategies for improving healthcare outcomes, enhancing patient experience and quality of care.

L.A. Care's MOC program ensures medically necessary covered services are available and accessible to Members, including but not limited to Members who:

- Have limited English proficiency or reading skills
- Are of ethnic, cultural, racial, or religious minorities
- Have disabilities
- Identify as lesbian, gay, bisexual, other diverse sexual orientations, transgender, non-binary, and other diverse gender identities, or people who were born intersex
- Live in rural areas and other areas with high levels of deprivation

Delegated Entities are expected to follow L.A. Care's MOC program to coordinate a Member's care to ensure they achieve the best possible outcomes as described within the MOC program.

Our MOC program addresses the following areas:

- Extensive care coordination and Care Management through HRA, Individualized Care Plan -(ICP), face-to-face encounters, Interdisciplinary Care Team (ICT), Transition of Care (TOC) and Continuity of Care (COC)
- Provider networks are trained to care for the needs of our target population
- Continuous quality improvement program and benchmark performance goals to improve Member health outcomes
- Initial and annual MOC training for Delegated Entities, Providers, and their staff seeing Members on a routine basis
- Initial and annual ICT training to a Member's care team participants, specifically addressing new key areas:
    - A comprehensive understanding of Medicare and Medi-Cal LTSS programs including home and community-based services and long-term institutional care. The members ICT must include Medi-Cal providers when a Member is receiving Medi-Cal coordinated services
    - Providers caring for Members with cognitive impairment are encouraged to leverage Dementia Care Aware curriculum to gain an understanding for the importance of cognitive care and screening. A Provider must have an understanding of Alzheimer's disease and Related Dementias (ADRD), symptoms and progression, understanding and managing behaviors and communication problems caused by ADRD, caregiver stress and its management, and community resources for Members and their caregivers.
    - Dementia care specialists (Non-physician providers) must be trained in understanding cognitive disease process and the importance of completing a full diagnostic workup. Dementia care specialists can leverage tools presented in the California Alzheimer's Disease Centers' "Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease" to find training curriculum that will provide the necessary competencies to care for members with cognitive impairments

New Program Requirements for CY2024:

- **Medicare Enhanced Care Management (ECM)**
  - L.A. Care will be required to deliver ECM-like services beginning in 2024, delegates are encouraged to use the targeted criteria and populations below to refer members to this internally managed program
  - L.A. Care's most vulnerable Members include four distinct populations of focus from the Medi-Cal ECM model:
    - Pregnancy, Postpartum and Birth Equity
    - Adult Nursing Facility Residents Transitioning to the Community
    - Members At Risk for Avoidable Hospital or Emergency Department Utilization
    - Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization

- **Medicare Palliative Care**
  - Members may receive the same Medi-Cal palliative care services, as outlined in Senate Bill 1004 and DHCS All Plan Letter 18-020, which are also covered by Medicare, such as:
    - Advance Care Planning
    - Palliative Care Assessment and Consultation
    - Plan of Care
    - Palliative Care Team of doctors, nurses, social workers, chaplain, and other specialists
    - Care Coordination
    - Pain and Symptom Management
    - Mental Health and Medical Social Services
  - Eligible palliative care Members must be referred to L.A. Care's MLTSS department to coordinate services. The palliative care coordinator will serve as lead Care Manager for the Member and will be involved in care team meetings. For Members with serious illness participating in a palliative care program, a palliative care focused ICT, with the participation of palliative care providers and/or care managers will be required.

- **Caregiver Assessment**
  - If a caregiver is identified during the HRA process, L.A. Care will perform a separate assessment with the Member's caregiver to ensure that the Member's needs are being met

9.2 Care Management

The care management program provides care coordination and health education for health condition management, as well as, identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals, in accordance with federal and state requirements and L.A. Care's MOC. Care management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members. The care management program is designed to specifically identify and support those most vulnerable and provide Members with tools and services to manage their conditions within the least restrictive environment. Members receive a HRA upon initial enrollment and annually thereafter. The HRA screens for physical health, behavioral health, medication management problems, and social determinants of health (such as housing, transportation, education, income, food, security, etc.). The HRA stratifies Members into either complex, high or low risk levels in accordance with L.A. Care policy. Risk stratification helps target high-need Members who would benefit from more intensive support and education from a case manager. Additionally, functional, social support, and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

Upon completion of the risk stratification there is a division of responsibility between L.A. Care and the Delegated Entity's care management teams. Unless otherwise specified in the Provider's contract, L.A. Care's care managers

will be responsible for the care management of Members stratified as high or complex risk. Delegated Entity's Care Managers will be responsible for the care management of Members stratified as low risk. If there is a change in the risk stratification levels assessed, L.A. Care and the Delegated Entity will coordinate the transfer of care management between the two (2) parties.

The role of the Care Manager includes:

- Coordination of quality services and timely interventions that increase efficiency and effectiveness of care and services provided to the Member
- Development and implementation of an ICP driven by the Member's clinical and behavioral conditions, social determinants of health and preferences. ICP is regularly updated as the Member's conditions, needs, and/or health status changes
- The use of historical medical and pharmacy claims data will be utilized to develop the Member's ICP if the Member cannot be reached
- The ICP must identify any carved-out services the Member needs and how L.A. Care will facilitate access and referrals (at least three (3) documented outreach attempts). Those services may include but are not limited to the following:
    - Community based services
        - Ex: Legal aid, financial assistance, access to phone and internet, programs and services for families of members living with dementia Senior centers
    - County mental health and substance use disorder services
    - Community Supports Services
        - L.A. Care's Ex: Housing transition and sustaining services, recuperative care, short-term non-medical respite and sobering centers)
    - Home and Community Based Services (HCBS) and Multipurpose Senior Service Program (MSSP) under 1915(c) waiver programs
        - Ex. Case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care.
    - LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
    - Non-Emergent or Non-Medical transportation
- Medi-Cal dental benefitsPromotion of the health, independence, and optimal functioning of Members in the most proactive, effective, and least restrictive way
- Collaboration and communication with the PCP and/or specialists, and other health care Providers regarding completed clinical assessments and care plans
- Education and involvement of the Member and family in the coordination of services to promote self-management
- Coordination of access to Member benefits and appropriate services across the healthcare continuum
- Assistance with transitions between care settings and/or Providers including timely notification to L.A. Care from its Delegated Entities
- Facilitation of ICT meetings and updates to Member care plan goals and intervention based on ICT recommendations and Member health status progress
- Promotion of multidisciplinary care including clinical, behavioral, and rehabilitative services

Referral to and coordination of appropriate resources and support services, including but not limited to Long-Term Services & Supports (LTSS):

- Attention to Member preference and satisfaction
- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality

- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence
- Protection of Member rights
- Promotion of Member responsibility and self-management

Referral to Care Management can be made by the following entities:

- Member or Member's designated representative(s)
- Member's PCP
- Specialists
- PPGs
- Hospital Staff
- Home Health Staff
- L.A. Care Staff
- Care Management Contact

Providers may direct Members in need of Intensive Care Management by calling (844) 200-0104.

9.3 Advance Care Planning (ACP)

Face-to-face services between a physician or other qualified healthcare professional (QHP) and the Member, including in the presence of their family member, a caregiver, or surrogate, to discuss the Member's healthcare choices if they become unable to make their own medical decisions.

Advance Care Directive (ACD)
As part of this discussion, you may talk about forms such as advance directives.. An advance directive appoints an agent and records a Member's medical treatment wishes/choices based on their values and preferences.
Examples include:

- Living wills
- Medical orders for life-sustaining treatment
- Health care proxy
- Durable power of attorney for health care
- Psychiatric advance directives

Documentation Requirements
Documentation of Advanced Care Planning activities, including discussions, education, completion or member refusal, should be documented in the Members chart/notes and inputted into the electronic medical record (EMR). Examples of additional findings that should be recorded in the Member's record include:

- The voluntary nature of the visit
- The explanation of advance directives
- Who was present
- The time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the member becomes unable to make their own decisions

Coding

Table 1. CPT Codes & Descriptors
In order to be billable under Medicare, Advance Care Planning discussions must be face-to-face or eligible Telehealth conversations with D-SNP Members and/or their authorized representatives (the Member does not need be present).

The Advanced Care Planning discussions should cover the Member's specific health conditions, their options for care and what care best fits their personal wishes, and the importance of sharing those wishes in the form of a written document. The table below presents billable codes for ACP activities and a description of each:

CPT Code	Description
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the Member , family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
G0438 or G0439	Added on HCPCS codes when performed on the same day as a Annual Wellness Visit

Table 2. ACP Minutes & Corresponding CPT Codes & Units

ACP Minutes	Description
less than 15 min	Don't bill any ACP services
16 – 45 min	CPT code 99497 (1 unit)
46 – 75 min	CPT code 99497 (1 unit) **and** CPT code 99498 (1 unit)
76 – 105 min	CPT code 99497 (1 unit) **and** CPT code 99498 (2 units)

9.4 Referrals

With the exception of emergency services, a referral may be necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice, or if it is necessary to consult or obtain services from other in-network specialty health professionals. Information is to be exchanged between the PCP and specialist to coordinate Member care. Providers need to document referrals that are made in the Member's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers that are contracted with L.A. Care. In the case of urgent and emergency services, Providers may direct Members to an appropriate service including, but not limited to, urgent care, and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from L.A. Care or its Delegated Entity, as applicable, except in the case of urgent and Emergency Services.

9.5 Plan-Directed Care

When a Provider or a non-contracted Provider furnishes non-covered services to a Member that the Member believes are covered, federal law prohibits holding the Member financially liable for the service. The Provider is responsible for ensuring that the services rendered are covered services and, if applicable, the covered services are pre-authorized prior to rendering such services. In these circumstances, the service may be referred to as "Plan Directed Care."

Services with a denied authorization request will not be covered. L.A. Care requires the following below:

- Providers should not refer to out-of-network Providers without prior authorization
- If a Provider knows or believes an item or service furnish by an out-of-network Provider will not be covered, the Member or Provider must request a prior authorization request. An Advance Beneficiary Notice (ABN) may not be used. In the case of a Member who routinely receives the same non-covered service, one denied authorization request received at the beginning of the course of service may be used, as long as it is clear that the Member understands that the services will never be covered.

If a Provider fails to follow these authorization requirements, L.A. Care or Delegated Entity, as applicable, may decline to pay the claim, and the referring Provider will be held financially responsible for services received by the Member. Refer to CMS's *Medicare Managed Care Manual* Chapter 4 - Benefits and Beneficiary Protections Section 160 Beneficiary Protections Related to Plan-Directed Care at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.**

PLEASE NOTE—A PROVIDER MUST NEVER USE AN ABN WITH A HMO D-SNP OR MEDICARE MANAGED CARE MEMBER

9.5.1 Continuity of Care for Medicare Primary and Specialty Providers

Under the DHCS CalAIM D-SNP Policy Guide, upon Member request, or request by other Authorized Representative as noted below, and as required by applicable Laws, rules, and guidance, D-SNP or Delegated Entity must offer COC with out-of-network Medicare Providers to all Members if all of the following circumstances exist:

- A Member has an existing relationship with a primary or specialty care Provider. An existing relationship means the Member has seen an out-of-network PCP or a specialty care Provider, at least once, during the 12 months prior to the date of their initial enrollment in D-SNP for a non-emergency visit;
- The out-of-network Provider is willing to accept, at a minimum, payment from L.A. Care based on the current Medicare fee schedule, as applicable; and
- The out-of-network Provider does not have any documented quality of care concerns that would cause L.A. Care or a PPG to exclude the Provider from its network

Each COC request must be completed within:

- 30 calendar days from the date L.A. Care or Delegated Entity receives the request;
- 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- Three (3) calendar days if there is risk of harm to the Member

After a review of COC request resulting in denial for not meeting the above criteria, an integrated denial notice known as the Coverage Decision Notice will be issued to the Member along with their rights to appeal.

9.5.2 Continuity of Care for Medicare Durable Medical Equipment and Medical Supply Providers

Members will have access to medically necessary Medicare covered Durable Medical Equipment (DME) and medical supplies as required by both 42 CFR 422.100(l)(2)(iii) and CalAIM D-SNP Policy Guide.

New Members joining the D-SNP that have an open authorization for Medicare covered medical supplies may continue to receive their supplies through the existing provider for 90 days or until L.A. Care or its Delegated Entity is able to evaluate the Member's care and treatment, and if medically necessary, authorize the applicable supplies through their in-network Provider.

For more information on COC requirements please refer to the CalAIM D-SNP Policy Guide at **https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx.**

9.6 Utilization Management

Providers must obtain the appropriate Prior Authorizations (PA) for plan covered inpatient and outpatient services listed within this section below. Coverage decisions are based on Medicare guidance, including National Coverage Determinations (NCD) and Local Coverage Determination (LCD) guidelines, state guidelines, and L.A. Care policies.

Specialty Providers must obtain advance approval for a prior authorization or referral for pre service request and payment of a service to a Member. Unless specified by L.A. Care, or its Delegated Entity, Members are not responsible for obtaining prior authorizations or referrals.

In some instances, Delegated Entities may be responsible for Utilization Management (UM) and claims processing functions and must meet the same regulatory and accreditation requirements as L.A. Care. In such cases, specialty Providers must obtain a prior authorization from the Member's assigned Delegated Entity.

For questions, please call L.A. Care's Provider Solutions Center at (866) 522-2736.

9.7 Prior Authorizations

Prior authorization ensures services are based on medical necessity, are a covered benefit, and are provided by appropriate Providers. Providers are responsible for verifying eligibility and ensuring the appropriate prior authorization review has been conducted by L.A. Care, or its Delegated Entity for elective non-emergency and scheduled services, before providing those services.

Prior authorization is required for all elective and out-of-network services with the exception of emergency room or urgent care visits. HMO D-SNP services requiring prior authorization include but are not limited to:

- Inpatient Hospital-Acute
- Inpatient Hospital-Psychiatric
- Skilled Nursing Facility (SNF)
- Cardiac and Pulmonary Rehabilitation Services
- Partial Hospitalization
- Home Health Services
- Dialysis Services
- Occupational Therapy Services
- Physician Specialist Services excluding Psychiatric Services
- Podiatry Services
- Specialty Professional Services
- Physical Therapy and Speech-Language Pathology Services
- Opioid Treatment Program Services
- Outpatient Diagnostic Procedures, Tests, X-rays and Lab Services
- Outpatient Diagnostic and Therapeutic Radiological Services
- Outpatient Hospital Services
- Ambulatory Surgical Center (ASC) Services
- Outpatient Substance Abuse Services
- Ground and Air Ambulance Services
- Outpatient Blood Services
- Durable Medical Equipment
- Prosthetics/Medical Supplies

- Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts
- EKG following Welcome Visit
- Medicare Part B Chemotherapy/Radiation Drugs
- Medicare Part B Insulin Drugs
- Other Medicare Part B Drugs
- Comprehensive Dental
- Eyewear
- Hearing Exams

9.8 Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request a second opinion from another Provider at no cost to the Member. Members, or their Authorized Representatives, or Providers should call Member/Provider Services line to find out how to get a second opinion. Second opinions may require prior authorization.

9.9 Integrated Organization Determination

9.9.1 Definitions

Integrated Organization Determination: Any determination (an approval or denial) made by L.A. Care, or its Delegated Entity, for both Medicare and Medi-Cal. Providers must implement the process set by L.A. Care for Members to request an Integrated Organization Determinations. The process for requesting an Integrated Organization Determinations must be the same for all covered benefits.

Coverage Decision Notice: Notices are only sent to Members as a result of an adverse decision on Integrated Organization Determinations for a covered service or item (including a Part B drug) that is not resolved fully in favor of the Member. The notice will contain the Member's rights to an integrated appeal.

Processing Timeframes
L.A. Care and/or its Delegated Entity will process a request for Integrated Organization Determination within the following timeframes shown below.

Type	Processing Timeframe	With Extension
Part C Pre-Service	5 business days of receipt of information or 14 calendar days	N/A
Part B Drug	72 hours	N/A
Part B & C Payment: Clean Claims	30 days	N/A
Part B & C Payment: Other Claims	60 days	N/A
Part C Pre-Service: Expedited	72 hours	N/A
Part B Drug: Expedited	24 hours	N/A

Notification
If the request was filed by the Member's Authorized Representative, the Authorized Representative must be notified instead of the Member. L.A. Care or its Delegated Entity may provide notice to both the Authorized Representative and the Member but such notice to both is not required.

Decision Type	Reason	Action
Pre-Service Approval	Services approved	Written or verbal notification If the Member agrees, L.A. Care or its Delegated Entity may send the notice by fax or e-mail
Denials	Reduce, stop, suspend, or deny, in whole or in part, a request for a service/item (including a Medicare Part B drug) for new services	A written denial notice "Coverage Decision Letter" and separate attached Department of Managed Health Care's (DMHC's) Independent Medical Review (IMR) (if applicable) is required to be sent to the Member (and physician involved, as appropriate) Delegated Entities should not send a notice for a service/item that is fully covered under the HMO D-SNP or L.A. Care Medi-Cal plan
Reducing, suspending or terminating a previously approved service	Reduce, stop, suspend, or deny, in whole or in part, a request for a service/ item (including a Medicare Part B drug) for previously approved services	A written denial notice "Coverage Decision Letter" and separate attached DMHC IMR (if applicable) is required to be sent to the Member (and physician involved, as appropriate) within 10 calendar days before the date of action (termination, suspension, or reduction becomes effective) Delegated Entities should not send a notice for a service/item that is fully covered under the HMO D-SNP or L.A. Care Medi-Cal plan

L.A. Care and its Delegated Entities will process standard organizational determinations within five (5) business days from receipt of information reasonably necessary to make the determination and no later than 14 calendar days from when the request is received.

For Expedited Integrated Organizational Determinations, a notice must be sent as expeditiously as the Member's health condition requires and no later than 72 hours from when the request is received. No extension of the above timeframe is permitted.

Prior to terminating, suspending, or reducing a previously approved item or service, notice to Member's with an integrated coverage determination will be sent at least 10 calendar days in advance of the effective date of the adverse organizational determination. In the event of the adverse organizational determination, if the Member wants continuation of benefits for the previously approved Medicare and/or Medi-Cal benefit(s) that the plan is terminating, suspending, or reducing then the Member must ask for the continuation of the applicable benefit within 10 calendar days of the notice's postmark date or by the intended effective date of the action, whichever is later.

When the following requirements are met, an Integrated Coverage Decision Letter will be sent to Members within the required timeframes for fully or partially denied Integrated Organization Determinations and a separate notice, will be attached, using the most current form available informing Members of their appeal and state fair hearing rights after the L.A. Care's appeal process has taken place:

- The denied Integrated Organization Determination is not for a Medicare only service or benefit; and
- The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal service/ benefit, including cases where there is an overlap of Medicare/Medi-Cal
- Members must be informed of their rights to the DMHC's IMR and include the verbatim language required by HSC § 1368.02(b), the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:
- The denied Integrated Organization Determinations is for experimental or investigational therapy, or is a denial of urgent care or emergency service; and
- The denied Integrated Organization Determinations is not for a Medicare only service or benefit; and
- The Integrated Organization Determinations is relating to a denial, in whole or in part, of a Medi-Cal service/ benefit, including cases where there is an overlap of Medicare/Medi-Cal

9.10 Utilization Management Contacts

L.A. Care Utilization Management Department:

Phone Numbers:
General UM and Inpatient Referrals: (877) 431-2273
Provider Solutions Center: (866) 522-2736

Fax Numbers:
General Routine: (213) 438-5777
Urgent: (213) 438-6100
Inpatient: (877) 314-4957
Long Term Care: (213) 438-4877
Community Based Adult Services: (213) 438-5739
Behavioral Health Treatment: (213) 438-5054

If the Member is assigned to a Delegated Entity, the scope of delegated functions varies based on each entity, and L.A. Care retains responsibility for providing authorization and coordination of services for all non-delegated functions.

For more information regarding the appropriate entity responsible for providing an authorization, please visit: **www.lacare.org/umforms**

9.11 Emergency Services, Urgent Care, and Post-Stabilization Services

9.11.1 Emergency Services

L.A. Care covers emergency services as well as urgently needed services and post-stabilization care for Members in accordance with applicable federal and state law.

Covered services provided to evaluate or treat an emergency medical condition ("Emergency Services"). ("Emergency Medical Condition") is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

The attending physician treating Members for Emergency Services will determine when the Member is stabilized and deemed ready for discharge out of an emergency setting or transfer to another care setting.

9.11.2 Urgently Needed Services

Covered services:

- Are not Emergency Services, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when (a) the Member is temporarily absent from the L.A. Care service area and therefore cannot obtain the needed service from a network Provider; or (b) when the Member is in L.A. Care's service area, but the network is temporarily unavailable or inaccessible; and

- Given the circumstances, it was not reasonable for the Member to wait to obtain the needed services from the Member's regular plan Provider after returning to the service area, or the network becomes available

Emergency Services and Urgently Needed Services do not require pre-authorization, although contracted Provider notification requirements may apply. See Emergency Inpatient Admissions below.

9.11.3 Post-Stabilization Care Services
Post-stabilization services are services related to an emergency medical condition. They are provided after the Member's immediate emergent medical problems are stabilized. They may be used to stabilize, improve or resolve the Member's condition. Post-Stabilization Care Services do require pre-authorization.

9.11.4 Inpatient Admission Notification and Management
L.A. Care requires contracted PPGs, hospitals and SNFs to provide timely electronic notification within 24 hours of any admission to the hospital or SNF of all Members in accordance with federal, state, and contractual requirements in order to coordinate appropriate care.

9.11.5 Elective Inpatient Admissions
L.A. Care requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., including hospitals, SNF, and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACH), and acute inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the Member.

Inpatient facilities are also required to notify L.A. Care of the admission within 24 hours. Inpatient notifications may be submitted by fax.

Continued inpatient stays must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission, or documentation to support the level of care may result in denial with Provider liability. Members cannot be held liable for failure of a contracted Provider to follow the terms of the relevant Provider agreement and Provider Manuals.

9.11.6 Inpatient at Time of Termination of Coverage
Members hospitalized on the day L.A. Care coverage terminates are usually covered through discharge. Specific plan rules and Provider Agreement provisions may apply.

9.11.7 NOTICE Act
Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the Member that they are an outpatient receiving observation services and not a hospital inpatient. The Member is informed that the Member's services are covered under Medicare Part B. Additional information is provided to the Member with regard to how an observation stay may affect the Member's eligibility for a SNF level of care and that Medicare Part B does not cover self-administered drugs.

9.11.8 Readmissions
Readmission review is important to ensure that Members receive hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

9.11.9 Out-of-Network Providers and Services
For out-of-network Providers and services, at a minimum, L.A. Care or its Delegated Entity, as applicable, will perform a quality check to ensure the Providers are licensed, in good standing, certified, if applicable, and meet eligibility for reimbursement and payment for state and federal programs (free of restrictions, sanctions and exclusions).

L.A. Care requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services provided by non-contracted Providers must be prior authorized. Exceptions include Emergency Services obtained by the Member when the Member is outside the service area. See the section on Emergency Services, Urgent Care, and Post-Stabilization Services above. When no exception applies, L.A. Care will determine whether there are contracted Providers within the service area willing and able to provide the items or services requested for the Member.

9.11.10 Termination of Inpatient Hospital Services
Hospitals are required by CMS regulations to deliver the Important Message (IM) from Medicare (IM, Form CMS-10065), to all Members (who are hospital inpatients within two (2) calendar days of admission). This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery of the IM must be made to the Member or the authorized representative on behalf of the Member, in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two (2) calendar days before the planned discharge date.

The IM informs Members of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or the beneficiary's representative and provide a copy at that time. When the Member is no longer meeting criteria for continued inpatient stay, and the hospital has not initiated discharge planning, L.A. Care may require that the hospital issue a follow-up copy of the IM and notify the Member of the Member's discharge date, or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member cannot be held liable for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes the Member's appeal rights located within the IM, and if the Member exercises appeal rights, not until noon of the day after the Quality Improvement Organization (QIO) notifies the Member of an adverse determination to the Member.

When the Member exercises appeal rights with the QIO, the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible and no later than noon following the day of the QIO's notification to the hospital of the appeal. The hospital is also required to provide all information that the QIO requires to make its determination. At the Member's request, the hospital must provide to the Member a copy of all information provided to the QIO, including written records of any information provided by telephone.

9.11.11 Termination of SNF, CORF, and HHA Services
The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Member to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the Member with their appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When a determination that the Member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF, CORF, or HHA) for delivery with a designation of the last covered day. HMO D-SNP or its Delegated Entity is responsible for delivering the NOMNC to the Member or Member's representative and for obtaining signature(s) in accordance with CMS guidelines. The Provider must provide HMO D-SNP with a copy of the signed NOMNC. If the Member appeals the discharge to the Quality Improvement Organization (QIO), the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or copayments) without proper notification which must include their appeal rights located in the NOMNC. If the Member exercises their appeal rights, the Member cannot be liable for any care before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot be held liable for any care until a proper NOMNC is issued and the Member is given their appeal rights again. Failure of the Provider to complete the notification timely and in accordance with CMS guidelines, or to provide information timely to the QIO may result in the assignment of Provider liability. Members cannot be held responsible for the contracted Provider's failure to follow the terms of the relevant Provider agreement or this Universal Provider Manual.

A NOMNC is not issued in the following instances and instead send out the Coverage Decision Letter (denial):

- When Member never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care)
- When covered services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy)
- When Member is moving to a higher level of care (e.g., home health care ends because a Member is admitted to a SNF)
- When Member exhausts their benefits (e.g., a Member reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).
- When the Member ends their care on their own initiative (e.g., a Member decides to revoke the hospice benefit and return to standard Medicare coverage)
- When a Member transfers to another Provider at the same level of care (e.g., a Member transfers from one SNF to another while remaining in a Medicare-covered SNF stay).
- When a Provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the Member was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

9.11.12 Maintenance of Records

The Provider agreement between L.A. Care and the Provider states that upon five (5) business days' prior notice, or as otherwise required by the applicable law and or regulatory agency, and subject to applicable state and federal confidentiality or privacy laws, Provider shall make all books, records and papers relating to Provider Services provided to Members available during normal business hours for inspection by L.A. Care, DHCS, DMHC and other applicable state or federal regulatory agencies. Provider shall make and provide copies of such records as may be reasonably requested by L.A. Care or applicable regulatory agencies. If such records are maintained by Provider's management company, then Provider shall be responsible for ensuring that the records and information requested are provided within the specified time.

For standard and expedited prior authorization requests received by L.A. Care or its Delegates, the requesting Provider shall include or make available supporting clinical data and documents so L.A. Care or the Delegated Entity, as applicable, can make its determinations.

Chapter 10 – Risk Adjustment Management Program

10.1 What is Risk Adjustment?

CMS defines Risk Adjustment as a process that helps accurately measure the health status of a plan's Membership based on medical conditions and demographic information.

This process helps ensure L.A. Care receives accurate payment for services provided to Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

10.2 Why is Risk Adjustment Important?

L.A. Care relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions early
- Identify Members for care management referral
- Ensure adequate resources for the acuity levels of L.A. Care Members
- Identify the necessary resources to deliver the highest quality of care to L.A. Care Members

10.3 Your Role As A Provider To Ensure Accurate Medical Documentation And Coding

As a Provider, your complete and accurate documentation in a Member's medical record and submitted claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest level of specificity, as this will ensure L.A. Care receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address all clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by L.A. Care and reviewed with the Member
- Be compliant with CMS correct coding initiatives
- Use the correct International Classification of Diseases 10th revision clinical modification (ICD-10-CM) code by coding the condition to the highest level of specificity
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements
- Contain a treatment plan and progress notes
- Contain the Member's name and date of service
- Authentication with Provider's signature and credentials

10.4 Risk Adjustment Data Validation Audits

As part of the regulatory process, state and/or federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure the diagnosis data submitted by L.A. Care is appropriate and accurate. All claims/encounters submitted to L.A. Care are subject to state and/or federal and internal health plan auditing. If L.A. Care is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

10.5 Annual Wellness Exam Provider Incentive Program

The Annual Wellness Exam (AWE) Provider Incentive Program is designed to incentivize HMO D-SNP contracted PCPs to:

- Complete AWE and the Patient Health Questionnaire (PHQ-9) for each Member
- Determine each Member's health risk status and appropriate care plan
- Promote Member's involvement in their own care
- Assist in HEDIS®, STARS and Hierarchical Condition Categories (HCC) documentation

Providers treating Members who are 66 years and older should complete the "Care for Older Adult (COA) Assessments" annually. We have included the Current Procedural Terminology, Healthcare Common Procedure Coding System, and International Classification of Diseases (CPT/CPT II/HCPCS/ICD10CM) codes that can be submitted via claims. Please note, correct coding and submission of claims is the responsibility of the submitting Provider.

Code	Type	Measure	Description
1125F	CPT II	Pain Assessment	Pain severity quantified, pain present
1126F	CPT II	Pain Assessment	Pain severity quantified, NO pain present
1159F	CPT II	Medication Review	Medication list documented in medical record + (must be billed together)
1160F	CPT II	Medication Review	Review of all medications by a prescribing practitioner or clinical pharmacist and documented in the medical record
99483	CPT	Advance Care Directive	Cognitive Impairment Assessment and Care Planning
99497	CPT	Advance Care Directive	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health care professional; first 30 minutes, face-to-face with patients, family member(s), and/or surrogate
1123F	CPT II	Advance Care Directive	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
1124F	CPT II	Advance Care Directive	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
1157F	CPT II	Advance Care Directive	Advance care plan or similar legal document present in the medical record
1158F	CPT II	Advance Care Directive	Advance care planning discussion documented in the medical record
S0257	HCPCS	Advance Care Directive	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate
Z66	ICD10CM	Advance Care Directive	Do not resuscitate
1170F	CPT II	Functional Status Assessment	Functional status assessed
G0438	HCPCS	Functional Status Assessment	Annual wellness visit, includes a personalized prevention plan of service (PPPS), initial visit
G0439	HCPCS	Functional Status Assessment	Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

Qualified Providers that may complete the forms are limited to Medical Doctors, Nurse Practitioners, Family Nurse Practitioners and/or Physician Assistants.

As part of the incentive program, Members will be seen for their AWE along with completing the PHQ-9 during the face-to-face visit with their PCP. All previously, diagnosed conditions will be addressed and all STARS/HEDIS® measures will be noted, using L.A. Care's official AWE forms or electronic data from L.A. Care's approved list of Electronic Medical Records (EMR). After the face-to-face or Medicare allowed real time electronic interactive visit, the PCP must complete the corresponding forms completely and submit them back to L.A. Care. L.A. Care will pay Providers up to $350 per Member to complete and submit the AWE Form and PHQ-9 to L.A. Care. Please refer to L.A. Care's AWE program manual for more details.

For questions about L.A. Care's Risk Adjustment and AWE programs, please email: **riskadjustment@lacare.org**

Chapter 11 – Claims and Compensation

11.1 Member Eligibility and Claim Status

All Providers should verify Member eligibility at the point of service and all services are subject to eligibility on the date of service. Verification of eligibility status is necessary to assure that payment is made to the Provider or affiliate for health care services rendered. Member eligibility confirmation and/or verifying the status of a claim can be conducted in two (2) ways:

1. L.A. Care Provider Portal
   - Register for access to the Provider Portal here: **https://www.lacare.org/providers/provider-central/la-care-provider-central**
   - Sign in to the Provider Portal at: **https://www.lacare.org/**
   - From menu, select option: Member Eligibility Verification
   - Complete the Member information marked with an asterisk, as required
   - Click: Submit to disclose Member eligibility information
   - Please note: Providers can also check claim status from the same menu options
   - From menu, select option: Search All Claims or Search a Claim
   - Enter requested claim information marked with an asterisk, as required
   - Click: Submit to see claim status

2. L.A. Care Provider Solutions Center at (866) 522-2736
   - Select option: one (1) for Eligibility, two (2) for Claims Status, three (3) for Payment Dispute, four (4) for Prior Authorization, and five (5) for Contracting
   - Follow IVR instructions
   - Enter requested Member information
   - IVR will telephonically disclose Member information
   - For further inquiries, Providers can stay on the line to speak with a representative during business hours: Monday thru Friday (8:00 am - 6:00 pm PST).

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

Available claim forms include:

- **CMS 1500 Claim Form**
- **CMS 1500 Claim Form - Instructions**
- **Provider Dispute Resolution Request Form**
- **Claims UB-04 Form**

11.2 Financial Responsibility

L.A. Care uses a delegated model for many of its Provider contracts. The term "delegated model" describes when financial risk and certain administrative functions for a healthcare service is contractually assumed by a Provider (e.g. physicians or hospitals). For those Providers with whom L.A. Care has a delegation arrangement, in order to determine who is financially responsible for a health care service and/or paying a claim for a health care service, and to avoid misdirected claims, Providers should refer to the Division of Financial Responsibility (DOFR) in their agreement with L.A. Care.

At all times Providers are responsible for complying with L.A. Care policies and obtaining prior authorization for services, for timely and accurate claim submission, and coordination of care. Providers are required to have an approval for all services requiring authorization prior to submission of a claim, except for emergency services.

11.3 Medicare Claims Submission

In order to ensure timely processing and payment for all claims, which L.A. Care is responsible for, Providers may submit claims as follows:

- **Electronic Claims Submission (Preferred Method)**
  L.A. Care encourages Electronic Data Interchange (EDI) claim submission. EDI is the electronic interchange of business information using a standardized format and secure method. Two (2) ways to bill claims electronically:

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

2. Third Party Billing Service or Clearinghouse that bills directly through Change Healthcare
   For more information on EDI or claims information, please visit:
   https://www.lacare.org/Providers/claims-edi/submitting-claim
   - Hard Copy (Paper) Claims Mailed to:
     L.A. Care Health Plan
     Attn: Claims Department
     P.O. Box 811580
     Los Angeles, CA 90081

11.4 Timely Filing

Providers must submit accurate and timely claims to ensure timely processing and payment as stipulated in the Provider's agreement.

Timely filing of a claim is a claim submitted accurately for authorized Provider services to L.A. Care or its Delegated Entities as soon as possible, but no later than 365 days from the date of service, unless a shorter timeframe is specified in the Provider's agreement.

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

11.5 Claim Processing Timeframes

L.A. Care and its Delegated Entities who are responsible for processing claims should process clean claims in accordance with the guidelines specified by CMS and within 30 calendar days, unless another timeframe is specified in the Provider's agreement.

11.6 Misdirected Claims

A misdirected claim is defined as claims erroneously submitted to an entity for which that entity does not have financial responsibility.

- Claims erroneously submitted to a Delegated Entity – Misdirected claims should be submitted to L.A. Care within 10 working days via U.S. mail or electronic submission. The delegated entity should include a written confirmation of the original claim and the date it had knowledge of the misdirection. The date of receipt is the oldest date stamp on the claim.

L.A. Care delegates have two (2) options to submit misdirected claims:

- **By Mail:**
  L.A. Care Health Plan
  Attn: Claims Department
  P.O. Box 811580
  Los Angeles, CA 90081
- **By Electronic Submission:**
  Change Healthcare Providers that have an account with Change Healthcare can visit **www.changehealthcare.com** or call the Customer Support line at (877) 363-3666.
- Claims erroneously submitted to L.A. Care – Misdirected claims received by L.A. Care will be forwarded to the appropriate delegated entity within 10 calendar days. The date of receipt is the oldest date stamp on the claims received by L.A. Care.

L.A. Care will perform one (1) of the following within 10 calendar days of receipt of a misdirected claim:

- Send the claimant a notice of denial with instructions to bill the Delegated Entity, or
- Forward the claim to the appropriate Delegated Entity L.A. Care will forward misdirected claims to the appropriate delegated entity within 10 calendar days of receipt.

No Member Liability Claim Denials

For claims involving HMO D-SNP payment denials where services are medically necessary and covered by Medi-Cal, L.A. Care Members are not financially liable for services rendered. L.A. Care and its Delegated Entities will issue a denial notice to the Member advising them that they are not financially liable for any of the services provided. We remind Providers that Members are full dual and cannot be balanced billed under applicable laws.

Appeals Involving Provider Liability

Claim denial appeal rights are only applicable to non-participating Providers. Disputes between L.A. Care and a contracted Provider are subject to the claims disputes provisions of this Provider Manual Chapter. Parts C & D Member grievances, prior authorization request processing, and appeals guidance of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider agreement. When L.A. Care determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services.

For Contracted Provider Disputes: Providers should mail or fax their written dispute to L.A. Care at:

- L.A. Care Health Plan
  Attn: Appeals and Provider Dispute Resolution (PDR) unit
  P.O. Box 811610
  Los Angeles, CA 90081
  Fax: (213) 438-5793

Coordination of Benefits

In accordance with requirements of the BBA of 1997, L.A. Care's Medi-Cal, as a secondary payer, may pay deductibles and or coinsurance and copays for Medi-Cal covered services as long as the total cost for all services, deductible and coinsurance does not exceed the Medi-Cal FFS rate.

California law limits Medi-Cal's reimbursements for a crossover claim to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum allowed for similar services (Welfare and Institutions Code, Section 14109.5).

For coordination of Medicare and Medi-Cal claims payments, L.A. Care or its delegated entity will process claims under Medicare as primary. If there is any applicable Medicare cost sharing, Medi-Cal crossover claims will be created and processed by L.A. Care for any applicable Medicare cost share amounts.

If a Member has primary commercial coverage and after the Member has exhausted all primary coverage benefits, Providers may submit claims to L.A. Care's HMO D-SNP. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than L.A. Care has contracted allowable rate or more than the Medicare allowable (for non-contracted Providers) the claim is considered paid in full and zero dollars will be applied to the claim.

Fee-for-Service Claims

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

L.A. Care will adjudicate all claims for covered services rendered on a FFS basis within 30 calendar days. Should L.A. Care deny a claim, L.A. Care will notify the Provider in writing of the denial and the reasons. The denial should also set forth the appeal process that the Provider may take to seek payment of the claim.

Medi-Cal Services

There are certain benefits that will not be covered by the L.A. Care Medi-Cal program but may be covered by Medi-Cal FFS. In this case, the Provider should bill Medi-Cal with a copy of the L.A. Care Medicare remittance advice and the associated state agency will process the claim accordingly.

Balance Billing and Protections

Federal law prohibits balance billing of beneficiaries eligible for Medicare and Medi-Cal, including L.A. Care's HMO D-SNP Members. Balance billing is the practice of billing a Member for the difference between what is reimbursed for a covered service and what a Provider feels should have been paid. It includes asking a Member to enter into a private payment agreement or waive their balance billing protection and charging deductibles, coinsurance, copays, or other administrative fees.

If you have questions regarding Balance Billing, please call our Provider Solutions Center at (866) 522-2736.

Maximum Out-of-Pocket

Federal law requires Medicare Advantage (MA) plans to track individual Member's Medicare covered Part A and Part B cost share amounts. MOOP amounts are set by L.A. Care annually. If the MOOP is met, the following will apply for the remainder of the calendar year:

- Member will have no out-of-pocket responsibility
- Providers will receive 100% of their Medicare payment

Delegated Entities must submit timely encounters in order for L.A. Care to appropriately track the Medicare deductible and cost share amounts of covered Medicare Part A and Part B services. L.A. Care will provide updates daily to its Delegated Entities of accumulated out-of-pocket amounts of each of its Members.

Encounter Data

A Delegated Entity responsible for claims processing is required to submit encounter data to L.A. Care or its clearinghouse partner as directed for all adjudicated claims. The data is used for many purposes, including regulatory reporting, rate setting, risk adjustment, hospital rate setting, the Quality Improvement program, HEDIS® reporting and MOOP.

Encounter data should be submitted daily or after each check run, to ensure Member's cost-share and deductible amounts are accumulated towards the Member's MOOP timely. Services must be coded accurately, comply with national standards, and be at the code's highest specificity provided through L.A. Care's or its clearinghouse partner's operational and companion guides. Encounters rejected or denied must be corrected and resubmitted within 30 days of notice to meet timeliness and contractual requirements.

In order for L.A. Care to track out-of-pocket accruals, the Delegated Entity must populate and transmit Member cost share amounts (deductible, coinsurance and copay) within the encounters 837 files.

For more information, contact the following:

L.A. Care:

- Provider Network Management (PNM) Department email at **ProviderRelations@lacare.org**
- Provider Solutions Center: (866) 522-2736
- FinThrive (formally TransUnion):
  Website: **https://finthrive.com**

Chapter 12 – Medicare Appeals and Grievances

CMS and DHCS require L.A. Care to establish and maintain meaningful procedures for timely resolution of Member appeals and grievances on both a standard and expedited basis. L.A. Care does not delegate Member appeals and grievance functions to Providers or Delegated Entities. Should the Provider receive a Member grievance, the Provider or Delegated Entity should direct and report back to L.A. Care's Customer Solution Center.

12.1 Definition of Key Terms used in the Medicare Member Appeals and Grievances Process

Integrated Appeals and Grievances: AIPs must implement Integrated Medicare and Medi-Cal grievance and plan-level appeals processes to provide simpler, more straightforward grievance and appeals processes.

Example of the Integrated Appeals and Grievances process flow provided by Integrated Care Resource Center (ICRC) at:

https://www.integratedcareresourcecenter.com/sites/default/files/Grievances-and-Appeals-Flowcharts.pdf

Appeal: Medicare defines an Appeal as the procedures that deal with the review of adverse initial determinations made by the Plan regarding health care services or benefits under Medicare Part C or Medicare Part D that the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the Member's health) or regarding any amounts the Member must pay for a service or drug. These appeal procedures include a Plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an Independent Review Entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Integrated Appeal: The procedures that deal with, or result from, adverse Integrated Organization Determinations by an applicable integrated plan on the benefits both under Part C and Medi-Cal rules the Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service. Integrated Appeals do not include Appeals related to Part D benefits.

Expedited Integrated Appeal (Integrated Reconsideration): The AIP grants the request from the Member or Provider on their behalf, to expedite the Integrated Reconsideration when an imminent and serious threat to the health of a Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function is determined.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare Advantage Plan or its Delegated Entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from an Appeal. Examples of a grievance include, but are not limited to, the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the Organization or Coverage Determination or Appeals process, the Plan formulary, or the availability of contracted Providers.

For an EAE SNP, a grievance is referred to as an integrated grievance because the Member's complaint may qualify as a grievance under Medicare or Medi-Cal rules. Integrated grievances follow a Unified Grievances process.

Integrated Grievance: An integrated grievance made by a Member in an AIP is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c).

Integrated Expedited Grievance: Members may request grievances at any time. Integrated Expedited Grievance is available to Members if the following apply:

- Refusal to grant a Member's request for an Expedited Integrated Organization Determination or Expedited Integrated Appeal
- A decision to invoke an extension relating to an Integrated Organization Determination or Integrated Appeal

Authorized Representative: An individual appointed by the Member or authorized under state law to act on behalf of the Member in filing a grievance or appeal. An Authorized Representative has all of the rights and responsibilities of the Member. For Medicare, a Member may appoint an individual to be their Authorized Representative by using the CMS Appointment of Representative Form found at **cms.hhs.gov/cmsforms/downloads/cms1696.pdf**.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO or QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, SNFs, home health agencies (HHA), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and Comprehensive Outpatient Rehabilitation Facilities (CORF). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care Provider (e.g., physician, hospital, etc.) and beneficiary.

Part D Drug Coverage Determination: Any determination made by a Part D plan sponsor, or its Delegated Entity, with respect to:

- A decision about whether to provide or pay for a drug that a Member believes may be covered by the Plan sponsor, including a decision related to a Part D drug that is: not on the Plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded by law if applied to Medicare Part D
- A decision on the amount of cost sharing for a drug;
- Failure to provide a Coverage Determination in a timely manner when a delay would adversely affect the Member's health;
- Whether a Member has (or has not) satisfied a prior authorization or other utilization management requirement;
- A decision about a tiering exception; or
- A decision about a formulary exception request

12.2 Medicare Member Appeals

12.2.1 How to File an Appeal

For standard appeals:

- Mail:
  L.A. Care Health Plan
  Attn: Customer Solution Center Appeals and Grievances
  1055 W 7th Street
  Los Angeles, CA 90017

- Fax: (213) 438-5748
  Phone: Customer Solution Center: (833) 522-3767 or TTY 711.

For Expedited Appeals: Members or Authorized Representative should call the Customer Solution Center phone number provided above.

Members or Authorized Representative has 60 calendar days from the date of the denial to file an Appeal. This timeframe may be extended for good cause.

12.3 What to Include with Appeal Requests

Members or Authorized Representative should include their full legal name, contact information, Member ID number, health plan name, reason for appealing, and any evidence the Member wishes to attach. Members or Authorized Representative may send in supporting medical records, documentation or other information that explains why L.A. Care should provide or pay for the item or service.

12.4 Participating Provider Responsibilities in the Medicare Member Appeals Process

Providers can request Expedited or Standard Pre-service Appeals both orally or in writing. When submitting an Appeal, include all medical records and/or documentation to support the Appeal. Please note that any missing or incomplete information may result in delays of processing of the Appeal.

Expedited Appeals should be requested if the timeframe for a Standard Appeal could jeopardize the Member's life, health, or ability to regain maximum function.

An integrated reconsideration (appeal) must be filed within 60 calendar days from the date of the Integrated Coverage Decision Letter. L.A. Care or its Delegate Entities must send each Member a written acknowledgement of receipt of all appeals within five (5) calendar days.

12.5 Appeal Timeframes

Appeal decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

Type	Part C	Part C w/ Extension	Part D
Standard Pre-Service or Benefit	30 days	--	7 days
Expedited Pre-Service, and Benefit	72 hours	--	72 hours
Standard Part B Drug	7 days	--	--
Expedited Part B Drug	72 hours	--	--

Standard Integrated Appeals must be resolved as expeditiously as the Member's health condition requires, but not exceeding 30 calendar days from the date of receipt of the request for the Integrated Appeals.

Expedited Integrated Appeals must be resolved within 72 hours of receipt of the request. No extended timeframes will be available for Integrated Appeals of Medicare and Medi-Cal services. Plans need to ensure they are obtaining all relevant information needed to make a decision within the required timeframes. No extended timeframes for integrated reconsiderations (appeals) of Medicare and Medi-Cal services.

12.6 Continuation of Benefits (aka "Aid Continuing")

Members may be entitled to continue benefits pending Appeal if authorization for services is terminated, suspended or reduced prior to the expiration of the authorization period. This typically occurs with Medi-Cal covered services such as personal care services, but can be applicable to other Medicare or Medi-Cal services not authorized for a limited, defined benefit period when the services are terminated, suspended, or reduced prior to the expiration of the authorization period. The right to continue benefits is subject to the filing of the Appeal and/or providing a written request for continuation of benefits within 10 calendar days of the date of the notice of suspension, termination, reduction or the expiration of the authorization, whichever is later. The right to request continuation of benefits typically resides with the Member. When Providers are allowed to request continuation of benefits under applicable federal and state regulations, they may be required to have the written consent of the Member to file the Appeal.

If the Member's Appeal is upheld by L.A. Care, their notice of the Appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing. Federal and state rules applicable to the specific plan determine whether recovery of costs applies if the Member receives an adverse decision on Appeal or at State Fair Hearing.

Further Appeal Rights

If L.A. Care upholds the initial adverse determination, in whole or in part, for a Medicare Part C item or service (including a Part B drug), the Appeal will be forwarded to an IRE. For Part D upholds, the Member must request review by the IRE. The IRE is a CMS contractor independent of L.A. Care. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an ALJ or attorney adjudicator. Additional levels of Appeal are available to the Member if amount in controversy requirements are met, including appeal to the Medicare Appeals Council (MAC) and federal court.

The Member may have additional appeal rights. In these plans, when the item or service is or could be covered by Medi-Cal or by both Medicare and Medi-Cal (overlap), the Member will be provided with their State Fair Hearing rights and any other state appeal rights to which they are entitled. (For example, the Member may be entitled to additional appeal rights for Medi-Cal-covered services under the state HMO law.) Additional levels of appeal follow the applicable state rules and requirements.

Hospital Discharge Appeals

Hospital discharges are subject to an expedited Member appeal process. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, see the Termination of Inpatient Hospital Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate Appeal to the QIO. The QIO will typically respond within one (1) day after it receives all necessary information.

If the QIO agrees with the discharge decision, the Member may request a reconsideration from the QIO if they remain in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an ALJ or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an Appeal with the QIO and is still in the hospital, the Member (or their Authorized Representative) may request an expedited pre-service Appeal with L.A. Care. In this case, the Member does not have financial protection during the course of the expedited pre-service Appeal and may be financially liable for paying for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

12.9 SNF, CORF, and HHA Discharge Appeals

Discharges from care provided by a SNF (including a swing bed in a hospital providing Part A and Part B services), CORF, or HHA are subject to an expedited (fast track) Member Appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy, and home health aide services from an HHA and only the home health aide services are terminated while the other services continue). When a single service is terminated and other services continue, a Plan Coverage Decision Letter with Member appeal rights is issued to the Member.

12.10 Obtaining Additional Information about the Member Appeal Process

For additional information about Member Appeal rights, call the L.A. Care Customer Solution Center toll free at (833) 522-3767, or 711, for persons with hearing impairments (TTY/TDD). A detailed explanation of the Appeal process is also included in the L.A. Care Medicare Plus (HMO D-SNP) Member Handbook, which is available on L.A. Care's website.

12.11 Medicare Member Grievances

A Member may file a grievance verbally or in writing at any time. Members may file a grievance for Medicare covered services (including Part C and D) or Medi-Cal coverage at any time.

A Member may file a grievance by contacting the L.A. Care Customer Solution Center by telephone, fax, or by sending a written grievance to any of the following:

- Phone: (833) 522-3767
- Mail:
  L.A. Care Health Plan
  Attn: Appeals and Grievances
  1055 W 7th Street
  Los Angeles, CA 90017
- Fax: (213) 438-5748

Upon receipt of the grievance, L.A. Care must send a written acknowledgement of the grievance that is dated and postmarked within five (5) calendar days of receipt. Standard grievances must be resolved and a written resolution sent to the Member as expeditiously as the Member's health condition requires, but no later than 30 calendar days from receipt of the grievance. Expedited grievances must be resolved in 24 hours.

Chapter 13 – Medicare Part D

13.1 Medicare Part D Coverage and Copay

or CY2024, Members will have no co-pay for Medicare Part D covered prescriptions filled at a network pharmacy.

Category	Copay for a one month (30 day supply) per prescription filled at a network pharmacy
TAll Covered Part D Drugs	The copay will be $0.

13.2 Medicare Part D Coverage and Limitations

L.A. Care has a formulary that lists all covered drugs. Drugs on the formulary will generally be covered as long as the drug is medically necessary, is covered by Medicare Part D, and/or the prescription is filled at a network pharmacy or through L.A. Care's network mail order pharmacy services. Certain prescription drugs have additional requirements for coverage or limits. The formulary is updated monthly and the current formulary list can be found on the L.A. Care website at **https://medicare.lacare.org**.

13.3 Other Drug Coverage

Medi-Cal Rx will pay for certain medically necessary drugs and items not covered under Medicare Part D.

Drugs commonly covered under Medi-Cal Rx may include, but are not limited to, the following:

- Cough/cold medications
- Over-the-counter medications
- Prescription vitamins and minerals
- Certain medical supplies (except for medical supplies associated with the delivery of insulin, syringes which are covered by Medicare Part D)

For any questions regarding coverage of drugs not covered under Medicare Part D, contact Medi-Cal Rx:

- **Medi-Cal Rx – Magellan**
  Phone: (800) 977-2273
  Website: **https://medi-calrx.dhcs.ca.gov/home/**

Pharmacy Network

A large number of network pharmacies are available to Members across Los Angeles County. The network includes most major chain drug stores, retailers, and community pharmacies. Members should fill prescriptions at network pharmacies. The pharmacy list is updated monthly.

How Do Members Get Their Part D Prescription Filled?

Members must obtain their prescriptions from a network pharmacy or through the network mail order pharmacy service. A pharmacy directory is provided to Members in their new enrollment packet. A copy of the pharmacy directory can be found on the L.A. Care Medicare Member Materials website: **https://medicare.lacare.org**.

Mail Order Pharmacy Services

Members can obtain their prescribed medications, taken on a regular basis for a chronic or long-term medical condition, through the network mail order pharmacy service. L.A. Care offers Members the option of getting up to a 100-day supply of select maintenance medications mailed to their home or alternate address through our prescription mail order program.

A Member is not required to use the mail order service in order to get an extended supply. Network pharmacies can also provide extended supplies. Most drugs listed on L.A. Care's formulary are available through the mail order pharmacy service.

Providers can call, mail, e-prescribe, or fax prescriptions to Quality Drug Clinical Care. Prescriptions will be delivered to a Member three (3) days from when the request was processed.

- **Quality Drug Clinical Care**
  NPI: 1417453226
  18 Technology Dr, Suite 104,
  Irvine, CA 92618
  Phone: (949) 471-0223
  Fax: (949) 404-3760

13.7 Specialty Pharmacy

L.A. Care has specific policies for use of specialty drugs. Specialty drugs are often high cost pharmaceuticals, which may require special handling by the manufacturer and/or the FDA, and their effectiveness is driven by coordinated clinical support for the Member. Most of these therapies require prior authorization or step therapy; this is to ensure the patient achieves the optimal clinical benefit from the prescribed therapy.

To learn more about specialty drug access and coverage determination for these drugs and therapies, prescribing Providers and pharmacies may call:

- **Navitus Health Solutions**
  Phone: (866) 270-3877
  Fax: (855) 688-8552
  Website: **www.navitus.com**

13.8 Medication Therapy Management Programs

The Medication Therapy Management (MTM) program is required by CMS and offered by L.A. Care at no additional cost to Members with multiple chronic conditions who are taking multiple prescription drugs. L.A. Care encourages Providers to utilize the MTM program for their Members to ensure medications have the desired therapeutic outcome and reduce possible medication issues.

To qualify for HMO D-SNP's MTM program, Member must meet one (1) of the following two (2) qualification categories:

Qualification Category One (1):

Member must meet ALL of the following criteria:

- Have at least three (3) of the following conditions or diseases:
  - Bone Disease-Arthritis-Osteoporosis
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Dyslipidemia
  - Hypertension
  - Mental Health-Depression
  - Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD)
- Take at least eight (8) covered Part D medications
- Likely to incur Part D medication costs greater than the annual threshold set by CMS each year ($5,330 for 2024)

Qualification Category Two (2):

Member is enrolled in the L.A. Care Drug Management Program (DMP) MTM program qualification criteria is updated annually. For more up-to-date information, please visit: **https://medicare.lacare.org** or call the L.A. Care Provider Solutions Center at (866) 522-2736 – 24 hours a day, seven (7) days a week, including holidays.

Opioid Overutilization

L.A. Care has an opioid overutilization program, or "Drug Management Program (DMP)" that can help Members safely use their prescription opioid medications or other medications that are frequently abused. This program is called the Opioid Home Program.

Opioid utilization is monitored by L.A. Care and Navitus to reduce the potentially inappropriate and unsafe use of opioids. Member specific reports are generated when pre-established overutilization criteria are met during a defined time period, and the reports are supplied to the appropriate Providers. The information is shared with Providers to increase awareness and facilitate next steps to address opioid overutilization. The monitoring program also improved Drug Utilization Review (DUR) controls at the point-of-sale, formulary management, case management, and overall utilization reviews.

Please refer to the Controlled Substance Utilization Review and Evaluation System (CURES) before prescribing opioids.

If the Member uses opioid medications from several Providers or pharmacies, we may talk to you and other Providers to make sure the use is appropriate and medically necessary. If L.A. Care decides that the Member is at risk for misusing or abusing the opioid or benzodiazepine medications, we may limit how the Member can get those medications.

Limitations may include the following:

- Requiring the Member to get all prescriptions for those medications from one (1) pharmacy and/or from one (1) doctor
- Limiting the amount of those medications L.A. Care will cover for the Member

If L.A. Care decides that one (1) or more limitations should apply to the Member, a letter will be sent in advance to the Member. The letter will explain the limitations that should apply. The Member will have a chance to tell us which Providers or pharmacies they prefer to use. If a Provider thinks L.A. Care made a mistake, disagrees that the Member is at risk for prescription drug abuse, or disagrees with the limitation, Providers and the Member can file an appeal.

For more information, please call the Provider Solutions Center at (866) 522-2736 – 24 hours a day, seven (7) days a week, including holidays.

13.10 Part D Prescription Drug Prior Authorizations

Certain formulary medications and all non-formulary medications require a PA request to be submitted by the prescribing Provider for Members. Each PA request will be reviewed based on the individual Member's need. Determination will be based on documentation of existing medical need. The PA criteria and the length of PA approval follow CMS requirements. For Medicare Part B covered drugs, see the Utilization Management section within this HMO D-SNP Provider chapter.

Instructions on how to submit PA requests are located on the Prescription Drug Prior Authorization forms, which can be found at: **www.lacare.org/Providers/Provider-resources/pharmacy-services/prior-authorizations**

Prescribers may also access additional information regarding the formulary and the specific PA criteria on the coverage determination process from L.A. Care's contracted Pharmacy Benefit Managers (PBM).

Below is the PBM vendor that handles the processing of HMO D-SNP pharmacy benefits and PA:

- **Navitus Health Solutions**
  LOB: Medicare
  Phone: (844) 268-9785
  Fax: (855) 878-9207
  Website: **www.navitus.com**

13.11 Part D Coverage Determinations

A Medicare Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug, or whether a Member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative, or a Member's prescriber) may request an Appeal. A Member, a Member's representative, or Provider, are the only parties who may request that L.A. Care expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

- **Initiating a Part D Coverage Determination Request** – Navitus will accept requests from Providers or a Member who has an appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized L.A. Care Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within 72 hours/three (3) calendar days after Navitus receives the completed request.
  Navitus will request submission of additional information if a request is deemed incomplete for a determination decision. Review criteria will be made available at the request of the Member or their prescribing Provider. Navitus will determine whether a specific off-label use is a medically accepted indication based on the following criteria:
  - A prescription drug is a Medicare Part D drug only if it is for a medically accepted indication, which is supported by one (1) or more citations included or approved for inclusion with the following compendia:
    - American Hospital Formulary Service Drug Information
    - DRUGDEX Information System
  - Requests for off-label use of medications will need to be accompanied by excerpts from one (1) of the two (2) CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.
  - Depending upon the prescribed medication, Navitus may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.
  - Denial decisions are only given to the Member or Member's representative by a Navitus Pharmacist. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial, the explanation of both the standard and expedited appeals process, and an explanation of a Member's right to, and conditions for, obtaining an expedited appeal.

- If Navitus denies coverage of the prescribed medication, Navitus will give the Member a written notice within 72 hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified timeframe, Navitus will start the next level of appeal by sending the Coverage Determination request to the IRE within 24 hours.
- If a coverage determination is expedited, Navitus will notify the Member of the coverage determination decision within the 24 hour timeframe by telephone and mail the Member a written Expedited Coverage Determination within three (3) calendar days of the oral notification. If Navitus does not give the Member a written notification within the specified timeframe, Navitus will start the next level of appeal by sending the Coverage Determination request to IRE within 24 hours.

13.12 Appeals/Redeterminations

First Level Appeal – If L.A. Care's initial coverage determination is unfavorable, a Member may request a first level of appeal or redetermination, within 60 calendar days from the date of the notice of the coverage determination. In a Standard Appeal L.A. Care has up to seven (7) days to make the redetermination, whether favorable or adverse, and notify the Member in writing within seven (7) calendar days from the date the request for redetermination is received. Members or a Member's prescribing Provider may request L.A. Care to expedite a redetermination if the standard appeal timeframe of seven (7) days may seriously jeopardize the Member's life, health, or ability to regain maximum function. L.A. Care has up to 72 hours to make the redetermination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for redetermination. If additional information is needed for L.A. Care to make a redetermination, L.A. Care will request the necessary information within 24 hours of the initial request for an expedited redetermination. L.A. Care will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

Second Level Appeal - If the redetermination is unfavorable, the Member, Member's representative, or Member's prescribing Provider may request a second level appeal with an independent reviewer. The Part D Qualified Independent Contractor is currently C2C Innovative Solutions, Inc., a CMS contractor that provides second level appeals.

- **Standard Appeal:** The IRE has up to seven (7) calendar days to make the decision
- **Expedited Appeal:** The IRE has up to 72 hours to make the decision
- **Administrative Law Judge:** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable at this level of appeal
- **Medicare Appeals Council:** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable at this level of appeal
- **Federal District Court (FDC):** If the MAC's decision is unfavorable, the Member may appeal to a Federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable at this level of appeal

13.13 Part D Prescription Drug Policy

The Pharmacy and Therapeutics (P&T) Committee meets on an annual basis at minimum to review L.A. Care's Part D policies which includes the following:

- **Formulary** – A formulary is a list of medications selected by L.A. Care in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. L.A. Care will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an L.A. Care network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used), and other plan rules are followed.
  Formularies are updated annually. Current formularies may be downloaded from our website at **https://medicare.lacare.org**.

- **Restrictions on L.A. Care's Medicare Drug Coverage** – Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
  - **Prior Authorization**: L.A. Care requires PA for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, L.A. Care may not cover the drug
  - **Quantity Limits**: For certain drugs, L.A. Care limits the amount of the drug that it will cover
  - **Step Therapy**: In some cases, L.A. Care requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, L.A. Care may not cover drug B unless drug A is tried first
  - **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration

- **Non-Covered L.A. Care Healthcare Medicare Part D Drugs:**
  - Agents, when used for anorexia, weight loss, or weight gain (no mention of medically necessary)
  - Agents, when used to promote fertility
  - Agents used for cosmetic purposes or hair growth
  - Agents used for symptomatic relief of cough or colds
  - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations
  - Non-prescription drugs, except those medications listed as part of L.A. Care's Medicare OTC monthly benefit as applicable and depending on the plan
  - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
  - Members with Medi-Cal coverage may have a limited selection of these excluded medications as part of their Medi-Cal coverage through the State of California's Medi-Cal Rx program for Members assigned to L.A. Care Medi-Cal
  - Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System)

- **There may be differences between the Medicare Part D and Medi-Cal Formularies** – L.A. Care's formulary includes many injectable drugs not typically found in the State of California's Medi-Cal Rx formulary, such as those for the aged, blind, and disabled.

13.14 Part D Formulary Exception

Exceptions are required when your Members needs a drug that is not on the Formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an exception. (The process for filing an exception is predominantly a fax-based system). The form for exception requests is available on the L.A. Care website. All initial exceptions are handled by Navitus. Appeals are handled by L.A. Care.

Part D Exceptions Contact Information:

- **Navitus Health Solutions**
  LOB: Medicare
  Phone: (844) 268-9785
  Fax: (855) 878-9207
  Website: **www.navitus.com**

13.15 Pain Safety Initiative Resources

Safe and appropriate opioid prescribing and utilization are a priority for all of us in health care. L.A. Care requires Providers to adhere to L.A. Care's drug formularies and prescription policies, which are designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

L.A. Care is dedicated to ensuring Providers are equipped with additional resources, which can be found on the L.A. Care Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at **https://www.lacare.org/Providers/Provider-resources/tools-toolkits/toolkits** under the Health Resource tab. Please consult with your Provider Services Representative or reference the medication formulary for more information on L.A. Care's Pain Safety Initiatives (PSI).

Chapter 14 – Appendix: L.A. Care and State Agency Contacts

14.1 L.A. Care Contacts

Area	Phone/Fax	Other Contact Info
L.A. Care Customer Solution Center	(833) 522-3767	Available 24/7
L.A. Care General Utilization Management	(877) 431-2273	Available 24/7
Specific Utilization Management Fax Numbers	UM Routine: (213) 438-5777 UM Urgent: (213) 438-6100 Inpatient: (877) 314-4957 Clinical Review: (213) 438-5063 Discharge Orders: (213) 438-5066 Behavioral Health Treatment: (213) 438-5054 Transportation: (213) 438-2201 Long Term Care: (213) 438-4877 Community Based Adult Services: (213) 438-5739	–
Inpatient Referrals	(877) 431-2273	Available 24/7
Care Management	(844) 200-0104	Available Monday - Friday 8:00 am - 4:30 pm
Behavioral Health Services	Carelon Behavioral Health Mild to Moderate Behavioral Health (877) 344-2858 Available 24/7 Department of Mental Health Specialty Mental Health Services (800) 854-7771 Available 24/7	L.A. Care Provider Support Line Only: (844) 858-9940 **Email: behavioralhealth@lacare.org** Available Monday – Friday 8:00 am – 4:30 pm Website: **https://www.carelonbehavioralhealth.com/**

Certain services will need to be sent to the Members' assigned medical group (PPG or IPA). Please check the patient's ID card or call L.A. Care's Provider Solutions Center (866) 522-2736.

Area	Phone/Fax	Other Contact Info
Substance Use Treatment	Substance Abuse Service Helpline (SASH): Department of Public Health (DPH) (844) 804-7500	--
Interpreter Services	Telephonic interpreting services (855) 322-4034 In.person interpreting services (833) 522-3767	Telephonic interpreting services: Available 24 hours a day, seven (7) days a week. In-person interpreting services: To schedule, call L.A. Care 10-15 days before the appointment.
Claims Status	For L.A. Care Direct Network, (844) 361-7272 For all other Network Providers, (866) 522-2736	Available 24/7
Claims: Overpayment Recovery	For L.A. Care Direct Network, (844) 361-7272 For all Network Providers, (866) 522-2736	Available Monday - Friday 8:00 am – 6:00 pm
Provider Solutions Center	For L.A. Care Direct Network, (844) 361-7272 For all Network Providers, (866) 522-2736	Available Monday - Friday 8:00 am – 6:00 pm
Provider Dispute Resolutions	For L.A. Care Direct Network, (844) 361-7272 For all other Network Providers, (866) 522-2736	Available Monday - Friday 8:00 am - 4:30 pm

Certain services will need to be sent to the Member's assigned medical group (IPA or PPG). Please check the L.A. Care Member ID card or call the L.A. Care Provider Solutions Center (866) 522-2736.

14.2 State Agency Contacts

State Services	Phone/Fax	Other Contact Info
Automated Eligibility Verification System (AEVS)	(800) 456-2387	--
California Children's Services (CCS)	Los Angeles County Phone: (800) 288-4584 Fax: (855) 481-6821	Referrals: **https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx**
Community-Based Adult Services (CBAS)	L.A. Care Health Plan: (855) 427-1223	**https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/**
Medi-Cal Dental Program	(800) 322-6384 Monday) Friday, 8:00 am – 5:00 pm	**www.dental.dhcs.ca.gov/**
Department of Health Care Services Medi-Cal Managed Care Ombudsman	(800) 452-8609	**www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx**
Department of Health Care Services Office of Family Planning (DHCSOFM)	(800) 942-1054	**www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx**
Department of Mental Health (DMH) of L.A. County	(800) 854-7771	**https://dmh.lacounty.gov/**
Department of Social Services Public Inquiry and Response Unit (DSSPIRU)	(800) 952-5253	--
Department of Managed Health Care (DMHC)	(888) 466-2219	**www.dmhc.ca.gov** Email: **Providercomplaintunit@dmhc.ca.gov**
Early Start Program (ESP)	(800) 515-2229	**www.dds.ca.gov/services/early-start/**
Hearing Impaired Services: California Rely Service	711 Voice/TTY (800) 806-1191	**https:ddtp.cpuc.ca.gov/default1.aspx**