



L.A. Care *Cal MediConnect Plan* *(Medicare-Medicaid Plan)*

Provider Manual

2019



Dear Provider:

Thank you for your participation in L.A. Care Health Plan's (L.A. Care) Cal MediConnect (CMC) program. Our goal is to provide our members with quality care delivered in the right setting at the right time. Collaboration and communication with our Provider partners and their staff is key to meeting this important goal.

The purpose of this Manual is to provide you and your staff with information and assistance in serving L.A. Care CMC members.

Thank you again for your participation in our plan. If you need hard copies of any of the information available on the website, please contact us at **866.LACARE6 (866.522.2736)**.

1.0 L.A. CARE HEALTH PLAN

1.1 GENERAL INTRODUCTION

1.1.0 About the L.A. Care Cal MediConnect Provider Manual

In coordination with the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) has developed a demonstration pilot that provides comprehensive health services to individuals eligible for both Medicare and Medi-Cal ("Dual eligibles" or "Duals"). This national demonstration program provides physician, hospital, behavioral health, long term services and supports (LTSS) and other services through a single organized delivery system. The three-year pilot tests how aligning financial incentives can drive patient-centered care and rebalance the current health care system away from institutionalization and toward keeping Members in their communities. Effective April 1, 2014, L.A. Care's "Cal MediConnect" program began serving enrolled dual-eligible members.

The purpose of this L.A. Care Cal MediConnect Provider Manual is to furnish all Providers, including Participating Physician Groups (PPGs) and their affiliated Provider networks, with information on the critical processes related to the L.A. Care Cal MediConnect program. The Manual is broken down by functional area and provides information and applicable requirements for both Medicare and Medi-Cal processes, as required by Cal MediConnect. Updates to the Manual are made annually and are available online at

<http://www.calmediconnectla.org/providers/resources>

1.1.1 Rules of Participation

To ensure high quality care is provided to L.A. Care's dual eligible members, L.A. Care requires that all Providers meet the following criteria to participate in its CMC Provider network:

- Meet all credentialing standards outlined in Section 7.0 of this manual
- Meet all requirements set forth by the Health Insurance Portability Accountability Act (HIPAA)
- Have a signed contract with L.A. Care (or with a PPG contracted with L.A. Care) for the CMC program
- Share our commitment to working with members who are diverse culturally and linguistically and those living with disabilities

1.1.2 Responsibility of Participating Providers

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

1.1.3 L.A. Care’s Commitment to Provide Excellent Services

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

1.1.4 Traditional and Safety Net Providers

L.A. Care considers the following Provider types as Traditional or Safety Net Providers: Child Health and Disability Prevention (CHDP) Providers, Federally Qualified Health Centers (FQHCs), licensed community clinics, and Disproportionate Share Hospitals.

1.2 GLOSSARY OF TERMS

ACRONYM OR WORD(S)	DEFINITION
Ancillary Service	Ambulance transportation; durable medical equipment (DME) including but not limited to apnea monitor, artificial limbs, and hearing aids; home health care; prosthetic and orthodontic devices; and skilled nursing facilities.
BOG	Board of Governors
Cal MediConnect (CMC)	A national demonstration program designed to test the effectiveness of providing medical, behavioral health, long-term services and supports and other services under a single plan for beneficiaries eligible for both Medicare and Medi-Cal. CMC is a partnership between CMS, DHCS and L.A. Care and is regulated by both CMS and DHCS.
CAP	Corrective Action Plans
CBAS	Community Based Adult Services

ACRONYM OR WORD(S)	DEFINITION
CPO	Care Plan Options
DDS	Developmental Disability Services
DHCS	Department of Health Care Service
DME	Durable Medical Equipment
DMHC	Department of Managed Health Care
DOFR	Division of Financial Responsibility
FSR	Facility Site Review
HEDIS	Health Plan Employer Data and Information Set
IBNR	Incurred But Not Reported
IHSS	In Home Supportive Services
HIPPA	Health Insurance Portability and Accountability Act
IPA	Independent Practice Association – In the L.A. Care Cal MediConnect Provider Manual, IPA will be referred to as Participating Physician Group (PPGs).
L.A. Care	L.A. Care Health Plan (Local Initiative Health Authority for Los Angeles County)
LTC	Long Term Care
Medi-Cal	The California Medical Assistance Program (Medi-Cal or MediCal) is the name of the California Medicaid welfare program serving low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. It is jointly administered by the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS), with many services implemented at the local level mainly by the Counties of California.
Medicare	A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MOU	Memorandum of Understanding
MA-PD	Medicare Advantage Prescription Drug
MLTSS	Managed Long Term Services and Supports (a.k.a. Long Term Services and Supports)
MNS	Medically Necessary Services – reasonable and necessary services rendered for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR§1395(y)
MSSP	Multipurpose Senior Services Program
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider – a physician who has a current, unrestricted license as a physician and/or surgeon in California, whose area of medical practice is one of the five categories designated as a PCP by the Department of Health Care Services (DHCS) and the Knox Keene Act. The five designated categories are general practitioner, internist, pediatrician, family practitioner and obstetrician/gynecologist (OB/GYN). Note: Specialists who also meet the requirements and are willing to assume the responsibilities of a PCP may also be designated as a PCP.

ACRONYM OR WORD(S)	DEFINITION
QIP	Quality Improvement Program
SED	Severely Emotionally Disturbed
SNF	Skilled Nursing Facility
SNP	Special Needs Plan

1.3 NOTICE TO PROVIDERS

From time to time L.A. Care amends provider contracts and updates the provider manual and/or its policies and procedures. Updates to the provider manual and policies and procedures are done to ensure providers have necessary information on the most up-to-date laws, regulations, and revisions to provide the highest quality services to L.A. Care members and ensure regulatory compliance. L.A. Care will provide updates of material changes with a 30-day notice to providers. To ensure you have the most up-to-date information, please refer to the provider manual located at <https://www.calmediconnectla.org/providers/resources>

L.A. Care maintains a provider portal for reference to applicable policies and procedures. From time to time, these policies and procedures are revised. L.A. Care notifies providers when revisions are material. However, to ensure you have the latest and most current policies and procedures, please refer to the policy and procedure provider portal at [calmediconnectla.org/providers](https://www.calmediconnectla.org/providers)

Any updates to the provider manual or policies and procedures that change a material term of the contract between provider and L.A. Care shall comply with the notice and negotiation procedures required by applicable law.

1.4 L.A. CARE DEPARTMENTAL CONTACT LIST

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

DEPARTMENT	CONTACT INFORMATION
Capitation	1.213.694.1250, x 4363
Care Management	1.844.200.0104
Claims	1.866.522.2736 For all claims L.A. Care is responsible for, please mail to: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081
Cultural and Linguistic Services	1.855.856.6943
Eligibility Verification	1.866.522.2736 or 1.866.LACARE6

DEPARTMENT	CONTACT INFORMATION
Encounter Data	Provider Inquiry Line: 1.866.LA.CARE6 or 1.866.522.2736
Health Education Unit	1.855.856.6943
Managed Long Term Services and Supports (MLTSS)	1.855.427.1223 or 1.213.694.1250, x 5422 Fax: 1.213.438.4866 mltss@lacare.org
Marketing/Sales	1.213.694.1250, x 5712
Customer Service Solutions	General Information Line 1.888.522.1298, x 4055, x 6393, x 4145
Pharmacy	1.877.795.2227
Prior Authorizations/ Hospital Admissions	L.A. Care Cal MediConnect UM Department must be notified within 24 hours or the next business day following the admission. To obtain an Authorization: Call Toll-Free: 1.877.HF1.CARE (1.877.431.2273) Fax: 1.213.623.8669 Inpatient 1.877.314.4957 Outpatient 1. 213.438.5777 Written Requests: L.A. Care Health Plan 1055 W. 7th Street, 10th Floor Los Angeles, CA 90017 Attn: Authorization
Provider Credentialing, Performance, and Certification	1.844.530.7596 E-mail: credinfo@lacare.org
Provider Information/Data Issues	Provider Solution Center 1.866.LA.CARE6 or 1.866.522.2736
Provider Network	L.A. Care Health Plan Attn: PNM/Contracts and Relationship Management 1055 W. 7th Street, 10th Floor Los Angeles, CA. 90017 Telephone: 1.213.694.1250, x 4719 E-mail: ProviderRelations@lacare.org
Quality Improvement, Director	1.213.694.1250, x 4312
Quality Improvement, Disease Management	1.213.694.1250, x 4262
Ethics and Compliance Hotline	1.800.400.4889
Utilization Management, Director	1.213.694.1250, x 7230

2.0 MEMBERSHIP AND MEMBERSHIP SERVICES

This section covers L.A. Care Cal MediConnect (CMC) Membership and Member Services. Topics include eligibility, enrollment and disenrollment, PCP assignment, complaint resolution, and Member rights and responsibilities.

2.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

L.A. Care CMC Participating Providers are responsible for adhering to the Member Services provisions and guidelines specified in this section.

2.2 PROGRAM ELIGIBILITY

Members who wish to enroll in L.A. Care's CMC program, must meet the following eligibility criteria:

- Age 21 or older at the time of enrollment
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits
- Eligible for full Medicaid (Medi-Cal)
 - o Individuals enrolled in the Multipurpose Senior Services Program (MSSP)
 - o Individuals who meet the share of cost provisions:
 - Nursing facility residents with a share of cost
 - MSSP enrollees with a share of cost
 - IHSS recipients who met their share of cost on the first day of the month, in the fifth and fourth months prior to their effective passive enrollment date for the Demonstration
- Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act
- Reside in Los Angeles County

L.A. Care Health Plan (L.A. Care) will accept all Members that meet the above criteria and elect L.A. Care's CMC program during their enrollment process.

2.2.1 Conditions of Enrollment

All new enrollments will be confirmed with the Centers for Medicare & Medicaid Services (CMS). L.A. Care will enroll all CMC Members through the Medicare/Medi-Cal sales and enrollment process, complying with CMS marketing, sales, and enrollment process requirements.

2.2.2 Disenrollment

All members of L.A. Care's CMC Plan are full benefit dual eligible (e.g. they receive both Medicare and Medicaid). CMS rules state that these members may enroll or dis-enroll from Participating Plans and transfer between Participating Plans on a month-to-month basis any time during the year; and will be effective on the first day of the month following the request to do so.

Members who do not meet the eligibility requirements may be disenrolled from L.A. Care's CMC.

2.3 ELIGIBILITY VERIFICATION

2.3.1 Possession of an L.A. Care CMC Membership identification card does not guarantee current Membership with L.A. Care CMC. Verification of an individual's Membership and eligibility status is necessary to assure that payment will be made to the PPG for the healthcare services being rendered by the Provider to the Member.

2.3.2 To verify Member eligibility, Providers can log on to L.A. Care's website calmediconnectla.org/providers or call L.A. Care's Provider Information Line at 1.866.LACARE6 (1.866.522.2736).

2.4 MEMBER ENROLLMENT, ASSIGNMENT, AND DISENROLLMENT

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

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

- Translation of Member materials into threshold languages
- Referral to physicians who can provide services in the Member's preferred language
- Use of qualified bilingual staff contracts for telephonic and face-to-face interpreting services, including American Sign Language (ASL) at medical and non-medical points of contact
- Use of California Relay Service and Plan teletypewriter (TTY) system

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

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

2.4.1 Member Enrollment

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

2.4.1.2 All Dual-Eligibles have a Medicare Special Election Period, which allows them to enroll in and disenroll from a Medicare-Advantage plan on a monthly basis. Dual-Eligibles may join a Medicare-Advantage plan outside of their Initial Election Period and Medicare's Annual Election Period. This applies to the CMC program as well.

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

2.4.2 Selection, Assignment, and Change of Primary Care Provider (“PCP”) and/or Participating Physician Group (“PPG”)

2.4.2.1 Selection and Assignment

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

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

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

2.4.2.1.4 The PCP is responsible for coordinating, supervising and providing primary health care services to a CMC Member. This includes, but is not limited to, initiating specialty care referrals and maintaining continuity of care.

2.4.2.1.5 Specialists who meet the requirements for PCP participation and are willing to assume the responsibilities of a PCP, may request designation as a PCP in the network.

2.4.2.2 Change of PCP and/or PPG

2.4.2.2.1 Members may change their PCP and/or PPG on a monthly basis by calling L.A. Care Member Services at **1.888.522.1298** (TTY: 711). The change will occur on the 1st of the following month, provided the request is received by L.A. Care Member Services by the 20th of the month.

2.4.2.2.2 Changes in the L.A. Care CMC Provider network may result in changes to Members’ PCPs and/or PPGs. L.A. Care will notify the Members of the change, the effective date of the change, and their right to request a different provider.

2.4.4 Disenrollment

2.4.4.1 Disenrollment refers to the termination of a Member’s enrollment in L.A. Care CMC. Disenrollment does not refer to a Member transferring from one PCP and/or PPG to another.

2.4.4.2 Members may *voluntarily* disenroll from L.A. Care CMC at their discretion by contacting HCO. These Members must remain in a Managed Care Medi-Cal plan for their Medi-Cal benefits. If they voluntarily disenroll from L.A. Care CMC, Members may choose one of the following options for their Medicare benefits:

- Enroll in another CMC Plan
- Elect to return to Medicare Fee-for-Service (FFS) and enroll in a Part D plan
- Enroll in a Medicare Advantage Plan

If a Member disenrolls from the Medicare portion of CMC, the Member can stay enrolled in L.A. Care for Medi-Cal only and will receive a new L.A. Care Medi-Cal identification card. FFS Medicare services will be primary and services will be subject to L.A. Care Medi-Cal rules and processes, as described in the L.A. Care Medi-Cal Provider Manual.

2.4.4.3 Members may be *involuntarily* disenrolled from L.A. Care CMC for the following reasons:

- Loss of Medicare Parts A and B.
- Loss of Medi-Cal eligibility. L.A. Care CMC provides up to two months of continued enrollment in CMC to regain Medi-Cal eligibility before disenrollment. *This is called deeming.*
- Moving out of Los Angeles County for more than 6 months.
- Knowingly falsifying or withholding information about other parties' reimbursement for prescription drug coverage.
- Intentionally providing incorrect information on the enrollment application, affecting eligibility to enroll in L.A. Care CMC.
- Behavior that is disruptive to the extent that continued enrollment seriously impairs L.A. Care's ability to arrange or provide medical care for them or for others who are Members of L.A. Care CMC. *This type of disenrollment requires CMS approval.*
- Allowing someone else to use his or her L.A. Care CMC Membership identification card to receive medical care. CMS may refer the case to the Inspector General for further investigation if this is the reason for disenrollment.

2.5 MEMBER IDENTIFICATION CARD

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

 Cal MediConnect Plan Member Name: Member ID: Health Plan (80840): 7477556592	Member Services: 1-888-522-1298 (TTY: 711) Behavioral Health Services: 1-877-344-2858 (TTY: 1-800-735-2929) Dental Services: 1-888-700-5243 24-Hour Nurse Advice Line: 1-800-249-3619 (TTY: 711) PCP Phone Number: <PCP Phone>
Effective Date: PCP Name: Medical Group:	RxBIN: 610602 RxPCN: NVTD RxGRP: CMC
H8258-001	MedicareRx Prescription Drug Coverage
Claims Inquiry: 1-866-522-2736 Pharmacy Help Desk (Providers Only): 1-844-268-9785	Send claims to: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081
Website: www.calmedicconnectla.org	

2.6 EVIDENCE OF COVERAGE

An L.A. Care CMC Evidence of Coverage/Member Handbook (“EOC”) is sent to Members upon enrollment and annually thereafter. The EOC provides Members with a description of the scope of covered services and information about how to access services under L.A. Care’s CMC plan. The CMC EOC is available electronically online at calmedicconnectla.org/members/2017-member-materials.

2.7 MEMBER’S RIGHTS AND RESPONSIBILITIES

L.A. Care CMC Members have specific rights and responsibilities that are fundamental to the provision and receipt of quality healthcare services. Member rights and responsibilities are described in L.A. Care CMC Evidence of Coverage/Member Handbook (EOC). For more information, please see calmedicconnectla.org/members/member-rights-responsibilities.

2.8 NOTICE TO MEMBERS REGARDING CHANGE IN COVERED SERVICES

L.A. Care is required to inform Members about any change in the provision of covered services. L.A. Care CMC must send written notification of any change to the Member no less than 60 days prior to the date of actual change, or as early as possible. In case of an emergency, the notification period will be within 14 days prior to changes, or as early as possible.

In some circumstances, when the event includes termination of a Provider’s contract, L.A. Care CMC arranges for Members affected by the termination to continue care with their Provider until their treatment is completed. In order for L.A. Care CMC to make these arrangements, the medical conditions must meet specific criteria and the Provider must be willing to continue seeing the Member, as well as be willing to accept L.A. Care’s CMC rate of reimbursement.

2.9 MEMBER GRIEVANCES & APPEALS

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

2.9.1 Member Grievances

CMS defines a grievance as any complaint or dispute (other than a service authorization request and/or coverage determination) expressing dissatisfaction from a member/ authorized representative, orally or in writing, related to any aspect of the operations, activities, or behavior of a health plan, or its providers, regardless of whether any remedial action can be taken. An expedited grievance may also include a complaint that the plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints about the operations of L.A. Care CMC or its Providers such as:

- Waiting times
- Appropriateness, access to, and/or setting of a provided health service, procedure or item
- Demeanor of health care personnel
- Adequacy of facilities
- Respect paid to Members

2.9.1.1 Participating Physician Group Responsibility L.A. Care does not delegate the grievance or appeal process to Participating Physician Groups (PPGs). Therefore, any expression of dissatisfaction by the Member, and/or any dispute regarding a service authorization request or coverage determination, must be forwarded to the L.A. Care Appeals and Grievances Department immediately upon receipt, by telephone at **1.888.522.1298**, by fax at **213.438.5748**, by L.A. Care's website at lacare.org/online-grievance-form or by mail at:

L.A. Care Health Plan
Appeals & Grievances Department
PO BOX 811610
Los Angeles, CA 90081

L.A. Care maintains a comprehensive grievance resolution system, which includes tracking grievances by category, PPG, delegate and by Provider. PPGs are required to respond to urgent requests for information related to a grievance or dispute expeditiously but no greater than 24 hours. All other requests will require a response within five (5) calendar days. If a PPG fails to provide such information or medical records within 24 hours or five (5) calendar days, PPG shall provide L.A. Care access to copy the appropriate medical records at the PPG's expense.

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

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

2.9.1.2 Acting as an Appointed Representative A Member may have any individual, including a provider, act as his or her representative, as long as the designated representative has not been disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law.

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

2.9.1.3 L.A. Care's Resolution Process for Standard and Expedited Grievances

Standard Grievances

- L.A. Care accepts any information or evidence concerning a Member grievance pertaining to the CMC program, orally or in writing, without any time limit.
- L.A. Care acknowledges, thoroughly investigates, and resolves standard Member grievances within thirty (30) calendar days of the oral or written request. However, if information is missing or if it is in the best interest of the Member, L.A. Care may extend the timeframe by an additional fourteen (14) days with the verbal consent of the member/authorized representative.

Expedited Grievances

- A Member can request an expedited grievance, when the plan has refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration time frame.
- L.A. Care responds to expedited grievances within twenty-four (24) hours of receipt of the oral or written request.

If a complaint is not resolved to the Member's satisfaction, the Member has the right to seek the opinion of the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO).

2.9.2 Member Appeals

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

Medicare Appeals Process and Medi-Cal Appeals Process

Medicare and Medi-Cal have distinct appeals processes. Medicare benefits appeals follow the Medicare process, and Medi-Cal benefits appeals follow the Medi-Cal process. A Member with an overlapping health issue retains the right to a State Fair Hearing, regardless of whether they choose the Medicare appeals process, or the Medi-Cal appeals process. See the section on “Overlapping Benefits” below.

2.9.3 Member Appeals Procedure – Medicare

2.9.3.1 Organization Determination An initial decision made by L.A. Care to deny or pay for a benefit or service that the Member has requested or has already received. When L.A. Care completes the organization determination process, we will notify the Member with the decision and information about the Member’s appeal rights.

2.9.3.2. Appeal Level 1: Appeal to L.A. Care

2.9.3.2.1 Standard Reconsideration of Organization Determination

Members may file reconsiderations of organization determinations for Medicare services with L.A. Care’s Grievance and Appeals Department. All reconsiderations must be filed within sixty (60) calendar days of notification of the organization determination decision. L.A. Care will resolve all reconsiderations regarding payment for services already received within sixty (60) calendar days. L.A. Care will resolve all standard reconsiderations regarding medical care within thirty (30) calendar days. However, if information is missing, or if it is in the best interest of the Member, L.A. Care may extend the timeframe by an additional fourteen (14) calendar days. If L.A. Care decides in favor of the Member with respect to payment reconsideration, L.A. Care must make the payment within sixty (60) calendar days of receiving the appeal. If L.A. Care decides in favor of the Member with respect to a standard reconsideration of medical care, L.A. Care must authorize or arrange to provide the services within thirty (30) calendar days of receiving the appeal. If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the Independent Review Entity (IRE) within thirty (30) calendar days for cases involving medical care, and within sixty (60) calendar days for cases involving payment decisions from the date the plan received the request for reconsideration.

2.9.3.2.2 Expedited Reconsideration of an Organization Determination

L.A. Care will resolve all expedited reconsiderations within seventy-two (72) hours, or sooner, as required based upon the health condition of the Member. L.A. Care may extend the timeframe for an additional fourteen (14) days if information is missing, or if it is in the best interest of the Member. If L.A. Care decides in favor of the Member, L.A. Care must authorize or provide care within seventy-two (72) hours of receiving the expedited appeal. If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the IRE within twenty-four (24) hours of affirmation of the adverse determination.

2.9.3.3 Appeal Level 2: Independent Review Entity

At the second level, the appeal is reviewed by an outside IRE that is contracted with CMS. If the IRE decides in favor of the Member with respect to payment of medical services already received, L.A. Care must make the payment within thirty (30) calendar days of receiving the IRE decision. If the IRE decides in favor of the Member with respect to a standard decision about medical care not yet received, L.A. Care must authorize the services within seventy-two (72) hours for expedited requests, or arrange to provide the services within fourteen (14) calendar days of receiving the IRE decision for standard requests. If the IRE upholds the Plan's determination, the Member may request a Level 3 appeal, review by an administrative law judge (ALJ).

2.9.3.4 Appeal Level 3: Administrative Law Judge

If the amount remaining in controversy meets the appropriate threshold requirement, any party to the reconsideration who is dissatisfied with the reconsideration determination has a right to a hearing before an ALJ. During the ALJ review, Members may present evidence, review the record and be represented by counsel. The request must be filed within sixty (60) calendar days of notification of the decision made by the IRE. The ALJ will make a decision as soon as possible. If the ALJ decides in favor of the Member, L.A. Care must pay for, authorize, or arrange to provide the medical care or services within sixty (60) days of receiving the decision. If the ALJ upholds the IRE's determination, the Member may request a Level 4 appeal, review by the Medicare Appeals Council (MAC).

2.9.3.5 Appeal Level 4: Medicare Appeals Council

Members must file with the MAC within sixty (60) calendar days of the decision made by the ALJ. If the MAC reviews the case (it does not review every case it receives), it will make a decision as soon as possible. If the MAC decides in favor of the Member, L.A. Care must pay for, authorize, or arrange to provide the medical care or services within sixty (60) days of receiving the decision. If the MAC upholds the ALJ's determination, or decides not to review the case, the Member may request a Level 5 appeal, review by a Federal Court.

2.9.3.6 Appeal Level 5: Federal Court

In order to request judicial review by a Federal Court, the Member must file a civil action in a United States district court within sixty (60) calendar days after the date notified of the decision made by the MAC. However, the amount in controversy must meet the appropriate minimum threshold. For 2016, the amount in controversy minimum threshold is One Thousand Five Hundred Dollars (\$1,500.00). If the minimum threshold is met and a federal court judge agrees to review the case, a decision will be made according to the rules established by the federal judiciary.

2.9.4 When Members Disagree with Hospital Discharge

A hospitalized Member who wishes to appeal L.A. Care's discharge decision that inpatient services are no longer necessary may request an immediate review with the Quality Improvement Organization (BFCC-QIO). The Member will not incur any additional financial liability if the following conditions are met:

- The Member remains in the hospital as an inpatient
- The Member submits the request for immediate review to the BFCC-QIO that has an agreement with the hospital
- The request is made either in writing, by phone or by fax
- The request is received by noon of the first working day after the Member receives written notice of the Plan's determination that the hospital stay is no longer necessary

The Member has the right to request a review by a BFCC-QIO of any hospital discharge notice. The notice shall include information on filing the BFCC-QIO appeal. The Member must contact the BFCC-QIO before he/she leaves the hospital, but no later than the planned discharge date.

If the Member asks for immediate review by the BFCC-QIO, the Member will be entitled to the immediate review process. Provider and/or PPG must ensure that the Member receives the Detailed Notice of Discharge (CMS-10066). A Member may file an oral or written request for an expedited seventy-two (72) hour appeal if the Member has missed the deadline for requesting the BFCC-QIO review.

The BFCC-QIO will make its decision within one (1) business day after it receives the Member's request, medical records, and any other information it needs to make its decision. If the BFCC-QIO agrees with the PPG's discharge decision, PPG and L.A. Care CMC are not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the BFCC-QIO notifies the Member of its decision. If the BFCC-QIO overturns the PPG's discharge decision, PPG must pay for the remainder of the hospital stay.

2.9.5 Special Considerations Regarding Termination of Skilled Nursing Facility, Home Health Agency, and Comprehensive Outpatient Rehabilitation Facility Services

Regarding Medicare Members, a termination of service means the discharge of a Member from Covered Services, or discontinuation of Covered Services, when the Member has been authorized by L.A. Care to receive an ongoing course of treatment from that Provider. The following is required for Special Consideration:

- The Member must contact the BFCC-QIO, verbally or in writing, no later than noon of the day before the Covered Services are to end. At the same time, the Provider and/or PPG will notify L.A. Care of the Notice of Medicare Non Coverage (NOMNC) issued to the Member. L.A. Care will track issuance and follow-up on all NOMNCs from delegated Providers and/or PPGs.
- If the Member disagrees with the NOMNC and requests an appeal, L.A. Care will prepare the Detailed Explanation of Non-Coverage (DENC) for the Provider and/or PPG to issue to the Member. If the Member requests an appeal with the BFCC-QIO, L.A. Care must obtain the Member's medical records from the Provider/PPG, and send a copy of the DENC, along with the Member's medical records, to the BFCC-QIO by close of business on the day the BFCC-QIO submitted the appeal notification to L.A. Care.

- L.A. Care may request that the records be sent directly to the BFCC-QIO. The BFCC-QIO must make a decision and notify the Member and L.A. Care by close of business the following day.

On the next business day, L.A. Care will notify the PPG of the fast-track appeal request and the BFCC-QIO's determination. If the BFCC-QIO overturns the decision, the PPG must continue authorization to the Group Provider, provide L.A. Care with proof of continued authorization, and prepare and issue a new NOMNC notice when new discharge orders are written.

If the Member fails to file a timely appeal with the BFCC-QIO, the Member may request an expedited appeal from L.A. Care [42 CFR 422.624; 42 CFR 422.626]

2.9.6 Member Appeal Procedure – Medi-Cal

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

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

- o Allowance of least sixty (60) days for Medi-Cal Members, after notification of the denial, for the Member to file an appeal.
- o Acknowledgement of the receipt of the appeal within five (5) calendar days (acknowledgement upon receipt by phone, if expedited).
- o Documentation of the substance of the appeal and any actions taken.
- o Full investigation of the substance of the appeal, including any aspects of clinical care involved.
- o The opportunity for the Member to submit written comments, documents or other information relating to the appeal.
- o An authorized representative to act on behalf of the Member.
- o The appointment of a new person to review the appeal, who was not involved in the initial determination, and who is not the subordinate of any person involved in the initial determination.
- o The appointment of at least one person to review the appeal, who is a practitioner in the same or similar specialty, that typically treats the medical condition, performs the procedure, or provides the treatment.
- o Notification of the decision of the appeal to the Member within thirty (30) calendar days of receipt of the request, or seventy-two (72) hours if expedited.
- o Providing to the Member, upon request, access to and copies of all documents relevant to the Member's appeal.
- o Notification to the Member about further appeal rights.
- o Members who disagree with the appeal decision, and wish to appeal further, have the right to contact and file a grievance with the Department of Managed Health Care (DMHC), or to request an Independent Medical Review (IMR).

2.9.6.1 Standard Review

- Upon receipt of a standard appeal, the Appeal & Grievance department will immediately begin their investigation.
- An acknowledgment letter will be sent to the Member, or Provider acting on behalf of the Member, within five (5) calendar days. The letter will include information regarding the appeals process.
- The physician reviewer will review the standard appeal and determine if he/she is qualified to make a determination on the clinical issues presented in the case.
- If the physician reviewer determines he/she is qualified, he/she will make a resolution/disposition determination.
- If the physician reviewer determines he/she is not qualified, he/she will consult with another qualified professional prior to making a determination.
- The physician reviewer may also contact the Provider requesting services, to further discuss the Member's clinical condition.

- A determination will be made within thirty (30) calendar days from receipt of the appeal, and information necessary to make a determination.
- Written notification is due within thirty (30) calendar days of receipt of appeal for standard requests.
- Written notification of determination will be sent within five (5) business days of the reviewing physician's determination. The notification will include:
 - o Final determination
 - o A statement setting forth the specific medical and scientific reasons for the determination, and a description of alternative treatments, supplies, and/or services, as appropriate
 - o Reasons other than medical necessity (e.g. non-covered benefits, etc.) will include a statement of benefit structure
 - o Instructions for appealing further to the Department of Managed Health Care (DMHC) and/or the Department of Health Care Services (DHCS) for a State Hearing
 - o The phone number and extension of L.A. Care's physician reviewer

2.9.6.2 Expedited Review

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

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

A Member has the right to request assistance from the DMHC for determinations that cannot be completed within thirty (30) calendar days for standard appeals, or within seventy-two (72) hours for expedited appeals.

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

Medi-Cal Members, or their representative, may contact the State Department of Social Services to request a State Hearing or an Expedited State Hearing, up to a hundred and twenty (120) days from receipt of the denial/modification letter. Members must exhaust the plan's appeal process prior to requesting a State Hearing.

2.9.6.4 Medi-Cal Managed Care Ombudsman

Medi-Cal Members also may contact the Office of the Ombudsman to request assistance with their appeal. Contact information for the Medi-Cal Managed Care Ombudsman is as follows:

Assistance for people in Medi-Cal managed care plans is available at **1.888.452.8609** (in many languages). To access the online site go to dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx.

2.9.7 Independent Medical Review

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

- The medical necessity of a proposed treatment
- Experimental or investigational therapies for a life-threatening or seriously debilitating disease or condition
- Claims for out-of-plan emergency or urgent medical services

The application and process for seeking an IMR is always included with the appeal response notification letter resulting from upholding a denial or modification of a request for service. The DMHC Internet Website has complaint forms, IMR application forms and instructions online.

To access the online site, go to the State Department of Managed Health Care (DMHC) Independent Medical Review page:

dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaint.aspx#.VvMW1U3bKUk
dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaint.aspx#.VvMW1U3bKUk

2.9.8 Member Appeal Procedure – Overlapping Benefits

For benefits covered by both Medicare and Medi-Cal, the Member retains the right to a State Hearing, regardless of whether they choose the Medicare appeals procedure, or the Medi-Cal appeals procedure.

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

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

3.0 ACCESS TO CARE

This section summarizes the access to care requirements for L.A. Care Participating Physician Groups (“PPGs”) and their affiliated Provider networks.

3.1 RESPONSIBILITY OF PARTICIPATING PROVIDER NETWORK

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

3.2 PRIMARY CARE AND SPECIALIST PHYSICIAN ACCESS REQUIREMENTS

Primary Care Provider Accessibility Standards:	
Types of Service	Standards
Routine Primary Care Appointment (Non-Urgent) Services for a symptomatic patient who does not require immediate diagnosis and/or treatment.	≤ 10 business days of request
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request if no authorization is required
Emergency Care Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	Immediate, 24 hours a day, 7 days a week.
Preventive health examination (Routine)	≤ 30 business days of request
First Prenatal Visit A periodic health evaluation for a Member with no acute medical problem.	≤ 14 calendar days of request

Specialty Care Provider (SCP) Accessibility Standards:	
Types of Service	Standards
Routine Specialty Care Physician Appointment (Non-Urgent)	≤ 15 business days of request
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 96 hours, if prior authorization is required

Ancillary Care Accessibility Standards:

Types of Service	Standards
Non-Urgent Ancillary Appointment (Non-Urgent)	≤ 15 business days of request

Behavioral Health Care Accessibility Standards:

Types of Service	Standards
Routine Appointment (Non-Urgent)	<ul style="list-style-type: none"> ≤ 15 business days of request (Physicians) ≤ 10 business days of request (Non-Physicians)
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request if no authorization is required
Emergency Care Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	≤ 48 hours of request
Life Threatening Emergency	Immediate, 24 hours a day, 7 days a week
Non-Life Threatening Emergency	≤ 6 hours of request
Emergency Services	Immediate, 24 hours a day, 7 days a week

After Hours Care Standards:

Types of Service	Standards
After Hours Care Physicians (PCP, Behavioral Health Provider and Specialists, or covering physician) are required by contract to provide 24/7 coverage to Members. Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to Members, upon request, within 30 minutes. Please note clinical advice can only be provided by appropriately qualified staff, e.g. physician, physician assistant, nurse practitioner or RN.	<ul style="list-style-type: none"> • Automated systems must provide emergency 911 instructions • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician within 30 minutes If process does not enable the caller to contact the PCP, Behavioral Health Provider, Specialist or covering practitioner directly, the “live” party must have access to a practitioner or triage/screening clinician for urgent and non-urgent calls.

Practitioner Telephone Responsiveness:

Types of Service	Standards
<p style="text-align: center;">In-Office Waiting Room Time</p> <p>The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.</p>	Within 30 minutes
<p style="text-align: center;">Speed of Telephone Answer (Practitioner’s Office)</p> <p>The maximum length of time for practitioner’s office staff to answer.</p>	Within 30 seconds
<p style="text-align: center;">Missed Appointments</p> <p>The period of time after a missed appointment that a patient is contacted to reschedule their appointment.</p>	Within 48 hours

3.3 MONITORING

The PCP is responsible for responding to any access deficiencies identified by any one of L.A. Care’s review methods, including the following:

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

4.0 SCOPE OF BENEFITS

This section summarizes the scope of benefits for L.A. Care Cal MediConnect (“CMC”).

4.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

L.A. Care contracts with Providers, PPGs, and other vendors to provide healthcare services to CMC Members. Under the terms of Provider agreements with L.A. Care, certain PPGs and hospitals have agreed to assume the financial responsibility of providing specified health benefits. To determine which health benefits a PPG and/or hospital may be delegated and for which this entity is financially responsible, please refer to the Division of Financial Responsibility (“DOFR”) of the entity’s agreement with L.A. Care or contact the PPG with which you are contracted under L.A. Care.

Regardless of coverage limitations, L.A. Care may not restrict communications between Providers and their Cal MediConnect Members when such communications relate to the patient’s treatment.

4.2 COST SHARING FOR BENEFITS

Cal MediConnect benefits include all Medicare Parts A, B and D benefits (more information about Part D coverage is provided below in Section 4.4, CAL MEDICONNECT PHARMACY BENEFITS). With the exception of certain Part D covered drugs, there must be no cost sharing for any Medicare benefits.

Cal MediConnect benefits include all Medi-Cal covered services, including services for the detection of symptomatic diseases, as defined by Title 22, Section 51301 through Section 51365, of the California Code of Regulations. *Medi-Cal benefits must be provided with no co-payment.*

4.3 CAL MEDICONNECT BENEFITS

The table below includes (but is not limited to) the types of services included in the Cal MediConnect program.

Basic Medical Care and Preventive Services	Emergency and Specialty Care	Support Services and Long-Term Care
Doctor and Specialist visits, including Podiatry	Hospital Stays	Skilled Nursing Facilities
Prescription Medications	Medical Equipment and Supplies	In-Home Supportive Services
Lab Work and X-Rays	Mental/Behavioral Health	Home Health
Dental	Rehabilitation Services	Community-Based Adult Services (CBAS)
Vision	Dialysis	Care Plan Options
Nurse Advice Line	Emergency Care anywhere in the U.S.	Multipurpose Senior Service Programs
Health Education and Exercise Classes		Help with Social Services
Transportation		Home- and Community-Based Waiver Programs
Interpreters (for doctor appointments)		
Asthma and Diabetes Management Programs		
Acupuncture		

4.3.1 How to Access Behavioral Health Services:

L.A. Care Cal MediConnect has partnered with Beacon Health Options (“Beacon”), a managed behavioral health care company, to provide behavioral health services to L.A. Care Cal MediConnect Members. Both Members and Providers can call Beacon at **1.877.344.2858** to coordinate access to care, and Providers can also call L.A. Care’s Behavioral Health Provider Information line at **1.844.858.9940**.

4.3.2 Supplemental Benefits

4.3.2.1 How to Access Non-Emergency Medical and Non-medical Transportation:

Transportation services for CMC Members can be scheduled by contacting L.A. Care’s Customer Service Solution Center to arrange Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. The authorization or referral of transportation services for CMC Members requires the completion and submission of the Physician Certification Statement (PCS) Form for NEMT and the referral form for NMT. The prior authorization and referral requests have been combined into one form which can be accessed through the following link: L.A. Care PCS and Referral Form. Once you have completed and signed the form appropriately, submit it to L.A. Care’s Utilization Management Department for approval. Once the services have been approved, both you and the Member will be notified and the Member will be able to schedule his/her transportation. It is highly recommended that services be requested **at least 48 hours prior** to the Member’s appointment. CMC Members can call L.A. Care’s Customer Solution Center at **1.888.839.9909** select transportation, and be routed to Call the Car.

Facilities can call to arrange or obtain an update on discharge, transfer, or auto approval transportation by calling L.A. Care’s Health Services Department at **1.877.431.2273**, select transportation, then follow the prompts.

4.3.2.2 How to Access Vision Services: Vision care can be accessed by contacting VSP Member Services at **1.800.877.7195** or **1.800.428.4833** for the hearing impaired, or visit their website at vsp.com to locate a participating Provider.

4.3.2.3 How to Access Acupuncture Services: Acupuncture services can be accessed by contacting American Specialty Health (“ASH”) at **1.800.848.3555**. Authorization is not required for the first two (2) visits per month.

4.4 CAL MEDICONNECT PHARMACY BENEFITS

4.4.1 Medicare Part D 2019 Coverage

L.A. Care Cal MediConnect Members may pay copayments for medications. Co-payments vary depending on the Coverage Stage the Member is in and the medication's formulary tier. Members who reach \$5,100 in yearly out-of-pocket drug costs enter the Catastrophic Coverage Stage and pay \$0 for covered drugs. Co-payments may also vary depending on the Member's low-income subsidy level. Co-payments for Members in the Initial Coverage Stage (Members with out-of-pocket costs from \$0 - \$5,099) are identified by the Tiers listed below.

TIER	2019 CO-PAY FOR A ONE MONTH (30 DAY SUPPLY) PER PRESCRIPTION FILLED AT A NETWORK PHARMACY
1. Generic Drugs	The copay will be \$0.
2. Brand-Name Drugs	The copay will be from \$0 to \$8.50, depending on the Member's level of Medi-Cal eligibility (subsidy).
3. Non-Medicare Prescription Drugs	The copay will be \$0.
4. Non-Medicare Over-the-Counter Drugs	The copay will be \$0.

4.4.1.1 What drugs are covered by L.A. Care's Cal MediConnect Program?

L.A. Care Cal MediConnect has a formulary that lists all drugs covered. Drugs on the formulary will generally be covered as long as the drug is medically necessary, is covered by 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 Cal MediConnect website at calmediconnectla.org/members/2019-member-materials

4.4.1.2 How do Members get their 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 Cal MediConnect Member Materials website:

calmediconnectla.org/members/2019-member-materials

4.4.1.3 What is mail order pharmacy service?

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. Orders can be for up to a 90-day supply of the drug. Mail orders should be requested at least 14 calendar days prior to the drug running out.

It is not required to use the mail order service 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.

For more details about Part D Coverage, please call our Pharmacy Department at **1.888.4LA.CARE** and refer to Section 16, Pharmacy, of this Manual.

4.4.2 Pharmacy Benefits – Medi-Cal

4.4.2.1 Prescription Drugs Covered by Medi-Cal

Medi-Cal will pay for certain medically necessary drugs not covered under Medicare Part D when they are: 1) prescribed by a participating licensed practitioner acting within the scope of his or her licensure, 2) on L.A. Care’s Drug Formulary, and 3) filled at a participating pharmacy. These drugs include:

- Cough/cold medications
- Over-the-counter medications (except for insulin & syringes which are covered by Medicare Part D)
- Prescription vitamins and minerals

4.4.2.2 Excluded Medi-Cal Pharmacy Benefits

- Experimental or investigational drugs, unless accepted for use by the standards of the medical community
- Drugs or medications for cosmetic purposes
- Medicines not requiring a written prescription order (except insulin and diabetes monitoring supplies, spacer devices, and peak flow meters)
- Dietary supplements, appetite suppressants, or any other diet drugs or medications (except when medically necessary for treatment of morbid obesity)
- Any benefits in excess of limits specified previously
- Services, supplies, items, procedures, or equipment; which are not medically necessary as determined by L.A. Care; unless otherwise specified

4.4.2.3 Non-Formulary Drugs Prior Authorization Required – Medi-Cal

Drugs not included in L.A. Care’s Drug Formulary and deemed medically necessary may be provided subject to prior authorization. Provider questions concerning non-formulary drug coverage and prior authorization requirements may be directed to Navitus, L.A. Care’s pharmacy benefit manager, at Navitus Customer Care at **1.844.268.9785** (for Cal MediConnect). Providers calling Navitus must have all the necessary information relating to their inquiry.

L.A. Care’s Director of Pharmacy will review all requests not meeting prior authorization criteria. Denials may be appealed through the L.A. Care Grievance and Appeals process.

More information about Pharmacy Authorization is provided in Section 16, Pharmacy, of this Manual.

4.5 MECHANISMS TO CONTROL UTILIZATION OF SERVICES

PCPs are responsible to directly provide primary care services and refer Members to specialty care through L.A. Care’s authorization process. The PCP is the point of entry for all specialized care. For services that do not require a prior authorization, Members have a “self-direct option,” allowing them or their caregivers to directly refer to the service (mental health or substance abuse) or MLTSS program.

4.5.1 Model of Care Overview

The purpose of L.A. Care Cal MediConnect is to provide Dual-Eligible Members with the full, seamless, person-centered continuum of medical care and social supports and services needed to maintain good health and remain in the community with quality of life. This is intended to be achieved through risk stratification and assessment processes, care management capacity, outreach and enrollment strategies for hard-to-reach populations, a large and diverse network of public and private Providers, and health information technologies. The Cal MediConnect program will build on L.A. Care's extensive Medi-Cal and Medicare networks and local stakeholder relationships to coordinate and streamline the full range of primary, acute, behavioral, and long-term services and supports.

The L.A. Care Cal MediConnect "Model of Care" demonstrates various methodologies to coordinate and provide services and care to Members who are frail, disabled, have multiple chronic illnesses, and require end of life care. The Model of Care aims to delay institutional placement and manage the complex chronic health conditions of the Dual-Eligible population. The Cal MediConnect Model of Care provides a comprehensive approach to health care delivery in a delegated network to Members in danger of premature institutionalization, via the following:

4.5.1.1 Network – To ensure an adequate network of primary and specialty care practitioners, L.A. Care's Provider Network Management has established quantifiable standards for both geographic distribution and the ratio of Providers to Members of PCPs and high volume specialists. L.A. Care endorses and promotes comprehensive and consistent standards for accessibility to, and availability of, health care services for all Members. L.A. Care will measure compliance with these standards and implement interventions to improve access to, and availability of, health care services as appropriate.

4.5.1.2 Behavioral Health – Cal MediConnect delegates Behavioral Health services to a Managed Behavioral Health Organization (MBHO), and collaborates with behavioral health practitioners using information collected to improve coordination between medical and behavioral care. L.A. Care has established quantifiable standards to align with federal, state, and accreditation requirements for measuring emergent, urgent and routine appointment access to behavioral health services.

4.5.1.3 Health Risk Assessment – Cal MediConnect conducts outreach to Members to perform the health risk assessments that ensure assessment and referral to the appropriate health plan program and access to plan benefits aimed at maintaining independence in the community. This includes referrals to various social service programs, such as MLTSS, MSSP, and CBAS services.

4.5.1.4 Cultural and Linguistic Services – L.A. Care's comprehensive program ensures medically necessary covered services are available and accessible to Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, sex, marital status, sexual orientation, health status, or disability.

4.5.1.5 Integrated Benefit Sets – Cal MediConnect’s Member access to care is improved by providing specialized care through combining available Medicare and Medi-Cal benefits. The ability to integrate benefit sets and provide enhanced or supplemental benefits improves the coordination of health care services.

4.5.1.6 Appropriate Utilization, Coordination, and Transition of Care – Appropriate utilization of services is assured by L.A. Care’s monitoring and measuring hospital-based care goals. These include reducing inappropriate/preventable or avoidable admissions, emergency room utilization, and premature institutionalization. Every Member will be offered a seamless, person-centered plan of care that integrates physical health, behavioral health, and MLTSS. The immediate goal is for every Member to have a Care Manager as a clearly identified point of contact for all coordination of care. Cal MediConnect has alternative service Providers and facilities necessary to support care transitions of Members.

4.5.1.7 Preventive Benefits – Cal MediConnect promotes the appropriate use of preventive benefits to provide early disease detection and intervene in the disease process to avoid complications.

4.5.1.8 Improved Outcomes – L.A. Care adopts evidence-based clinical practice guidelines promulgated by recognized sources (e.g. leading academic and national clinical organizations, including the California Guidelines for Alzheimer’s Disease Management) for selected conditions identified as relevant to its Membership. To understand and implement programs that are impactful to Members and their perception of their health, L.A. Care annually assesses Member satisfaction.

4.5.2 Utilization Management

L.A. Care may create mechanisms to help contain costs for providing health care benefits to Members. Such mechanisms may include, but are not limited to the following:

- Requiring prior authorizations for benefits
- Providing benefits in alternative settings
- Providing benefits by using alternative methods

More about Cal MediConnect Utilization Management is provided in Section 5, Utilization Management, of this Manual.

5.0 UTILIZATION MANAGEMENT

Key L.A. Care Health Plan and State Contacts*

Area	Phone/Fax	Other Contact Info
L.A. Care Health Plan Member Services	1-889-839-9909	Available 24/7
L.A. Care General Utilization Management	1-877-431-2273	Available 24/7
Specific Utilization Management Fax Numbers	UM: (213) 438-5777 Urgent: (213) 438-6100 Out of Network: (213) 438-5046 Inpatient: (877) 314-4957 Long Term Care: (213) 438-4877 Community Based Adult Services: (213) 438-573	
For DHS and Community Access Network (CAN) Fax Numbers	Prior Auth: (213) 437-2202 Inpatient: (213) 437-2203 Urgent: (213) 437-2204	
Inpatient Referrals	1-877-431-2273	Available 24/7
Care Management	1-844-200-0104 Select Option 2 for Cal MediConnect or Option 3 for all other lines of business	Available Monday - Friday 8am - 4:30pm
Behavioral Health	Mild to Moderate Mental Health Services (Beacon Health Options) 877-344-2858 Severe Mental Health Services (Department of Mental Health) 855-854-7771	L.A. Care Behavioral Health Information Services Phone: 844-858-9940 or email: behavioralhealth@lacare.org

Certain services will need to be sent to the patient's assigned medical group (IPA or PPG). Please check the patient's ID card, the Medi-Cal or call L.A. Care's Provider Service Line (**866.522.2736**).

Area	Phone/Fax	Other Contact Info
Substance Use Treatment	Speciality Substance Abuse (Disorder Department of Public Health) 800-564-6600	
Interpreter Services	1-888-839-9909	Available 24 hours a day, 7 days a week (In-person can be arranged if needed)
Claims Status	For CAN Network, 1-844-361-7272, Select Option 3 For all other Network Providers, 1-866-522-2736, Select Option 4	
Claims: Overpayment Recovery	For CAN Network, 1-844-361-7272, Select Option 4 For all Network Providers, 1-866-522-2736, Select Option 5	
Provider Solution Center	For CAN Network, 1-844-361-7272 For all Network Providers, 1-866-522-2736	Available 24/7
Provider Dispute Resolutions	For CAN Network, 1-844-361-7272, Select Option 4 For all other Network Providers, 1-866-522-2736, Select Option 5	Available Monday - Friday 8am - 4:30pm
Behavioral Health	Mild to Moderate Mental Health Services (Beacon Health Options) 877-344-2858 Severe Mental Health Services (Department of Mental Health) 855-854-7771	L.A. Care Behavioral Health Information Services Phone: 844-858-9940 or email: behavioralhealth@lacare.org

Certain services will need to be sent to the patient's assigned medical group (IPA or PPG). Please check the patient's ID card, the Medi-Cal or call L.A. Care's Provider Service Line **(866.522.2736)**.

State-Based Services Contract

State Services	Phone/Fax	Other Contact Info
Automated Eligibility Verification System (AEVS)	1-800-456-2387	
California Children's Services (CCS)	Phone numbers are county-specific. Los Angeles County Phone: 1-800-288-4584 Fax: 1-800-924-1154 Referrals	Referrals: www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Community-Based Adult Services (CBAS)	Disabilities Rights California: 1-800-776-5746 L.A. Care Health Plan: 1-888-839-9909	www.dhcs.gov/services/medical/Pages/ADHC/ADHC.aspx www.aging.ca.gov/ProgramsProviders/ADHC-CBAS
Denti-Cal	1-800-423-0507 Monday - Friday, 8am - 5pm	www.denti-cal.ca.gov
Department of Health Care Services Medi-Cal Managed Care Ombudsman	1-800-452-8609	www.dhcs.ca.gov/services/medical/Pages/MMCDOfficeoftheOmbudsman.aspx
Department of Health Care Services Office of Family Planning (DHCSOFM)	1-800-942-1054	www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx
Department of Mental Health (DMH) of L.A. County	1-800-854-7771	
Department of Social Services Public Inquiry and Response Unit (DSSPIRU)	1-800-952-5253	
Department of Managed Health Care (DMHC)	1-877-525-1295	www.dmhc.ca.gov
Early Start Program (ESP)		
Hearing Impaired Services: California Relay Service	711 or Voice to TTY, English: 1-800-735-2922 Spanish: 1-800-855-3000 TTY to voice, English: 1-800-735-2929 Spanish: 1-800-855-3000 24 hours a day, 7 days a week	For additional information, visit the California Relay Service webpage at: http://ddtp.cpuc.ca.gov/default1.aspx?id=1482

Certain services will need to be sent to the patient's assigned medical group (IPA or PPG). Please check the patient's ID card, the Medi-Cal or call L.A. Care's Provider Service Line **(866.522.2736)**.

State Services	Phone/Fax	Other Contact Info
Indian Health Services	1-800-456-2387	
Medi-Cal for Families Information Line	1-800-880-5305 Monday - Friday, 8am - 8pm Saturday, 8am - 5pm	
Medi-Cal Telephone Service Center	1-800-541-5555	
Woman, Infant and Children (WIC)	1-888-942-2229 (1-888-WIC-BABY)	

Certain services will need to be sent to the patient's assigned medical group (IPA or PPG). Please check the patient's ID card, the Medi-Cal or call L.A. Care's Provider Service Line **(866.522.2736)**.

5.1 TIPS FOR FILLING OUT THE FORMS AND GETTING THE FASTEST AUTHORIZATION REQUEST RESPONSE:

- 5.1.1** Fill out the form completely; unanswered questions typically result in delays.
- 5.1.2** Print and fax the form to the numbers above.
- 5.1.3** Do not store the form offline; access it online only to ensure the most recent form is used. L.A. Care Health Plan revises forms periodically, and outdated forms can delay your request.
- 5.1.4** Include justification and support notes to your request when submitting.

5.2 SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

5.2.1 The following services do not require prior authorization for in-network providers:

5.2.1.1 Emergency services

5.2.1.2 Post-stabilization services (if medically necessary)

5.2.1.3 Formulary glucometers and nebulizers

5.2.1.4 Family planning/well woman checkup - members may self-refer to any Medicaid provider for the following services:

5.2.1.4.1 Pelvic and breast examinations

5.2.1.4.2 Lab work

5.2.1.4.3 Birth control

5.2.1.4.4 Genetic counseling

5.2.1.4.5 FDA-approved devices and supplies related to family planning (such as IUD)

5.2.1.4.6 HIV/STD screening

5.2.1.4.7 Obstetrical (prenatal) care - no authorization required for in-network physician visits and routine testing

5.2.1.5 Members not affiliated with an IPA or medical group do not need prior authorization from L.A. Care Health Plan for physician referrals to an in-network specialist for consultation or a nonsurgical course of treatment.

5.2.1.6 Standard x-rays and ultrasounds

5.2.1.7 In-network speech therapy and occupational therapy

5.3 SERVICES THAT REQUIRE PRIOR AUTHORIZATION

5.3.1 Prior authorization ensures services are based on medical necessity, are a covered benefit, and are provided by appropriate providers.

5.3.2 Providers are responsible for verifying eligibility and ensuring the appropriate prior authorization review has been conducted by L.A. Care Health Plan's Utilization Management (UM) Unit, for elective nonemergency and scheduled services, before providing those services. Prior authorization must be obtained for all out-of-network services or services provided outside of an emergency room or urgent care setting. Some L.A. Care Health Plan members are assigned to delegated medical groups or IPAs. Providers should contact the member's assigned medical group to confirm the need for prior authorization, before providing elective services. Services requiring prior authorization include but are not limited to:

5.3.2.1 Air ambulance (nonemergent)

5.3.2.2 Behavioral health services (except psychiatric assessments and mental health assessment by non-physician; for more information, see Chapter 5: Behavioral Health Services)

5.3.2.3 Cardiac and pulmonary rehabilitation

5.3.2.4 Cosmetic procedures

5.3.2.5 Dental (medically necessary facility and anesthesia services)

5.3.2.6 Dialysis services

5.3.2.7 Durable medical equipment and disposable supplies

5.3.2.8 Experimental and investigational services

5.3.2.9 Formula

5.3.2.10 Genetic testing

5.3.2.11 Home health care services

5.3.2.12 Hospice

5.3.2.13 Infusion therapies

5.3.2.14 Chemotherapy

5.3.2.15 Inpatient hospital services

5.3.2.16 Nonurgent inpatient admissions

5.3.2.17 Long-term acute care facility (LTAC)

5.3.2.18 Inpatient skilled nursing facility (SNF)

5.3.2.19 Rehabilitation facility admissions

5.3.2.20 Newborn stays beyond mother

5.3.2.21 Laboratory tests (specific)

5.3.2.22 Out-of-network referrals to specialists

5.3.2.23 Outpatient surgical services (delivered in an ambulatory surgical center or outpatient hospital)

- 5.3.2.24 Pharmacy and/or over-the-counter (OTC) products
- 5.3.2.25 Specialty injectable medications such as Palivizumab (Synagis[®]) and Botulinum toxin (Botox[®]) require prior authorization through L.A. Care Health Plan. Contact the UM Unit at PHONE NUMBER for more information.
- 5.3.2.26 Radiology services including MRA, MRI, PET and CT scans
- 5.3.2.27 Non-Emergent or ambulatory care surgeries
- 5.3.2.28 Kidney and cornea transplant services (excluding other major transplants not covered by L.A. Care Health Plan)

5.4 HOW TO REQUEST AN AUTHORIZATION

- 5.4.1 Contact L.A. Care Health Plan for questions or authorization requests regarding:
 - 5.4.1.1 Routine, nonurgent care reviews
 - 5.4.1.2 Urgent or expedited prior authorization reviews
 - 5.4.1.3 Urgent continued stay (concurrent) reviews
- 5.4.2 Providers can fax L.A. Care Health Plan's referrals to our main UM number: (213) 438-5777
- 5.4.3 When applicable, please provide the following information when requesting a prior authorization or report an inpatient admission:
 - 5.4.3.1 Member name and identification (ID) number
 - 5.4.3.2 Diagnosis related to the referral request with the ICD-10 code
 - 5.4.3.3 Procedure with the CPT code
 - 5.4.3.4 Number of units or visits requested if applicable
 - 5.4.3.5 Date of injury or hospital admission and third-party liability information (if applicable)
 - 5.4.3.6 Facility name (if applicable)
 - 5.4.3.7 Primary care provider (PCP) name
 - 5.4.3.8 Specialist or attending physician name
 - 5.4.3.9 Clinical justification for the request
 - 5.4.3.10 Level of care (if concurrent)
 - 5.4.3.11 Lab tests, radiology and pathology results that support the request
 - 5.4.3.12 Treatment plan including time frames
 - 5.4.3.13 Exceptional or special needs issues
 - 5.4.3.14 Ability to perform activities of daily living
 - 5.4.3.15 Discharge plans
- 5.4.4 Have the following additional information ready for the clinical reviewer when possible to facilitate approval:

5.5 AUTHORIZATION CRITERIA AND MEDICAL NECESSITY

5.5.1 Medical Necessity

5.5.1.1 “Medically Necessary” refers to any procedure, treatment, supply, device, equipment, facility, or drug (all services), which an appropriately qualified health care practitioner, exercising prudent clinical judgment, would provide to a covered individual for preventing, evaluating, diagnosing, or treating an illness, injury or disease or its symptoms. Medically necessary services are:

5.5.1.1.1 Provided in accordance with generally accepted standards of medical practice; and

5.5.1.1.2 Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the covered individual’s illness, injury, or disease; and

5.5.1.1.3 Not primarily for the convenience of the covered individual, physician, or other health care provider; and

5.5.1.1.4 Not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual’s illness, injury, or disease.

5.5.2 For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence, published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

5.5.3 An appropriately qualified health care professional is a primary care physician, specialist, or other licensed health care provider, acting within his/her scope of practice and possessing clinical background, training, and expertise related to the illness, disease, or other condition associated with the request for a second opinion.

5.5.4 L.A. Care Health Plan uses established national medical necessity criteria, based on professionally recognized standards of practice to review and authorize referral requests. When warranted, additional information regarding the member’s specific medical care needs is obtained from the primary care physician (PCP) or specialist to assist with decision-making. Such information may include physician visit notes, lab results, diagnostic results, inpatient documents, such as discharge plan and consult notes, digital photos, or any other medical record which is relevant to the request. This may also include direct conversations with the referring provider to gather verbal information.

6.0 QUALITY IMPROVEMENT PROGRAM

L.A. Care annually prepares a comprehensive Quality Improvement Program that defines L.A. Care's Quality Improvement (QI) structures and processes for all L.A. Care operations and products, including Cal MediConnect. The QI Program is designed to improve the quality and safety of clinical care and services for L.A. Care's membership. A copy of L.A. Care's QI Program is available upon request by emailing quality@lacare.org.

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

- Define, oversee, continuously evaluate, and improve the quality and efficiency of health care
- Ensure that medically necessary covered services are available and accessible to Members, taking into consideration the Member's cultural and linguistic needs
- Ensure L.A. Care's contracted network of Providers cooperates with L.A. Care quality initiatives
- Ensure that timely, safe, medically necessary, and appropriate care is available for our Members
- Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, the industry, and the community
- Promote health education and disease prevention designed to promote life-long wellness by encouraging and empowering each Member to adopt and maintain optimal health behaviors
- Maintain a well-credentialed network of Providers based on recognized and mandated credentialing standards
- Safeguard Members' protected health information (PHI)

6.1 ANNUAL QUALITY IMPROVEMENT PROGRAM EVALUATION

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

- Review of completed and continuing program activities and audit results
- Trending of performance data
- Analysis of the results of QI initiatives including barriers, successes and challenges
- Assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues
- Evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices as well as the goals and plans for the next year

6.2 ANNUAL QUALITY IMPROVEMENT WORK PLAN

The annual QI Work Plan is developed in collaboration with an interdepartmental team and is based, in part, upon the results of the prior year's QI Program evaluation. Each of the elements identified on the Work Plan has activities defined, responsibilities assigned, and an expected completion date. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee (QOC) and the Compliance and Quality Committee of the Board.

6.3 COMMITTEE STRUCTURE

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

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

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

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

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

6.4 CLINICAL CARE MEASURES

L.A. Care measures clinical performance through the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® measure reporting is required by state and federal regulations. L.A. Care expects the Provider network to assist the health plan in continuously improving its HEDIS® rates. Providers are required by contract to cooperate with the annual HEDIS® data collection efforts which include providing

medical records to the health plan at any time and submitting timely and accurate encounter data.

Providing medical records to L.A. Care for HEDIS® is a permitted use/disclosure under HIPAA. HEDIS® resources for provider groups, clinics and physician practices are posted on the L.A. Care Website under Provider Resources.

6.5 SERVICE MEASURES

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

As required by CMS, the following measures are collected and analyzed:

Annually:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Medicare Advantage and Prescription Drug Plan (CAHPS®)
- Health Outcomes Survey (HOS)

Quarterly:

- Grievances and Appeals Rates and Trends
- Member Services Telephone Accessibility Measures

6.5.1 Continuity and Coordination of Medical Care

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

- If referring to a specialist, contact the specialist before the Member's appointment
- Have staff set up a quick phone appointment and fax or securely message the Member's medical history
- Request that the specialist contact the Member's PCP once the evaluation and/or treatment is finished
- Keep track of specialty referrals that require prior authorization
- Track referrals to ensure the visit or service has been completed and the report received
- Talk to the PPG about getting timely hospital summary of care documents and discharge summaries that will help follow up and coordinate care after a hospitalization or emergency room visit.

6.5.2 Continuity and Coordination of Medical and Behavioral Health Care

L.A. Care contracts with a vendor to provide mental health services, however, specialty mental health services and substance use disorder services will remain the responsibility of the county as a “carve out.” L.A. Care is required to coordinate and ensure seamless access to all levels of behavioral health (mental and substance use disorder care). This includes the coordination of lower levels of care provided through the Member’s primary care physician. As a provider to Members with behavioral health needs, it is imperative for participating providers to initiate and maintain communication with other health care providers where appropriate. This communication promotes the sharing of clinical information for comprehensive treatment and continuity of care, when appropriate (*e.g. in cases of possible coexisting medical conditions, when medications are prescribed or other medical concerns are evidenced*).

6.6 CLINICAL PRACTICE AND PREVENTIVE HEALTH GUIDELINES

L.A. Care systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from peer reviewed sources and from organizations like the U.S. Preventive Services Task Force. Guidelines for diseases and health conditions identified as most salient to L.A. Care Members for the provision of preventive, acute or chronic medical and behavioral health services are regularly reviewed by L.A. Care’s Joint Performance Improvement Collaborative Committee and Physician Quality Committee to help improve the delivery of health care services to Members.

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

6.7 CHRONIC CARE IMPROVEMENT PROGRAMS

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

- Complete AWE and the Patient Health Questionnaire (PHQ-9) for each L.A. Care CMC 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 HCC documentation.

Qualified providers that may complete the forms are limited to medical doctors (M.D. and D.O.), nurse practitioners (N.P.), family nurse practitioners (FNP), and/or physician assistants (P.A.).

As part of the incentive program, Members will be seen for their AWE along with completing the Patient Health Questionnaire (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. After the face-to-face visit, the PCP must complete the corresponding forms completely and submit them back to L.A. Care. L.A. Care will pay up to \$350 per Member to Providers to conduct assessments for Members and to complete and submit the Annual Wellness Exam Form and Patient Health Questionnaire (PHQ-9).

6.9 PATIENT SAFETY

L.A. Care is committed to improving patient safety and promoting a supportive environment for network Providers to improve patient safety in their practices. Many of the ongoing QI Program measurement activities include safety components, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation. Potential Quality of Care Issues (PQIs) should be reported securely to PQI@lacare.org as soon as identified.. The PQI Referral Form is available online, Providers can log onto the L.A. Care Provider Portal and select the left tabbed option “FORMS.”

6.10 DISEASE REPORTING STATEMENT

L.A. Care complies with disease reporting standards as cited by Section 2500 of Title 17 of the California Code of Regulations, which requires public health professionals, medical providers, and others to report approximately 85 diseases or conditions to their local health department. “The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Information related to Mandatory Reportable Diseases & Conditions for the L.A. County Department of Public Health can be obtained through the following: publichealth.lacounty.gov/cdcp/proreporting.htm

6.11 PPG AND OTHER CONTRACTED PROVIDER AND VENDOR REPORTING RESPONSIBILITIES

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

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

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

- Abuse, neglect, or exploitation

- Serious, life-threatening, medical event that requires immediate emergency evaluation by medical professional(s)
- Disappearance / missing person
- Suicide attempt
- Unexpected Death
- Restraint or seclusion

6.12 CATEGORIES OF CRITICAL INCIDENTS

6.12.1 Abuse is characterized by any one of the following:

- Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any Member
- Knowing, reckless, or intentional acts or failures to act which cause injury or death or which place a Member at risk of injury or death
- Rape or sexual assault
- Corporal punishment or striking
- Unauthorized use or the use of excessive force in the placement of bodily restraints
- Use of bodily or chemical restraints, which is not in compliance with federal laws, state laws or administrative regulations

6.12.2 Exploitation is characterized by the following:

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

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

6.12.3 Neglect is characterized by any one of the following:

- Failure by a caretaker to secure food, shelter, clothing, health care, or services necessary to maintain Member's mental and physical health
- Failure by any caretaker to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care
- Negligent act or omission by any caretaker which causes injury or death or which places a Member at risk of injury or death
- Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an

appropriate individual program or treatment plan

- Failure by any caretaker to provide adequate nutrition, clothing, or healthcare
- Failure by any caretaker to provide a safe environment
- Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services

6.12.4 Disappearance/Missing Member is characterized by the following:

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

6.12.5 Unexpected Death is characterized by the following:

The unexpected death of a Member is reported when the death was not the result of a chronic disease process.

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

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

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

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

6.12.8 Suicide Attempt is characterized by the following:

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

6.13 REFERRALS TO LOCAL AGENCIES

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

Suspected Abuse, Exploitation and Neglect	Adult Protective Services (APS) County Contact Information. Los Angeles County cdss.ca.gov/inforesources/Adult-Protective-Services Community & Senior Services 3333 Wilshire Blvd. Suite 400 Los Angeles, CA 90010 24 Hour Abuse Hotline: 877.477.3646 or 888.202.4248 626.579.6905 Fax: 213.738.6485
Seclusion and Restraint	Report as Abuse Incident (see above) Los Angeles County Adult Protective Services (APS) Los Angeles County
Suicide Attempt	<i>For immediate threats: Call 911</i> For non-immediate threats: National Suicide Prevention Lifeline 1-800-273-TALK (8255)
Serious Life Threatening Medical Event that Requires Immediate Emergency Evaluation by a Medical Professional	Call 911 . L.A. Care staff will follow their departmental procedures
Missing Persons	Adult Missing Person Unit: 213.996.1800 Note: <i>Contrary to popular belief, law enforcement agencies in California do not require a person to wait a specific period of time before reporting a missing person.</i>
Unexpected Death	Report notification of unexpected death to immediate supervisor for further reporting direction. In addition, call L.A. Care's Customer Solution Center: 1.888.522.1298

6.13.1 Critical Incident Reporting Agency/Authority

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

7.0 CREDENTIALING

7.1 OVERVIEW

7.1.1 Criteria and Standards

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

7.1.2 Licenses and Qualifications

L.A. Care requires that all Providers/Practitioners who are performing services for L.A. Care Members have a current license at all times to provide patient care to Members. All contracted Providers/Practitioners must abide by all federal and state laws and regulations. All Providers/Practitioners must be qualified to participate in the Medi-Cal and Medicare product lines in order to participate in all lines of L.A. Care business. Failure to meet Medi-Cal, NCQA and CMS requirements may be cause for removal from L.A. Care's network.

7.2 DELEGATION OF CREDENTIALING

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

7.2.1 Monitoring Credentialing Activities

L.A. Care is responsible for monitoring all contracted PPG credentialing and recredentialing activities. A PPG must pass L.A. Care Credentialing Department's pre-delegation credentialing audit to be delegated with the credentialing responsibility. Otherwise, L.A. Care's Credentialing Department is responsible for a PPG's credentialing activities. Regardless of a PPG's credentialing delegation status, L.A. Care retains the right at all times to approve new Practitioners and sites, as well as to terminate or suspend individual Practitioners based on credentialing issues.

7.2.2 PPG Accountability

A PPG that has been delegated the credentialing responsibility is accountable for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. If the PPG delegates any credentialing and recredentialing activities, there must be evidence of oversight of the delegated activity. There must be annual evidence of a mutually agreed upon delegation agreement between the PPG and the delegate (i.e. NCQA certified CVOs, non-certified CVOs, etc.). The delegation agreement must meet all the elements of NCQA's standards.

7.2.3 Delegation Criteria

Prior to delegation, L.A. Care's Credentialing Department audits the PPG (the potential delegated entity) to determine whether the PPG meets L.A. Care's criteria for delegation. The Credentialing Department evaluates the potential delegated entity's ability to perform the delegated activities, including all activities related to credentialing and recredentialing in accordance with the standards required by L.A. Care, NCQA, DHCS and CMS. Using a modified version of the Standardized

Audit Tool, in accordance with L.A. Care, NCQA, DHCS and CMS standards, the Credentialing Department will evaluate the performance of delegated entities.

7.2.4 Types of Delegation Status

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

7.2.4.1.1 Full Delegation – PPG scores 100%. No Corrective Action Plan (“CAP”) required.

7.2.4.1.2 Full Delegation – PPG scores 80% to 99.9%. CAP required.

7.2.4.1.3 Denial of Delegation – PPG scores 70% to 79.9%. A CAP is required with an opportunity to cure deficiencies. A follow up audit will be conducted within 6 months. All corrective actions must be successfully completed.

7.2.4.1.4 Denial of Delegation – PPG chooses not to pursue delegation of credentialing, or receives less than 70% on the pre-delegation credentialing audit. A PPG keeps a non-delegated credentialing status for a minimum of one year. The credentialing of such PPG’s Practitioners is performed by L.A. Care’s Credentialing department. Denial of delegation letters will be sent to the PPG.

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

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

7.2.5 Delegation Status

When credentialing activities have been delegated to either the PPG or a combination of a hospital and medical group, the Delegation Agreement will identify in detail exactly what functions have been delegated to the PPG or hospital/medical group.

7.2.6 Delegation Oversight

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

7.2.6.2 On an annual basis, L.A. Care will audit the credentialing and recredentialing activities of the PPG. The PPG’s credentialing and recredentialing files will be reviewed according to the following file pull methodology:

- A list of Practitioners/Providers credentialed and recredentialed, to also include non-physicians and mid-levels within the audit period and a list of the PPG’s Utilization Management Practitioners who make medical decisions will be requested.

In addition, a full list of the PPG's network will be requested. L.A. Care will also review the PPG's quarterly reports for comparison and file selection.

- NCQA's 8/30 methodology will be used in evaluating files. The minimum number of files reviewed will be eight (8) initial files and eight (8) recredentialing files. If any credentialing elements are deficient during the review of the 8/30 Rule, then the deficient element(s) will be reviewed for the remaining files, up to a maximum of 30 initial credentialing and 30 recredentialing files.

7.2.6.3 L.A. Care's oversight audit will include a review of the PPG's credentialing policies and procedures, Committee meeting minutes, Practitioner credentialing and recredentialing files, Utilization Management Practitioners who make medical decisions, a list of contracted health delivery organizations ("HDOs"), ongoing monitoring reports, oversight audits and any sub-delegation agreements, if applicable.

7.2.6.4 The results of L.A. Care's oversight audit will be reported to the PPG, including the required CAP, if deficiencies are noted. L.A. Care's Credentialing Department will work collaboratively with the PPG through the oversight process when deficiencies have been identified. The PPG is given notice to submit a CAP and asked to respond within 30 calendar days. If no response is received within 30 calendar days, or if the CAP is not acceptable or complete as submitted, L.A. Care's Compliance Department will send a revised CAP letter that requests a response within 14 calendar days and advises that failure to respond may be cause for revocation of the delegation agreement. The PPG must implement the CAP within the stated time period, and it must permit a re-audit by L.A. Care or its agent, if requested.

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

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

7.2.6.6 At L.A. Care's discretion, or in the event that L.A. Care determines that the delegate has significant performance deficiencies that are without remedy (and failed the CAP process) and has gone through the relevant process which results in de-delegation, the PPG cannot appeal. The PPG must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals the same deficiencies identified in previous audits, delegation will be at the sole discretion of the Credentialing Committee, regardless of the audit score.

7.2.6.7 PPGs that receive an NCQA rating of "excellent," "commendable," "accredited," or "certified" will be deemed to meet L.A. Care's credentialing requirements. These PPGs may be exempt from L.A. Care's credentialing audit of the elements for which they are accredited or certified.

Note that CMS does not recognize NCQA-certified CVOs. In such cases, all files may be subject to full file CMS review. If a PPG sub-delegates to an NCQA CVO for primary source activities, the PPG must still perform annual oversight of these activities for the Medicare line of business, if applicable.

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

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

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

7.2.7 PPG Responsibilities

7.2.7.1 PPGs must have policies and procedures that address the Credentialing of Practitioners, non-Practitioner health care professionals, licensed independent Practitioners, UM Practitioners making medical decisions and HDOs that fall within its scope of credentialing. PPGs must state in their policies that they do not make credentialing and recredentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, sex, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the Practitioner specializes. A statement that the PPG does not discriminate does not meet the intent of the requirement. The policy must explicitly describe how it both monitors and prevents discriminatory practices to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner and how it is taking proactive steps to protect against discrimination occurring in the credentialing/recredentialing process. These practices may include, but are not limited to, periodic audits of credentialing files and Practitioner complaints, as well as documenting a heterogeneous credentialing committee’s decision to sign a statement affirming that it does not discriminate.

7.2.7.2 A PPG will establish standards, requirements and processes for the Practitioner/HDOs performing services for L.A. Care Members to ensure that these Practitioners and HDOs are qualified, licensed and/or certified consistent with L.A. Care, NCQA, DHCS, and CMS requirements. These standards, requirements and processes are applicable whether or not credentialing and recredentialing activities are delegated. For CBAS facilities, L.A. Care annually verifies license and credentialing status.

7.2.7.3 A PPG's policies must explicitly state the processes for ensuring all practitioners/providers that have a FFS enrollment pathway are enrolled in the Medi-Cal program. The policies must describe the process for verifying enrollment, process for practitioners/providers whose enrollment application is in process; the process for monthly monitoring to validate continue enrollment; the process for practitioners not currently enrolled in the Medi-Cal program and the process for practitioners/providers deactivated or suspended from the Medi-Cal program.

7.2.7.4 A PPG's policies must explicitly define the process used to ensure that information submitted to L.A. Care for inclusion in Member materials and Practitioner directories is consistent with the information obtained during the credentialing process. Specifically, Practitioner information regarding qualifications that is provided to Members must match the Practitioner's education, training, certification and designated specialty information that was gathered during the credentialing process. "Specialty" refers to an area of practice, including primary care disciplines.

7.2.7.5 A PPG must establish a peer review process by designating a Credentialing Committee that includes representation from a range of participating Practitioners. The credentialing process can encompass separate review bodies for each specialty (e.g., Practitioner, dentist, and psychologist) or a multidisciplinary committee with representation from various types of Practitioners and specialties.

7.2.7.6 A PPG must notify a Practitioner, in writing, of any adverse actions taken regarding the Practitioner. The PPG must also notify L.A. Care of its action taken as soon as the PPG has knowledge of the adverse action. The PPG must require the Provider/Practitioner to notify the PPG of any adverse action taken against the Provider/Practitioner within 14 days of knowledge.

7.2.7.7 For each adverse event, a PPG must document the review, actions taken, monitoring and follow through of the process, including timeframes and closure.

7.2.7.8 PPGs must promptly notify L.A. Care in writing if any contracted Practitioner has any adverse action or criminal action taken against him/her. This must be no later than 14 calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of Practitioners. Failure to do so may result in the removal of the Practitioner from L.A. Care's network.

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

7.2.7.9 PPGs delegated for credentialing and recredentialing must review, investigate and take appropriate action for any adverse events or criminal actions taken against a contracted Provider including, but not limited to, fair hearings and reporting to appropriate authorities

as delegated. L.A. Care retains the right to approve, close panel to new membership, and/or terminate contracted Practitioners at all times.

7.2.7.10 According to the PPGSA, L.A. Care reserves the right to coordinate, consolidate and participate in any PPG participating Practitioner disciplinary hearing. Hearings must be conducted in accordance with L.A. Care Policy and Procedures, and California Business and Professions Code Section 805.

7.2.7.11 PPGs must advise L.A. Care of any changes to its credentialing and recredentialing policies and procedures, processes, delegation or sub-delegation, and criteria within 30 days of the change. If L.A. Care deems the changed items do not comply with L.A. Care, NCQA, DHCS, and/or CMS requirements, L.A. Care will notify the PPG immediately. The PPG will have 30 days to comply. If the PPG does not comply, L.A. Care may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

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

7.2.7.11.1 Use the standardized ICE format and Excel grid to include the following:

- Number of adds/deletes of PCPs, SCPs, Mid-levels (i.e., MDs, DOs, PAs, NPs, etc.)
- Number of adds/deletes of HDO (i.e., MDs, DOs, etc.)
- Numbers of adds/deletes of independent Practitioners (i.e., DCs, DPMs, etc.)
- Any new or revised policies and procedures, additions of a computer system, CVO
- Practitioners termed for quality issues

7.2.7.12 PPGs must submit a profile of PCP, SCP, Mid-Level and Behavioral Health Practitioners credentialing information to L.A. Care. The following documents must also be attached:

- First and last page of the contract
- W-9
- All addenda to the California Participating Physician Application ("CPPA")
- Appropriate hospital coverage letter, if applicable

7.2.7.13 PPG profiles must meet L.A. Care's requirements as follows: A Practitioner without hospital privileges at an L.A. Care contracted hospital may use the PPG's admitting panel, or the Practitioner can have a direct agreement with a Practitioner with admitting privileges in the same specialty. This agreement must capture responsibility for the provision and coordination of care, discharge from the hospital, referral back to the PCP with a hospital discharge summary, and coordination of 24/7 call coverage using Practitioners who are contracted with the PPG.

7.2.7.14 A PPG is responsible for ensuring that Members have access to their assigned PCP 24/7. PPGs must notify L.A. Care 30 days prior to any status change of the PPG’s participating Practitioners, including, but not limited to, termination, resignation or any leave. PPGs must ensure that physicians on leave of any duration are covered by a Practitioner with a like specialty (e.g., Pediatrician covered by a Pediatrician) or a Provider who is otherwise experienced and qualified to provide appropriate coverage.

Failure to ensure that physicians on extended leave are covered by a credentialed Practitioner with a like specialty or by a Provider who is otherwise experienced and qualified to provide appropriate coverage will be considered a material breach. Such a breach may result in sanctions as outlined in Section 1.36 of the PPGSA.

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

7.2.7.16 A PPG’s Board of Governors (“Board”), or the group or committee to whom the Board has formally delegated the credentialing function, must review and approve the credentialing policies and procedures on an annual basis.

7.3 PROVISIONAL CREDENTIALING

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

7.4 CONFIDENTIALITY AND PRACTITIONER RIGHTS

7.4.1 Confidential Information

A PPG’s credentialing policies and procedures must clearly state the confidential nature of information obtained in the credentialing process. A PPG must also describe the mechanisms in effect to ensure confidentiality of information collected in this process. A PPG must also ensure that information obtained in the credentialing process is kept confidential and that Practitioners can access their own credentialing information, as outlined in *Right to Review Information* below.

7.4.2 Confidential Files

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

7.4.3 Right to Review Information

A PPG’s policies and procedures must state that Practitioners are notified of their right to review information obtained by the PPG to evaluate their credentialing application. The evaluation

includes information obtained from any outside source (malpractice insurance carriers, state licensing boards, etc.).

7.4.4 Written Policies and Procedures

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

7.4.5 Sources of Information

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

7.4.6 Right to Correct Erroneous Information

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

7.4.6.1 Timeframe for making corrections

7.4.6.2 Format for submitting corrections

7.4.6.3 The person to whom corrections must be submitted

7.4.6.4 Receipt of documented corrections

7.4.6.5 How Practitioners are notified of their right to correct erroneous information as outlined in this Manual

7.4.7 Right to Application Status Information

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

7.5 REQUIREMENTS

7.5.1 Qualifications

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

7.5.2 Notification of Sanctions or Reports

A PPG/Vendor is required to notify L.A. Care immediately when Providers/Practitioners are identified on any sanctions or reports for removal from network.

7.5.3 Required Verification

These requirements include verification of the following circumstances:

7.5.3.1 Excluded Providers

7.5.3.1.1 Confirmation that Practitioners/providers or other health care Providers/entities are not “excluded Providers” on the Office of the Inspector General (OIG) sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. Organizations employing or contracting with Practitioners/providers have a responsibility to check the sanction list with each new issuance of the list, because these organizations are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. All contracted PPGs and vendors are required to review OIG reports publication and take action as required by contract.

Lists of excluded Providers are available at:

exclusions.oig.hhs.gov

7.5.3.2 Medi-Cal Suspended and Ineligible Providers

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

7.5.3.2.2 Suspension is automatic when either of the above events occurs. Suspended Medi-Cal Providers will not be entitled to a hearing under the California Administrative Procedures Act.

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

List of suspended providers is available at:

files.medical.ca.gov/pubsdoco/SandILanding.asp

7.5.3.3 CMS Precluded Practitioners/Providers

7.5.3.3.1 The April 2018 final rule adopted a requirement that in order for contracted and non-contracted providers to receive payment from a Medical plan, 1876 Cost Plan, or PACE organization for health care items and services furnished to beneficiaries enrolled in Medicare plan, 1876 Cost Plans, or PACE organization, such providers must not be included on the Preclusion List. Likewise, in orders for Part D drugs to be covered by Part D plan, the prescriber must not be included on the Preclusion List.

7.5.3.3.2 The Preclusion List will consist of practitioners/providers that are currently revoked from Medicare, are under an active reenrollment bar, have engaged in behavior for which CMS should have revoked the practitioner/provider to the extent applicable and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

7.5.3.3.3 PPGs must remove any contracted provider, who is included on the Preclusion List from their network as soon as possible and should notify the impacted enrollees as soon as possible.

7.5.3.3.4 There will be one Preclusion list with subsequent updates. The Preclusion list will be made available approximately every 30 days, around the first business day of each month. PPGs are required to review the Preclusion List on a monthly basis for updates

Access to CMS Preclusion List Quick Reference Guide provides step by step instructions for accessing the list at:

cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html

7.5.3.4 Opt-Out Providers

7.5.3.4.1 A Practitioner/Provider who opts out of Medicare may not accept Federal reimbursement for a period of two (2) years. The only exception is for emergency and urgently needed services. Payment must be made for emergency or urgently needed Member services furnished by an “opt-out” Practitioner. Otherwise, payment should not be made to opt-out Providers. Information on Providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. This list must be checked on a regular basis.

7.5.3.4.2 All contracted PPGs and vendors are required to review the opt-out publication on a monthly basis, as well as to ensure they are reviewing the most current iteration and taking any action required by their contract.

List of Opt-Out providers is available at:

data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z

7.5.3.5 National Provider Identifier (“NPI”) Number

7.5.3.5.1 All Practitioners/Providers of Covered Services, including PCPs and specialists, must have a valid NPI Number.

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

7.5.3.6 Clinical Laboratory Improvement Amendments Certification

7.5.3.6.1 CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (“CLIA”). CLIA requires all facilities to meet certain federal requirements if they perform even one test, including waived tests, on materials derived from the human body for the purpose of providing information for the assessment of health, diagnosis, prevention or treatment of any disease or impairment of, human beings. Facilities performing tests for these purposes are considered a laboratory under CLIA. As such, they must apply for and obtain a certificate from the CLIA program that corresponds to the complexity of the tests performed.

7.5.3.6.2 All contracted PPGs and vendors must ensure that all contracted laboratory testing sites have either a current and valid CLIA certificate or waiver of a certificate of registration, along with a CLIA identification number. Compliance must be monitored on an ongoing basis. Vendors performing laboratory testing are required to have a CLIA certificate, and there must be a contract between both parties.

7.5.3.7 Drug Enforcement Administration (“DEA”) or Controlled Dangerous Substance (“CDS”) Certificate, As Applicable

7.5.3.7.1 PPGs must have a documented process for allowing a Practitioner with a valid DEA certificate who participates in L.A. Care’s network to perform the following activities:

- Write prescriptions for a Practitioner who has a pending DEA certificate.
- Require an explanation from a qualified Practitioner who does not prescribe medications and to provide arrangements for the Practitioner’s Members who need prescriptions for medications.

The PPG will maintain a current DEA or CDS certificate on all contracted Practitioners/Providers.

7.5.3.8 Medicare and Medi-Cal Participation

7.5.3.8.1 All PPGs must ensure that their contracted facilities and contracted Practitioners have a Medicare and Medi-Cal number.

Medicare numbers can be verified at: data.medicare.gov

7.5.3.8.2 All PPGs should conduct monthly checks of the Open Data Portal, which is updated monthly, to ensure practitioner/provider is actively enrolled in Medi-Cal FFS.

Medi-Cal enrollment can be verified at: <https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a>

7.5.3.9 Ongoing Monitoring of Sanctions, Complaints, and Quality Issues

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

7.5.3.9.2 PPGs must develop and implement policies and procedures for the ongoing monitoring of Practitioner sanctions, complaints and quality issues between recredentialing cycles. PPGs must take appropriate action against Practitioners when it identifies occurrences of poor quality. PPGs must identify and, when appropriate, act on important quality and safety issues in a timely manner during the interval between formal credentialing.

7.5.3.9.3 PPGs must show how they monitor all adverse events and demonstrate that this process has been reviewed by the Credentialing Committee at least every six months. PPGs' Credentialing Committees may vote to flag a Practitioner for ongoing monitoring. PPGs must fully demonstrate in their Credentialing Committees the types of monitoring they impose, the timeframe used, the intervention and the outcome.

7.5.3.9.4 PPGs must provide proof of their termination of the contractual relationship with any Practitioner identified on the OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc. PPGs must demonstrate that they have sufficient contractual language authorizing the right to terminate such Practitioner and to withhold payment for services rendered after the effective date of exclusion/suspension pursuant to applicable laws and regulations. PPGs must further demonstrate prompt action to terminate the contracted Practitioner. Practitioners identified on any of the lists above are to be terminated for all lines of business for L.A. Care.

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

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

7.5.3.9.7 PPGs who fail to comply with any request for information within the specific timeframe are subject to sanctions as described in L.A. Care's policies and procedures and PPGSA, Section 1.36 and 1.37. If a PPG fails to respond as required, L.A. Care will perform the oversight functions of the adverse event, and the PPG will be subject to L.A. Care's policies and procedures and the Credentialing Committee's outcome of the adverse events.

7.6 RECREDENTIALING

7.6.1 Recredentialing Standards

Participating Practitioners must satisfy L.A. Care's recredentialing standards for continued participation in the network. Recredentialing is completed three (3) years from the month of initial credentialing and every three (3) years thereafter.

7.6.2 Facility Site Reviews

A facility site review does not need to be repeated as part of the recredentialing process if the site has a current passing score (this applies to PCPs). A passing site review survey will be considered "current" if it is dated within the last three (3) years (with use of new tool) of the recredentialing date. A passing site review survey does not need to be repeated until the due date of the next scheduled facility site review survey or when L.A. Care monitoring activities determine that a review is necessary.

7.6.3 Medical Record Reviews

Practitioners/providers contracted for the Medi-Cal and Medicare programs are subject to both a facility site review and medical record review. However, if the Practitioner/provider is only contracted for Medicare, a medical record review is required. L.A. Care Facility Site Review or other staff may visit a Provider's office at any time without prior notification.

7.7 CREDENTIALING COMMITTEE

7.7.1 Composition

To ensure accurate representation of medical specialties, a PPG's Credentialing Committee must consist of not less than three (3) participating Practitioners in good standing with federal and state agencies.

7.7.2 Administrative Support Staff

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

7.7.3 Voting Quorum

A quorum consists of three (3) Practitioner committee members. Any action taken upon the vote of a majority of committee members present at a duly held meeting with a quorum present is an act of the committee.

7.8 MEETINGS AND REPORTING

7.8.1 Frequency and Records

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

7.8.2 Additional Meetings

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

7.9 COMMITTEE DECISIONS

7.9.1 Finality of Decisions

L.A. Care considers PPG Credentialing Committee decisions to be final.

7.9.2 Notification Timeframes

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

7.10 PARTICIPATION OF MEDICAL DIRECTOR OR OTHER DESIGNATED PRACTITIONER - OVERALL CREDENTIALING RESPONSIBILITY

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

7.11 COMMITTEE FUNCTIONS

7.11.1 Qualifications

The Committee reviews and evaluates the qualifications of each Practitioner applying for initial credentialing and recredentialing.

7.11.2 Additional Matters

The Committee investigates, reviews and reports on matters referred by the Medical Director, his/her designee or the Board regarding the qualifications, conduct, professional character or competence of any applicant or Practitioner.

7.11.3 Reports Review

The Committee reviews periodic reports of activities (i.e., ongoing monitoring reports, credentialing activity reports, etc.).

7.11.4 Review Policies and Procedures

The Committee annually reviews policies and procedures relevant to the credentialing process, and makes revisions as necessary to comply with L.A. Care, NCQA, DHCS, and CMS requirements, regulations and practices.

7.11.5 Recommendations

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

7.11.6 Documenting Discussions

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

7.11.7 In-House L.A. Care Credentialing

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

7.11.8 L.A. Care Right to Terminate, Suspend, Modify Participation

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

7.12 CREDENTIALING COMMITTEE FILE REVIEW

7.12.1 Policies and Procedures for Clean Files

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

7.12.2 Defined Process

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

7.13 APPEAL AND FAIR HEARING

7.13.1 Fair Hearing and Appeal Process

Delegated PPGs or, if not delegated, L.A. Care must have a mechanism for a fair hearing and appeal process to address adverse decisions based on issues of quality of care and/or service that could result in limitation of a Practitioner's participation that is in accordance with all applicable statutes. The process should include notification to the Practitioner in an established time frame, as well as the established time frames for the Practitioner to request a hearing and the scheduling of hearing requests. The notification should also include the hearing's procedures, the composition of the hearing committee and the agenda for the hearing.

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

7.13.3 Quality of Care Issues

A PPG must have an appeal process for instances in which it chooses to alter the conditions of a Practitioner's participation based upon issues of quality of care and/or service. Except as otherwise specified in this Provider Manual, any one or more of the following actions or recommended actions taken for a medical disciplinary cause or reason shall be deemed actual or potential adverse action and constitute grounds for a hearing.

7.13.3.1 Denial of initial panel appointment

7.13.3.2 Denial of reappointment to panel

7.13.3.3 Suspension of panel appointment (except as described below)

7.13.3.4 Revocation of panel appointment

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

7.13.4 Right to Rebut Before Final Determination

The following actions entitle the Practitioner the opportunity to appear at a hearing to present rebuttal evidence before a final determination is made. The Practitioner shall have the right to be represented by an attorney during this process. The following actions also entitle the Practitioner the opportunity for a hearing in the event that the final determination of a Credentialing Committee is adverse to the Practitioner, unless the right to a hearing has been forfeited.

7.13.5 Suspension of Panel Appointment

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

7.13.6 Immediate Suspension or Restriction

The Credentialing Committee has the right to recommend immediate suspension or restriction of a Practitioner's participation in network the committee reasonably believes that the health of any individual would be jeopardized by the continued participation of the Practitioner. In the case of such an immediate suspension or limitation on privileges (summary action), the Practitioner has the right to receive notice, an opportunity to present rebuttal information and a fair hearing, in accordance with the procedure described in L.A. Care's Policy LS-005. Those rights apply subsequent to the summary action, not prior to it.

7.14 REQUIRED REPORTING

7.14.1 Required Section 805 Report

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

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

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

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

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

7.14.1.4.1 Resigns, retires, or takes a leave of absence

7.14.1.4.2 Withdraws or abandons the application

7.14.1.4.3 Withdraws or abandons his or her request for renewal

7.15 EXPIRED LICENSE

7.15.1 Current License Required

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

7.15.2 Failure to Renew

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

7.15.2.2 If any Practitioner fails to renew his/her license by the expiration date, the following steps will be initiated by L.A. Care.

7.15.2.3 If the identified Practitioner(s) has Member enrollment, L.A. Care will do the following:

7.15.2.3.1 Close Provider's panel to new members upon license expiration

7.15.2.3.2 Notify PPG of expiration and possible reassignment of members

7.15.2.3.3 Remove assigned members from unlicensed Practitioner/provider five (5) business days following license expiration

7.15.2.3.4 Reassign members to a qualified licensed credentialed Practitioner

7.15.2.3.5 Remove unlicensed Practitioner from network

7.15.2.4 If the identified Practitioner(s) has no Member enrollment, L.A. Care will do the following:

7.15.2.4.1 Close Practitioner's panel to new members

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

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

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

8.0 PROVIDER NETWORK MANAGEMENT (PNM)

8.1 PROVIDER TRAINING AND EDUCATION

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

The goal of Provider training and education is to improve the delivery of services to L.A. Care Members by providing appropriate forums for Providers to:

- Be better informed about products offered by L.A. Care, its systems, and processes
- Understand the needs of L.A. Care Members
- Improve clinical/patient interaction
- Comply with regulatory requirements

Provider Manuals

Each PPG must make an L.A. Care Provider Manual available to its contracted Providers/network within 10 business days of its L.A. Care active status. Educating a new Provider on how to locate the L.A. Care Provider Manual on the L.A. Care website will also be sufficient. The website address where the manual can be located is lacare.org.

On-site Visits

On-site visits are another integral piece of Provider education because PPGs and their affiliated Providers must receive ongoing education. On-site visits consist of, but are not limited to, Operational Meetings and in-service educational opportunities. These visits will focus on policy updates and program updates as required by the Center for Medicare and Medicaid Services (“CMS”), the Department of Health Care Services (“DHCS”) and other regulatory bodies. These meetings are generally announced but may also be unannounced if L.A. Care deems it necessary. L.A. Care understands that in some instances on-site educational opportunities may be limited due to Provider offices working diligently to serve our Members. Therefore, updated information may also be shared online via the Provider Portal or Webinars for the convenience of our PPGs and our contracted Providers.

PPG Responsibility for Contracted Provider Education

It is the responsibility and contract requirement between L.A. Care and the PPG to ensure all contracted Providers receive on-going comprehensive training and education as required by L.A. Care, the Participating Provider Service Agreement (“PPSA”) and regulatory bodies.

Provider Bulletins, Newsletters and General Meetings

PPGs should publish and distribute provider newsletters and/or bulletins at least semi-annually. The newsletters should provide relevant and timely information concerning applicable standards, services available to Members, quality improvement activities, updates, and other pertinent issues related to the delivery of health services to L.A. Care Members. Semi-annual general meetings that provide updates on health care delivery issues, hosted by PPGs or its affiliated contracted Providers, will meet the requirement of publishing semi-annual newsletters/bulletins.

Monitoring and Oversight

In order to ensure that PPGs are conducting new Provider orientations and on-going Provider education and training within regulatory guidelines outlined in the contract, L.A. Care will, on a monthly basis, require PPGs to submit monthly reports. L.A. Care will also conduct quarterly and annual audits of PPG records and may sample Providers.

8.2 PROVIDER DIRECTORIES

8.2.1 Information and Access to Provider Directories

L.A. Care maintains both printed and online versions of its Cal MediConnect Provider Directory and takes appropriate steps to ensure the accuracy of the information concerning each provider listed in its Provider Directory in accordance with applicable law. L.A. Care's Provider Directory is required to include all of the following information:

- 1) The provider's name, practice location(s), and contact information (including telephone number(s) and website URL, as applicable).
- 2) Type of practitioner.
- 3) National Provider Identifier number.
- 4) California license number and type of license.
- 5) The area of specialty, including board certification, if any.
- 6) The provider's office email address, if available.
- 7) The name of each affiliated PPG currently under contract with L.A. Care through which the provider sees Members.
- 8) A listing for each of the following providers that are under contract with L.A. Care:
 - a. For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with L.A. Care.
 - b. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse midwives, dentists, and LTSS providers (as appropriate).
 - c. For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic, and names of the employed providers (described in subsections (a) and (b) above), to the extent their services may be accessed and are covered through the contract with L.A. Care.
 - d. Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.
 - e. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

- 9) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- 10) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
- 11) Identification of providers who no longer accept new patients.

An online Provider Directory shall be available on L.A. Care's website to the public, potential enrollees, Members, and providers without any restrictions or limitations. L.A. Care shall allow Members, potential enrollees, providers, and members of the public to request a printed copy of the Provider Directory by contacting L.A. Care through its toll-free telephone number, electronically, or in writing. The printed copy of the Provider Directory shall be provided to the requester by mail 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 requester resides or works or intends to reside or work.

8.2.2 Frequency of Updates to Provider Directories

L.A. Care's Cal MediConnect printed Provider Directory is updated monthly.

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

- 1) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.
- 2) A provider is no longer under contract for Cal MediConnect.
- 3) A provider's practice location or other information described in Section 8.2.1 has changed.
- 4) A change is necessary based on a Member complaint, and L.A. Care's completion of the related investigation, that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.
- 5) Any other information that affects the content or accuracy of the Provider Directory.

L.A. Care shall delete a provider from the directory upon confirmation of any of the following:

- 1) A provider has retired or otherwise has ceased to practice.
- 2) A provider or PPG is no longer under contract with L.A. Care for any reason.
- 3) The contracting PPG has informed L.A. Care that the provider is no longer associated with the PPG and is no longer under contract with L.A. Care.

Providers and PPGs shall promptly notify L.A. Care with any changes to the above information to keep an accurate and updated provider director in compliance with applicable laws and regulations.

8.2.3 Provider Compliance with Required Updates to Provider Directories

In addition to the updates described in Section 8.2.2, L.A. Care shall, at least annually, review and update the entire Provider Directory. Each calendar year L.A. Care shall notify all contracted providers, as follows:

- 1) For individual providers who are not affiliated with a PPG, as described in Section 8.2.1, subsections (8)(a) and (b), L.A. Care shall notify each provider at least once every six months.
- 2) For all other providers described in Section 8.2.1 who are not subject to the requirements of section (1) above, L.A. Care shall ensure notification at least once annually.

L.A. Care's notice to its providers shall include all of the following:

- 1) The information L.A. Care has in its directory regarding the provider or PPG, including a list of networks and plan products that include the contracted provider or PPG.
- 2) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subsection (p) of Health & Safety Code section 1367.27.
- 3) Instructions on how the provider or PPG can update the information in the Provider Directory using L.A. Care's online interface.

Provider or PPG shall provide an affirmative response to L.A. Care's notification within thirty (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 or PPG is accepting new patients for L.A. Care Cal MediConnect. General acute care hospitals shall be exempt from this requirement.

In the event provider or PPG fails to provide the response within thirty (30) business days, L.A. Care shall take the following steps:

- 1) Attempt to verify whether the provider's information is correct or requires updates for a maximum of fifteen (15) business days. L.A. Care shall document the receipt and outcome of each verification attempt.
- 2) If L.A. Care is unable to verify the provider's information, L.A. Care shall notify the provider, ten (10) business days in advance of removal, that the provider will be removed from the Provider Directory.
- 3) 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.
- 4) If the Provider responds before the end of the 10-business-day notice period, the Provider shall not be removed from the Provider Directory.

Providers may verify or submit changes to the information required to be in the directory electronically through the Provider Portal at lacare.org with an appropriate login in information. A provider can also make changes through the online directory at lacare.org/members/member-tools/find-doctor-or-hospital/report-provider-inaccuracy. Upon completion of verification or submission of changes, provider shall receive an electronic acknowledgment from L.A. Care. Updated provider directories are located on the L.A. Care website at lacare.org.

Providers shall inform L.A. Care within five (5) business days when either of the following occur:

- 1) The Provider is not accepting new patients.
- 2) If the Provider had previously not accepted new patients but is currently accepting new patients.

If a Provider who is not accepting new patients is contacted by a Member or potential enrollee, the Provider shall direct the Member or potential enrollee to L.A. Care for assistance in finding a Provider and to report any inaccuracy in the Provider Directory.

Members, potential enrollees, other Providers, and members of the public may identify and report possible inaccurate, incomplete, or misleading information currently listed in L.A. Care’s Provider Directory by calling 1.877.LACARE6. L.A. Care shall promptly investigate any reports that information listed in its Provider Directory is inaccurate and update the Provider Directory, as applicable, within the time frames established by applicable law. Providers and PPGs who are contacted by L.A. Care for purposes of verification shall comply with the time frames requested by L.A. Care in order to maintain compliance with all applicable laws and regulations pertaining to provider directories.

L.A. Care may also require PPGs to provide the information to L.A. Care to satisfy the requirements of Section 8.2 for each of the Providers who contract with the PPG. PPGs should look to their PPG Services Agreement for additional information.

8.3 PRIMARY CARE AND MID-LEVEL MEDICAL PRACTITIONER CAPACITY

Primary Care Physicians (“PCPs”), including general medicine, family practice, internal medicine, obstetrician and gynecology (“OB/GYN”) and pediatrics, have a maximum membership capacity of 2,000 Members in the L.A. Care network. A single non-physician practitioner (mid-level extender) can potentially increase the supervising PCP’s total membership capacity by 1,000 Members. However, the PCP cannot be assigned more than 5,000 L.A. Care Members, including membership assigned across any product line or contract within L.A. Care’s network. Please note that physician panels close at 95% of capacity.

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

A scope of practice agreement that is signed by the non-physician practitioner and the supervising physician, as well as standardized procedures, must be filed and maintained at the medical practice site. The scope of practice agreement must address the following elements:

- Delegated responsibilities
- Disciplinary policies
- Method and frequency of physician supervision
- Monitoring and evaluation of the non-physician practitioner
- Chart review requirements
- Term of the agreement/contract

8.4 PROVIDER NETWORK INFORMATION

Please call L.A. Care's Provider Contracts and Relationship Management Line at 1.213.694.1250 ext. 4719 if you have any questions or concerns.

Providers directly contracted with L.A. Care may communicate with L.A. Care by telephone, in writing, or by e-mail for any general questions.

- **Telephone:** 877.LACARE6 (877.522.2736)
- **In Writing:** L.A. Care Health Plan
Attention: Provider Relations
1055 W. 7th Street, 10th Floor
Los Angeles, CA. 90017
- **Email:** ProviderRelations@lacare.org

8.5 PROVIDER APPEALS AND GRIEVANCES

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

Providers Contracted with PPGs:

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

L.A. Care Directly Contracted Providers:

- Providers directly contracted with L.A. Care must communicate their administrative grievance with L.A. Care. Providers may communicate with L.A. Care by telephone, in writing, or by email at the contacts listed above.

- Provider Relations will be responsible for resolving the grievance within 30 calendar days and communicating to the Provider the resolution/disposition.
 - o Provider Relations shall provide detailed instructions to Provider for filing a grievance.
 - o Provider Relations shall record the grievance on the Provider grievance log.
 - o Regardless of the method of filing of the Provider's grievance, Provider Relations will send an acknowledgment letter to the Provider within 5 business days.

9.0 HEALTH EDUCATION

9.1 HEALTH EDUCATION SERVICES

L.A. Care's Health Education Unit supports network Providers with point-of-service patient education by offering Health Education services, resources and programs at no cost to its Members.

9.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

L.A. Care CMC Participating Providers are responsible for adhering to the Member Services provisions and guidelines specified in this section.

9.1.1 Health Education Services- The Health In Motion™ Program

9.1.1.1 L.A. Care's Health Education Services program is called Health In Motion™. Health In Motion™ services help Members stay healthy and manage their chronic conditions. Topics include, but are not limited to the following:

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

9.1.1.2 Services are offered through the following modalities:

9.1.1.2.1 Wellness workshops and group appointments- An array of skills-based, interactive wellness workshops and group appointments are offered in various locations throughout Los Angeles County. To access a calendar of upcoming events, visit lacare.org/healthy-living/health-resources/workshops-and-classes

9.1.1.2.2 Telephonic consultations- L.A. Care's Registered Dietitians and health educators assist Members by offering individual counseling over the phone.

9.1.1.2.3 My Health In Motion™- Members are able to access online wellness videos, tools and resources 24 hours, seven days a week by going to calmedconnectla.org/. At the top of the home page, click on "Member Sign-In," then click on the "My Health In Motion" tab.

9.1.1.3 Providers can refer their patients to Health Education services by completing and faxing the referral form. The form is available on L.A. Care's website at lacare.org/providers/provider-resources/health-education-tools. For additional information, call **1.855.856.6943**.

9.2 HEALTH EDUCATION PROGRAMS

L.A. Care's Health Education Programs are a combination of coordinated and systematic health education Member outreach and distribution of materials designed to target a specific health problem or population. Members are identified as eligible for these programs based on specific inclusion criteria for each Program. The Programs are available at no cost to Members.

9.2.1 “Fight the Flu” Program – L.A. Care uses a coordinated series of communication methods to encourage Members to obtain a flu shot. Outreach efforts include: self-mailing educational postcards with promotional items, automated phone calls with messages targeted to the audience, and thank-you cards, which also help Members remember they received a flu shot.

9.2.2 “Smoke Free” Program – Adult L.A. Care Health Plan Members who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, inhaler, nasal spray, Bupropion SR, Varenicline) receive health education mailings that include smoking cessation health education materials and community resources that offer free in-person education and over the phone counseling provided by California Smokers Helpline.

9.2.3 “Healthy Pregnancy” Program – L.A. Care identifies pregnant women to provide educational materials and conduct phone outreach. L.A. Care educates them on the importance of prenatal visits and assists with scheduling an appointment with their obstetrician. Additionally, L.A. Care offers interpreting and transportation services and provides Members with a baby “onesie” gift upon confirmation of visit attendance.

9.2.4 “Healthy Mom” Program – L.A. Care conducts Member outreach services to new mothers in order to educate them on the importance of postpartum visit and assist with scheduling an appointment with their obstetrician. L.A. Care offers interpreting and transportation services as additional services in order to encourage attendance.

9.2.5 “Healthy Baby” Program – For caregivers of Members that are under 24 months old, L.A. Care mails health education materials about the importance of well-child visits and timely immunizations. In addition, Members are outreached via Interactive Voice Recognition (“IVR”) and live-agent calls about the importance of following the appropriate periodicity.

9.3 HEALTH EDUCATION RESOURCES

L.A. Care has copies of health education materials in Los Angeles County threshold languages. Health education material topics include: asthma, breastfeeding, dental, diabetes, exercise, family planning, HIV/STD prevention, hypertension, immunizations, injury prevention, nutrition, parenting, perinatal/pregnancy, substance abuse, tobacco prevention/cessation, weight management and more.

Providers may order educational materials at no cost. The health education materials order form is located at lacare.org/providers/provider-resources/health-education-tools

9.3.1. Staying Healthy Assessments

PCPs are responsible for administering an Individual Health Education Behavioral Assessment (“IHEBA”). The IHEBA sponsored and approved by DHCS is the Staying Healthy Assessment (“SHA”). The SHA is available in nine (9) age categories and twelve (12) languages.

PCPs must administer the SHA to all new L.A. Care Members within 120 days of enrollment as part of the Initial Health Assessment. Current Members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-woman exam) and subsequently upon entering a new age category.

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

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

Providers may visit L.A. Care's SHA webpage at lacare.org/providers/provider-resources/staying-healthy-forms for all their SHA needs. On this page Providers can download the assessment tools as regular or writable PDFs, view an online training, link to the DHCS SHA site, and access additional resources.

Hard copies of the SHA may be ordered in larger quantities via the Health Education Materials order form at: lacare.org/Providers/Provider-resources/health-education-tools.

9.4 L.A. CARE FAMILY RESOURCE CENTERS

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

9.5 NURSE ADVICE LINE

L.A. Care offers a nurse advice line 24/7, including holidays. Members can call **800.249.3619** (TTY: 711) to get answers to their common health care related questions.

9.6 PROVIDER EDUCATION

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

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

L.A. Care Health Plan PPGs are responsible for educating Providers on health education requirements and available L.A. Care Cal MediConnect services as listed above. Methods may include, but are not limited to: Provider mailings and newsletters; meetings, seminars or other trainings; onsite visits; blast-faxes; Provider Manual and policies and procedures; and website postings.

10.0 CULTURAL AND LINGUISTIC SERVICES

L.A. Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability in its health programs and activities.

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

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

- Ensure that limited English proficient (“LEP”) Members and Members with disabilities receive the same scope and quality of health care services that others receive.
- Ensure the availability and accessibility of cultural and linguistic services, including quality interpreting services, auxiliary aids and services, and written materials in Members’ preferred languages and in a manner and format that is easily understood.
- Improve health outcomes and decrease disparities.
- Continually evaluate and improve C&L programs and services.
- L.A. Care Cal MediConnect C&L program includes the following:
 - Language proficiency assessment of bilingual Providers and staff
- Language assistance services that include the following:
 - Alternative formats
 - Auxiliary aids and services
 - Interpreting services
 - Translation services
- Cultural and linguistic trainings for Providers and staff

10.1 ASSESSING BILINGUAL LANGUAGE PROFICIENCY

Bilingual Providers and staff can be an integral part of language assistance services. If they communicate directly with Members in a language other than English at medical and non-medical points of contact, they must be assessed and qualified for their language capabilities to comply with regulations.

Qualified bilingual Providers and staff must:

- Be designated to provide oral language assistance as part of the individual’s current, assigned job responsibilities.
- Have documentation of demonstrated proficiency in speaking and understanding both spoken English

and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology.

- Be able to effectively, accurately, and impartially communicate directly with Members with limited English proficiency in their primary languages.

IMPORTANT: The federal guidance, published as Section 1557 of the Affordable Care Act, limits the use of bilingual staff as interpreters.

Please refer to Sections *10.2 Interpreting Services and 10.3 Translation Services and Alternative Formats* for qualification requirements for interpreters and translators.

10.1.1 For All Providers (PPGs, Network Providers, Specialty Plans, Vendors, Hospitals, and LTSS):

The Providers and staff who communicate directly with Members in a language other than English at medical and non-medical points of contact must be assessed and qualified for their language capabilities.

Bilingual Providers and staff, who are not assessed for their language skills or did not meet the requirements as qualified bilingual, must use qualified interpreting services to better serve LEP Members, ensure compliance with regulations and minimize the risk of liability and malpractice lawsuits.

The Industry Collaboration Effort (“ICE”) Employee Language Skills Assessment Tool is available to assist Providers and staff in identifying and documenting bilingual skills in your health care setting. However, more robust complete language proficiency assessment by a professional vendor is strongly encouraged to be fully compliant with the regulatory requirements.

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

- Name
- Title/Position
- Department
- Spoken and written languages (including English and non-English language)
- Proficiency level for each spoken and written language

This information must be kept up-to-date. Any changes to the language capability of bilingual Providers and their staff must be reported to the Provider Network Operations Department, as this information is published in the provider directories. Please refer to Section 8.2 *Provider Directories* for more details.

10.2 INTERPRETING SERVICES

L.A. Care Members must be provided with qualified interpreting services, including American Sign Language (“ASL”), at no cost to them. Interpreting services must be available 24/7 at medical and non-medical points of contact. Languages for interpreting services should not be limited to the threshold languages. Language assistance services must be accurate, timely, and protect the privacy and independence

of LEP Members. Effective communication through qualified interpreters improves quality of care, increases Member satisfaction, ensures compliance with regulations, and minimizes the risk of liability and malpractice lawsuits.

Qualified interpreters must have:

- Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from English and the other language.
- A fundamental knowledge in both languages of health care and medical vocabulary, terminology, phraseology and concepts relevant to the health care delivery system.
- Documentation of demonstrated proficiency in speaking and understanding both English and at least one other spoken language.
- Documentation of successful completion of education and training in interpreting ethics, conduct, and confidentiality that align with the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare or their equivalent.

AND one or more of the following:

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

10.2.1 For All Providers (PPGs, Network Providers, Specialty Plans, Vendors, Hospitals, LTSS):

All Providers must perform the following activities:

- Document a Member's preferred language in the medical chart.
- Document a Member's request or refusal of no-cost qualified interpreting services and request to use a family Member or friend as an interpreter in the medical chart.
- Offer no-cost qualified interpreting services to Members.
- Not rely on staff, other than qualified bilingual/multilingual staff, to communicate directly with LEP Members.
- Not require, suggest to, or imply to Members that they provide their own interpreter.
- Post a Notice of Non-Discrimination at physical key points of contact.
- Post translated Language Assistance Tagline signage in the top 16 non-English languages of California at key points of contact regarding the availability of no-cost language services and how to access the services.
- Strongly discourage the use of friends and family members, especially minors, as interpreters. Except in extraordinary circumstances, such as medical emergencies, a Member may choose to use a family Member or friend (that is not a minor) as an interpreter only after they are informed of the right to no-cost qualified interpreting services.

10.2.2 Face-to-Face Interpreting Services

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

10.2.2.1 For PPGs and Network Providers:

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

To request a face-to-face medical interpreter (including ASL), call L.A. Care's Customer Solution Center at 888.522.1298 at **least 10 business days** prior to the medical appointment.

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

The following information is needed:

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

IMPORTANT: If the appointment date, time, or location is changed, call L.A. Customer Solution Center at 888.522.1298 immediately.

10.2.2.2 For Specialty Plans, Vendors, Hospitals, and LTSS:

L.A. Care delegates interpreting services to Specialty Plans, Vendors, Hospitals, and LTSS. Please contact the appropriate personnel at your organization or facility to learn how to access face-to-face interpreting services.

10.2.3 Telephonic Interpreting Services

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

10.2.3.1 For PPGs and Network Providers:

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

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

PPGs: 855.322.4022

Network Providers: 855.322.4034

The following information is needed:

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

10.2.3.2 For Specialty Plans, Vendors, Hospitals, and LTSS:

L.A. Care delegates interpreting services to Specialty Plans, Vendors, Hospitals, and LTSS. Please contact the appropriate personnel at your organization or facility to learn how to access telephonic interpreting services.

10.2.4 California Relay Service – 711

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

10.2.4.1 For All Providers:

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

The following information is needed:

- Member's name
- Member's phone number

10.3 TRANSLATION SERVICES AND ALTERNATIVE FORMATS

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

The use of a translation vendor is strongly encouraged to ensure compliance and minimize the risk of liability and malpractice lawsuits.

- Translations must meet the following specifications:
 - o A complete accurate meaning-for-meaning rendition of the source text (English) in the target language(s)

- o At the 6th grade reading level (calculated by Readability software, including but not limited to SMOG, Fry Graph, FOG, Flesch Reading Ease, and Dale-Chall)
- o Culturally appropriate and relevant to L.A. Care's Member population
- Translation process must include the following at a minimum:
 - o Three-step process including translation, editing, and proofreading
 - o Completion of this three-step process by at least two (2) separate qualified translators
- Qualified translators must have:
 - o Documentation of demonstrated written language proficiency in reading, writing and understanding both written English and at least one (1) other written non-English language
 - o Formal education in the target language
 - o A fundamental knowledge in both languages of health care and medical vocabulary, terminology, phraseology and concepts relevant to a health care delivery system
 - o Ability to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology
 - o Knowledge and experience with culture(s) of the intended audience
 - o Adherence to generally accepted translator ethics principles, including client confidentiality
- Written Member Informing Materials must be available in all Los Angeles County Threshold Languages. Following are 11 threshold languages for Cal MediConnect:
 - o English
 - o Spanish
 - o Arabic
 - o Armenian
 - o Chinese
 - o Farsi
 - o Khmer
 - o Korean
 - o Russian
 - o Tagalog
 - o Vietnamese

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

- Source document (English)
- Translated document
- A signed attestation for each translated document in each translated language from the translation services vendor or bilingual staff who performed the translation. It should attest to the accuracy and completeness of the translation using the three-step process by at least two (2) separate qualified translators.

All materials, regardless of language, must include an alternate language disclaimer on availability of non-English translations (refer to CMS Marketing Guidance for California Medicare-Medicaid Plans Appendix. The disclaimer on availability of non-English translations must be provided in all required threshold languages, including English. The non-English translations of the disclaimer must be placed below the English version and in the same font size as the English version.

Additionally, there are two notifications that must be included in all significant publications, regardless of language, in at least the top 16 non-English languages of California:

- Notice of Non-Discrimination
- Language Assistance Services Tagline (refer to CMS Marketing Guidance for California Medicare-Medicaid Plans § 30.5). The Tagline must accompany a Notice of Non-Discrimination.

The top 16 non-English languages of California are inclusive of threshold languages. As such, the Tagline can be used to help meet the requirements for an alternate language disclaimer as long as it is provided in these 16 non-English languages.

The requirement for significant publications and significant communications that are small-sized (such as postcards and tri-fold brochures), is that the Language Assistance Services Tagline and Non-Discrimination Statement must be provided in at least the top two (2) non-English languages of California.

The top 16 non-English languages of California are:

- o Spanish
- o Arabic
- o Armenian
- o Chinese
- o Farsi
- o Khmer
- o Korean
- o Russian
- o Tagalog
- o Vietnamese
- o Hmong
- o Hindi
- o Laotian
- o Japanese
- o Panjabi
- o Thai

The top two (2) non-English languages of California are:

- o Spanish
- o Chinese

10.3.1 For PPGs:

PPGs are delegated to translate the Member Informing Materials (e.g. Member-specific information in Notice of Action (“NOA”) letters, appointment reminders, flyers and consent forms) that they have developed. PPGs are responsible for translating these materials into threshold languages and distributing them to Members in the appropriate threshold languages on a routine basis and in alternative formats upon request.

While L.A. Care provides PPGs with translated NOA letter templates in all threshold languages, PPGs are responsible for sending fully translated NOA letters to Members including Member-specific information within these letters on a routine basis.

10.3.2 For Network Providers:

Please contact the appropriate personnel at your PPG to learn how to access Member Informing Materials in threshold languages and alternative formats.

10.3.3 For Specialty Plans, Vendors, Hospitals, and LTSS:

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

10.4 AUXILIARY AIDS AND SERVICES

All providers must:

- Make reasonable changes to policies, practices, and procedures to provide equal access for Members with disabilities.
- Take appropriate steps to ensure communications with disabled Members are as effective as communications with others in health programs/activities.
- Ensure newly constructed and altered facilities are physically accessible to Members with disabilities.
- Provide auxiliary aids and services.

Auxiliary aids and services may include but are not limited to:

- Qualified sign language interpreters (face-to-face or remote interpreting)
- TTY
- Video remote interpreting (VRI) services
- Alternative format (large print, audio)

10.4.1 For All Providers (PPGs, Network Providers, Specialty Plans, Vendors, Hospitals, LTSS):

Please refer to Sections *10.2 Interpreting Services* and *10.3 Translation Services and Alternative Formats* to learn more about auxiliary aids and services and how to access them.

10.5 CULTURAL AND LINGUISTIC SERVICE TRAININGS

Training on C&L requirements, cultural competency, and disability sensitivity is required for all Providers. Training must be offered to staff and Providers serving Members at both medical and non-medical key points of contact. These trainings must be completed initially and annually, especially by Interdisciplinary Care Team (“ICT”) members.

10.5.1 For PPGs and Network Providers:

L.A. Care offers the following trainings to PPGs and Network Providers at no cost. The trainings are available in person or online:

- Cultural Competency (including language assistance services)
- Disability Sensitivity
- Communicating Through Healthcare Interpreters (*CME – available only for Network Physicians*)

To schedule in person training sessions or obtain a registration code for online courses, email CLStrainings@lacare.org.

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

- PPG Staff: Staff orientations, in-service trainings, meetings, staff newsletters and email
- Network Providers: Provider orientations, in-service trainings, meetings, Provider newsletters, faxes and mailings

10.5.2 For Specialty Plans, Vendors, Hospitals, and LTSS:

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

- Availability of language assistance services, auxiliary aids and services, and C&L resources to comply with these regulations
- Cultural competency, including the following:
 - o Unbiased attitude and respect for cultural diversity
 - o Respect for the multifaceted nature and individuality of people
 - o Awareness that culture and cultural beliefs may influence health and health care delivery
 - o Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interactions with Providers and the health care system
 - o Skills to communicate effectively with diverse populations
 - o Language and literacy needs
- C&L Requirements, including the following:
 - o Posting of the translated Language Assistance Services Tagline signage in the top 16 non-English languages of California at Provider office sites.
 - o Posting of the Notice of Non-Discrimination at Provider office sites.
 - o Availability of no-cost qualified interpreting services, including American Sign Language, at all points of contact 24/7, including after-hours services and how to access the services.
 - o Not requiring, suggesting to, or implying to Members that they provide their own interpreter.
 - o Discouraging the use of family and friends, especially minors, as interpreters.

- o Not relying on staff, other than qualified bilingual/multilingual staff, to communicate directly with LEP Members.
 - o Documenting a Member's preferred language.
 - o Documenting a Member's request or refusal of interpreting services.
 - o Identifying, assessing and tracking the linguistic capability of bilingual clinical and non-clinical staff.
 - o Processes for filing a grievance if a Member's cultural or language needs are not met.
 - o Working effectively with Members who use in-person and telephonic interpreters.
 - o Availability of Written Member Informing Materials in threshold languages and alternative formats at no cost to Members and how to access the services.
 - o Availability and use of auxiliary aids and services such as qualified sign language interpreters, TTY, and alternative formats.
- Disability sensitivity
 - Legal obligations under state and federal laws regarding language assistance services
 - How to access the language assistance services, auxiliary aids and services, and C&L resources
- Documentation of all provided trainings must be kept on file including, but not limited to, sign-in sheets and training evaluation.

10.6 CULTURAL AND LINGUISTIC TOOLS AND RESOURCES

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

10.6.1 For PPGs and Network Providers:

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

10.6.1.1 Provider Toolkit for Serving Diverse Populations

The Provider toolkit is a comprehensive guide to culturally and linguistically appropriate services. It is organized in five (5) sections, which contain helpful C&L information and tools.

To order the toolkits, go to external.lacare.org/HealthForm/.

To download the toolkits (PDF), go to lacare.org/providers/provider-resources/tools-toolkits/health-education-tools.

10.6.1.2 Language Skills Assessment Tool

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

To download the assessment tool (PDF), go to lacare.org/Providers/Provider-resources/forms-manuals/.

10.6.1.3 Interpreting Services Poster

The poster is translated into 16 languages. It informs the availability of no-cost interpreting services and how to access the services from L.A. Care. It should be posted at all key points of contact such as front office and exam rooms

To order the posters, go to external.lacare.org/HealthForm/.

10.6.1.4 Telephonic Interpreting Card

The Telephonic Interpreting Card contains the telephone number for L.A. Care's no-cost telephonic interpreting services and information needed to place interpreted calls.

To order the telephonic cards, go to external.lacare.org/HealthForm/.

10.6.1.5 Culturally and Linguistically Appropriate Referrals

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

To access the online community resource directory, go to auntbertha.com/. To download the referral forms, go to

lacare.org/Providers/Provider-resources/tools-toolkits/health-education-tools/.

10.6.1.6 Patient Interpreter Services Labels

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

To download the labels (Word), go to

lacare.org/Providers/Provider-resources/forms-manuals/.

10.6.2 For Specialty Plans, Vendors, Hospitals, and LTSS:

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

10.7 REPORTING REQUIREMENTS

As part of L.A. Care's monitoring process, regular reports must be submitted via email to CLReports@lacare.org. Reports must be provided using either L.A. Care's reporting templates or L.A. Care's format requirements. To request the most up-to-date reporting templates or format information, please email CulturalandLinguisticServices@lacare.org.

10.7.1 For Specialty Plans and Vendors:

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

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

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

11.0 FINANCE

11.1 CAPITATION PAYMENTS

L.A. Care pays PPGs a pre-determined capitation each month for the provision of health services to L.A. Care Cal MediConnect Members. This section covers guidelines for financial reports and requirements, capitation, and other related issues.

11.1.1 100% of capitation payments will be remitted to a PPG no later than the 10th calendar day of a month (except as defined in “Financial Security Requirements,” and “Assumption of Financial Risk”). The payments will constitute payment in full for health care and administration services rendered under the PPG’s L.A. Care PPG Services Agreement (“PPGSA”).

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

11.2 CAPITATION STATEMENT REPORT

11.2.1 A Capitation Statement Report will be placed in a protected PPG website on or before the 10th business day of every month. The Capitation Statement Report will provide a summary of the capitation payment for each enrolled Member assigned to each PPG and will include the following information:

- Number of current active enrollees (initial eligibles)
- Number of retroactive disenrollments (decaps) – representing the number of retroactive disenrollment months processed
- Capitation amount
- Capitation total

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

11.3 INSURANCE

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

11.3.1 Professional Liability Insurance

A PPG must have and maintain, at its expense throughout the term of its PPGSA, Professional Liability Insurance for each employed physician and/or Affiliated Provider. Limits must not be less than \$1,000,000.00 per occurrence and \$3,000,000.00 in the aggregate for the year of coverage, or another amount acceptable and permitted by L.A. Care in writing. PPGs must provide copies of insurance policies within five (5) business days of a written request by L.A. Care.

11.3.2 Federal Tort Claims Act Alternative

In lieu of providing Professional Liability Insurance described above, a PPG may provide L.A. Care with evidence of liability protection under the Federal Tort Claims Act by the Bureau of Primary Health Care in accordance with Section 224(h) of the Public Health Service Act, 42 U.S.C. 233(h),

as amended (“FTCA Coverage”). However, a PPG must ensure that only those Providers covered under the Professional Liability Insurance described above or under FTCA Coverage may provide Provider services to Members.

11.3.3 Reinsurance/Stop-Loss Insurance

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

11.3.4 General Liability Insurance

A PPG must maintain general liability insurance in at least the minimum amounts acceptable to L.A. Care to cover any property loss that is not covered under any lease agreement with the landlord or contract agreement with the management company. The limits of liability must not be less than \$100,000.00 for each claim and \$300,000.00 in aggregate under each insurance policy period.

11.3.5 Errors and Omissions

A PPG must maintain Errors and Omissions (“E&O”) Insurance that covers the claims made against managed care activities. The insurance policy must be written on a claims made basis. The limits of liability must not be less than \$100,000.00 for each claim and \$100,000.00 in aggregate for each insurance policy period.

11.3.6 Directors and Officers

A PPG must maintain Directors and Officers (“D&O”) Insurance that covers claims made against directors and officers of the company. The insurance policy must be written on a claims made basis. The limits of liability must not be less than \$100,000.00 for each claim and \$100,000.00 in aggregate for each insurance policy period.

11.3.7 Independent Certified Public Accounting Firm Liability Insurance

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

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

11.4 MINIMUM FINANCIAL SOLVENCY STANDARDS

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

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

11.4.1.2 Pay 95% of clean claims within 30 calendar days and pay or deny 100% of all other claims within 60 calendar days consistent with applicable law, regulation and contractual timeliness requirements.

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

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

11.4.1.5 Maintain a fiscally sound operation by at least maintaining a positive net worth as defined in Title 42, C.F.R., Sections 422.2, 422.504(a)(14), 423.4, and 423.505(b)(23).

11.4.1.6 Maintain, at all times, the current minimum "cash to claims ratio" of .75. A cash to claims ratio is cash, readily available marketable securities and receivables (excluding all risk pool, risk-sharing, incentive payment program, and pay-for-performance receivables reasonably anticipated to be collected within 60 days) divided by the organization's unpaid claims (claims payable and IBNR claims) liability (as listed per SB 260 and Title 28, California Code of Regulations, Section 1300.75.4.2).

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

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

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

11.5 REIMBURSEMENT SERVICES AND REPORTS

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

11.5.1.1 PPGs that are delegated for the claims processing function must submit a quarterly claims timeliness report (in an ICE approved Medicare template) which is due 30 days after the end of the quarter. The supporting MTR claims data file (template provided by L.A. Care) is due the 15th calendar day of each month following the month being reported.

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

11.6 RECORDS, REPORTS, AND INSPECTION

11.6.1 Records

Each PPG must maintain all books, records, and other pertinent information that may be necessary to ensure its compliance with its PPGSA, as well as with CMS requirements for a period of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. This documentation must be maintained in accordance with generally accepted accounting principles, applicable state law and regulations, and CMS and DMHC requirements.

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

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

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

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

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

11.6.4 Inspection of Records

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

A PPG must also agree to require all related entities, contractors, or subcontractors, and downstream entities to agree to both of the following:

- DHHS and the Comptroller General, or their designees, have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s), and downstream entities involving transactions related to L.A. Care Cal MediConnect.
- Any federal/state/local regulatory agency, or their designees, has the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

11.6.5 Records Retention Term

A PPG's books and records must be maintained for a minimum of 10 years from the end of the fiscal year in which the PPG's contract with L.A. Care expires or is terminated or from the date of completion of any audit, whichever is later.

11.6.6 Financial Statements

As required by Section 11.4 above, each PPG must provide L.A. Care with a copy of its Quarterly Financial Statements and Annual Audited Financial Statements, if requested; these financial documents, as well as any other reports required by CMS and DMHC, must be made available to DMHC, CMS, and any other regulatory agencies.

12.0 CLAIMS AND PAYMENT

12.1 TIMELY FILING DEADLINE

L.A. Care cannot impose a timeframe for receipt of an “initial claim” submission less than 365 days for contracted Providers after the date of service for timely filing for a new claim.

12.2 BILLING

All paper claims must be submitted on CMS 1500 forms for professional services and on UB-04 forms for facility services. L.A. Care accepts Electronic Data Interchange (“EDI”) submissions partnering with Office Ally and Change Healthcare.

Providers can register with Office Ally at cms.officeally.com. L.A. Care’s Payer Identification is “LACAR.” After registration with Office Ally, fax an updated W-9 Form to L.A. Care at 213.438.5732, Subject: “Attention Electronic Claim Activation.” L.A. Care will complete the request within 10 business days to allow for claims to be submitted through EDI.

**Change Health (aka Emdeon) this clearinghouse allows providers to submit attachments. Please add the same information as the above paragraph in regards to how providers register, the ID number, etc...

Providers shall make a good faith effort to bill with the most current coding available.

12.3 PROFESSIONAL AND SUPPLIER CLAIMS

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

12.3.1 Cal MediConnect Claims

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

12.3.2 Incomplete Claims

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

12.3.2.1 Unclean Claims

Unclean claims include those with required information that is incomplete or missing; claims that contain complete and necessary but invalid information are also unclean. Valid information is required for all claims.

12.3.2.2 Incomplete Information

These claims include those with missing required or conditional information (e.g. procedure codes, diagnosis codes, or National Provider Identifier (“NPI”) when effective).

12.3.2.3 Invalid Information

These claims include those with required or conditional information on a claim that is illogical or incorrect (e.g. invalid CPT, HCPCS, or diagnosis codes).

12.3.3 Claims Submission

Initial and Resubmitted Claims may be submitted hard copy to:

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

12.4 CLAIMS ADJUDICATION

Every claim is subject to a comprehensive series of quality “edits” and “audits.” These quality checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit and audit checks include, but are not limited to, the verification of the following:

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

12.5 PROVIDER PORTAL CLAIMS VERIFICATION

The L.A. Care Provider Portal is the preferred method for contracted Providers to check claims status at calmediconnectla.org/providers/resources. Claim status can also be checked by calling **1.866.LA.CARE6**.

12.6 COORDINATION OF BENEFITS

In accordance with requirements of the Balanced Budget Act of 1997, L.A. Care, as a secondary payer, will pay deductibles and or co-insurance and co-payments 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)*. When a Member has other health insurance (including Medicare, a Medicare HMO or a commercial carrier), L.A. Care will coordinate payment of benefits. These other insurers are considered the primary payer, and L.A. Care is the secondary payer.

12.7 BALANCE BILLING

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

Balance billing is the practice of billing a Member for the difference between what is reimbursed for a covered service and what a Provider feels should have been paid. It includes asking a beneficiary to enter into a private payment agreement or waive their balance billing protection and charging deductibles, coinsurance, co-pays, or other administrative fees.

For information on a L.A. Care CMC Members’ eligibility, please call **1.866.522.2736**.

12.8 PROVIDER DISPUTES

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

12.8.1 Disputes

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

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

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

12.8.2 Second Level Disputes

A Provider who is unable to resolve a billing and payment issue can follow a second level dispute process.

A second level dispute shall be submitted to the address below with the applicable information described in Section 12.8.4.

12.8.3 Submitting Payment Disputes

A Provider must submit a written notice of a dispute ("Dispute Notice") to L.A. Care by U.S. Mail or other physical delivery to the following address:

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

12.8.4 Required Information for Provider Payment Dispute Notices

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

A Provider may submit an amended Dispute Notice (including the missing information) within 30 business days after the date the Provider Payment Dispute Notice was returned from L.A. Care.

Amended Dispute Notices can be sent to:

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

The following information is required for a Dispute Notice:

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

12.8.5 Acknowledgment of Receipt of Dispute

L.A. Care will acknowledge receipt of provider disputes as follows:

- In the case of an electronic provider dispute, within two (2) working days of the date of receipt of the electronic provider dispute; or
- In the case of a paper provider dispute, within fifteen (15) working days of the date of receipt of the paper provider dispute.

12.8.6 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 or amended dispute.

13.0 MARKETING

13.1 REGULATORY APPROVAL

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

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

13.2 DEFINITIONS OF MARKETING TERMS

13.2.1 Provider Promotional Activities – Activities that a Provider performs to educate potential enrollees or to assist potential enrollees in enrollment.

13.2.2 Marketing –

- Steering, or attempting to steer, a potential enrollee towards a plan, or limited number of plans, and for which the individual or entity performing marketing activities expects compensation directly or indirectly from the plan for such marketing activities; or
- Any communication from a health plan to an enrollee who is not enrolled in that health plan, that can reasonably be interpreted as intended to influence the enrollee to enroll in that particular plan's Medi-Cal product, or either to not enroll in or to disenroll from another health plan's Medi-Cal product.
- "Assisting in enrollment" and "education" are not activities that constitute marketing. Marketing activities are limited to those activities in accordance with marketing guidance from the CMS, DHCS, and/or DMHC.

13.2.3 Marketing Materials – Marketing materials include any informational materials that perform one or more of the following actions:

- Promote an organization.
- Provide enrollment information for an organization.
- Explain the benefits of enrollment in an organization.
- Describe the rules that apply to enrollees in an organization.
- Explain how Medicare services are covered under an organization, including conditions that apply to such coverage.
- Communicate various Membership operational policies, rules and procedures.

Marketing materials also include materials that are produced in any medium, by or on behalf of health plan, its employees, network providers, agents or contractors that can reasonably be interpreted as intended to market the plan to potential enrollees. Marketing materials should be distributed to L.A. Care's entire service area.

13.3 MARKETING ACTIVITIES AND STANDARDS

L.A. Care’s marketing standards for Providers’ CMC marketing and promotional activities are in accordance with CMS, DHCS, and/or DMHC marketing guidance. For a copy of the 2019 CMS Medicare Communications and Marketing Guidelines, please visit [cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html).

L.A. Care may impose sanctions on a Provider, in accordance with the Provider Manual or the Provider’s contractual agreement, for any violation of these standards.

13.3.1 Permitted Activities- The provisions of this policy do not affect L.A. Care Providers’ ability to communicate with L.A. Care or a Member pursuant to contractual, statutory, regulatory, or L.A. Care policy requirements.

Providers may enter into discussions with their Members when the Member is asking for information or advice from the Provider regarding their options, as long as the Provider gives the Member objective information in accordance with marketing guidelines from CMS, DHCS, and/or DMHC.

Providers may distribute L.A. Care materials or make them available in their office, provided that materials are distributed or made available for all plans with which the Provider contracts.

Providers may display posters or other materials announcing their L.A. Care contractual arrangements, provided they do so for all plans with which the Provider contracts.

Providers may provide information on and assistance with applying for the low-income subsidy.

Providers may provide objective information on all L.A. Care sponsors’ specific plan formularies, based on a particular Member’s medications and health care needs.

Providers may provide objective information regarding all plan sponsors’ specific plans being offered, such as covered benefits, cost sharing and Utilization Management tools.

Providers may distribute all Prescription Drug Plans’ marketing materials with which the Provider contracts.

Providers may refer their Members to other sources of information, such as the following:

- Centers for Medicare and Medicaid Services (“CMS”) at [medicare.gov/](https://www.medicare.gov/) or **800.MEDICARE**
- Los Angeles County HICAP: Center for Healthcare Rights at cahealthadvocates.org/hicap/los-angeles/
- L.A. Care’s Health Plan Field Representatives
- State Medi-Cal Office
- Local Social Security Offices

Providers may print out and share information with Members from CMS’s website.

Providers may distribute the “Medicare and You” Handbook, “Who Can Join a CalMediConnect Health Plan” toolkit or a printed copy of “Medicare Options Compare,” in accordance with marketing guidelines from CMS, DHCS, and/or DMHC.

Providers may distribute CMS documents or materials that provide comparative and descriptive information of a broad nature about plans.

New L.A. Care Cal MediConnect Providers may announce the new affiliation to their Members. This initial announcement, naming only L.A. Care and not the Provider's other affiliations, may occur only once within the first 30 days of a new contract agreement by direct mail or email. Any additional direct mail or email communications regarding continuing affiliations must name all of the Provider's affiliations.

Any affiliation materials that describe L.A. Care and L.A. Care Cal MediConnect in any way (including, but not limited to, plan benefits and formularies) must be submitted to L.A. Care for approval. L.A. Care will submit the materials to CMS, DHCS, and DMHC for approval. While materials listing a Provider's plan affiliations and including only plan names and contact information do not need regulatory approval, these materials must be submitted to L.A. Care.

Providers may distribute printed information provided by a plan that compares the benefits of all the different plans with which they contract. Plan benefit comparison materials must adhere to the following:

- Does not highlight any specific plan or rank order.
- Includes only objective information.
- Has the concurrence of all plans listed in the materials.
- Has been approved by CMS (these materials are not subject to File and Use provisions that states materials will only need to be submitted and do not have to wait for approval prior to use).

Providers may provide a link on their website to the CMS Online Enrollment Center.

13.3.2 Health Education & Wellness Materials

L.A. Care considers health education materials and wellness promotion materials as Marketing Materials, if such material:

- Is used in any way to promote L.A. Care, L.A. Care Cal MediConnect, or a Provider.
- Is used to explain benefits.
- Contains any commercial message or Member notification information.

13.3.3 Internet Communication

L.A. Care shall consider any communication via the Internet as both Marketing Materials and as Promotional Activities.

Communication via the Internet consists of, but may not be limited to, electronic transfer, transmittal, dissemination, and distribution through the Provider's or partner organization's website.

Providers must follow the approval procedures provided in this section for all Marketing Materials and Promotional Activities conducted through the Internet.

13.3.4 Marketing Standards

All Marketing Materials and Marketing Activities must follow all CMS, DHCS, and/or DMHC marketing guidelines, which pertain to, but are not limited to, the following:

- Advertising and pre-enrollment materials.
- Post-enrollment materials.
- Outreach to Members.
- Promotional activities/events.
- Other marketing activities.

Marketing Materials must not contain false, misleading, or ambiguous information.

L.A. Care and its contracted Providers must ensure all Marketing Materials are at a reading level no greater than 6th grade, and they must be both culturally and linguistically appropriate. Marketing Materials must be made available in alternative formats, upon request and as needed, to assure communication for blind and vision-impaired enrollees; as well as in a manner, format and language that may be easily understood by persons with limited English proficiency and developmental disabilities or cognitive impairments. (For additional information, please see Section 10 of this Manual, Cultural and Linguistic Services.)

13.3.4.1 Labeling

All Marketing Materials must clearly be labeled with the following:

- The year they were last updated
- The source of any representations, endorsements, or awards referred to in the Marketing Materials
- The entity responsible for producing the Marketing Materials

13.3.4.2 L.A. Care's Logo

L.A. Care reserves the right to review and ensure correct usage of the L.A. Care logo, including the contents of the material that contains the L.A. Care logo. L.A. Care must review and approve the use of the L.A. Care logo prior to publishing.

13.4 APPROVAL PROCESS

13.4.1 A Provider must submit all Marketing Materials and Promotional Activities to L.A. Care through the Provider Network Management Department for review and approval at least 45 calendar days prior to the scheduled date of use for the Marketing Materials or the scheduled event of the Promotional Activities.

Mail or fax to:

L.A. Care Health Plan
Attn: Provider Network Management Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Fax: 213.438.5732

13.4.2 If a Provider uses CMS model language without modifying Marketing Materials, the Provider must submit the Marketing Materials to L.A. Care. L.A. Care will submit the Marketing Materials to CMS at least 10 calendar days prior to use of the Marketing Materials.

13.4.3 Providers must submit documentation of proposed Marketing Materials and Promotional Activities to L.A. Care. This documentation must include all of the following:

- An English draft in final layout of the proposed Marketing Materials or description of the proposed Activities.
- A brief description of the use of the material.
- A draft of translated versions of the proposed Marketing Materials with a letter attesting that the translated material conveys the same information and level of detail as the English material (translation to only occur after the English version has been approved). The total cost of the proposed Marketing Materials or Promotional Activities.

13.4.4 If upon review, L.A. Care does not object to a Provider's Marketing Materials and Promotional Activities and associated documentation, L.A. Care will send a written notice to the Provider within 10 business days stating L.A. Care's review and intent to submit the proposed Marketing Materials and Promotional Activities to CMS.

13.4.5 If upon review, L.A. Care objects to a Provider's Marketing Materials or Promotional Activities, L.A. Care will send a written notice to the Provider within 10 business days after receipt of all documentation that describes its objections in detail. In this situation, the following process applies:

- The Provider may resubmit revisions of the Marketing Materials or Promotional Activities and all applicable documentation to L.A. Care within five (5) business days after receipt of L.A. Care's notice of objection.
- L.A. Care will review the resubmitted, revised documentation and will notify the Provider within five (5) business days after receipt if the Marketing Material or Promotional Activities are approved or disapproved.
- If approved, L.A. Care will submit the proposed Marketing Materials or Promotional Activities to CMS. If the resubmission is inadequate and disapproved, L.A. Care shall provide written notice and Provider shall re-engage in this same process.
- If a Provider fails to resubmit revisions of Marketing Materials or Promotional Activities within five (5) business days after receipt of L.A. Care's review, then the Provider must submit such materials as new Marketing Materials or Promotional Activities.

13.4.6 A Provider must **NOT** use Marketing Materials or engage in Promotional Activities prior to receipt of L.A. Care's written notice of approval.

13.4.7 L.A. Care must notify the Physician Group or Provider that proposed Marketing Materials or Promotional Activities have been approved within five (5) working days after receipt of CMS approval.

13.4.8 L.A. Care will consider Marketing Materials and Promotional Activities approved if CMS, DHCS, and/or DMHC fail to respond to L.A. Care's request to approve Marketing Materials or Promotional Activities within 45 working days.

13.5 PROHIBITED ACTIVITIES

13.5.1 Defining Prohibited Activities

Prohibited activities include:

- Engaging in activities characterized as prohibited by CMS, DHCS, and/or DMHC marketing guidelines.
- Use or distribution of Marketing Materials or engaging in Promotional Activities without prior written approval from L.A. Care and CMS, DHCS, and/or DMHC, as applicable.
- Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.
- Engaging in door-to-door, telephone, email, texting, or other cold-call marketing activities.
- Use of Marketing Materials that contain any assertion or statement (whether written or oral) that:
 - o The recipient must enroll with L.A. Care in order to obtain benefits or in order not to lose benefits.
 - o That L.A. Care is endorsed by CMS, Medicare, Medi-Cal, the federal government, DHCS, or similar entity.
- Use of logos or other identifying information used by a government or public agency, including L.A. Care, without prior authorization, including but not limited to:
 - o Offering sales/appointment forms.
 - o Accepting enrollment applications for L.A. Care's Cal MediConnect line of business.
 - o Directing, urging, or attempting to persuade potential enrollees to enroll in a specific plan based on financial or other interests.
 - o Mailing marketing materials on behalf of L.A. Care.
 - o Offering anything of value to induce L.A. Care Cal MediConnect Members to select them as their Provider.
 - o Offering inducements to persuade potential enrollees to enroll in L.A. Care's Cal MediConnect program.
 - o Distributing L.A. Care's Cal MediConnect information while conducting a health screening.
 - o Accepting any compensation directly or indirectly from L.A. Care Cal MediConnect Field Representatives or contracted brokers for enrollment activities.
 - o Giving any Member names, addresses, or phone numbers for the solicitation of enrollment to an L.A. Care Health Plan Field Representatives or contracted brokers.

13.5.2 Failure to Comply

L.A. Care may impose sanctions on a Provider for any violation of the terms and conditions of this section, in accordance with marketing guidelines from CMS, DHCS, and/or DMHC. These sanctions include, but are not limited to, the following:

- Financial penalties.
- Immediate suspension of use of all Marketing Materials and Promotional Activities for a period not to exceed six (6) months.
- Imposition of an enrollment cap or Membership cap and Provider Contract termination.

14.0 ENCOUNTER DATA

Contracted PPGs, Specialty Plans, Vendors, Hospitals and LTSS Providers are required to gather, process, and submit encounter data in a timely manner to L.A. Care for all L.A. Care Members.

Encounter data is the primary source of information about the delivery of medical services to L.A. Care Members. L.A. Care uses encounter data for oversight functions to meet regulatory requirements, analyzing the validity of capitation rates to Providers and identifying the need for benefit and/or program changes.

L.A. Care contracts with TransUnion Healthcare, a data clearinghouse company, to assist PPGs with the proper formatting for timely and accurate submission of encounter data. Encounter data must be submitted directly to TransUnion Healthcare.

14.1 REQUIREMENTS

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

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

14.2 USE OF TRANSUNION HEALTHCARE SERVICES

PPGs must use TransUnion Healthcare services, pursuant to the terms and conditions indicated below, free of charge. L.A. Care will reimburse TransUnion Healthcare for services rendered to all contracted PPGs.

Below is TransUnion Healthcare's contact information:

TransUnion HealthCare
200 Corporate Point, Suite 350
Culver City, CA 90230
310.337.8530 voice
TransUnionHealthCare.com

PPGs are required to submit data according to all of the following:

- PPGs (including capitated Hospitals) encounter data must be submitted in an electronic format in accordance with the encounter data specifications established by TransUnion Healthcare.
- PPGs must submit encounter data directly to TransUnion Healthcare.
- When a PPG uses TransUnion Healthcare to process its encounter data, TransUnion Healthcare will convert the PPG's encounter data into the appropriate format to meet L.A. Care's specifications.

15.0 COMPLIANCE

L.A. Care is ensuring all business operations are conducted in a manner that is compliant with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules pertaining to the Cal MediConnect program. L.A. Care's commitment to compliance extends to its own internal business operations, and its oversight and monitoring responsibilities extend to its business partners.

L.A. Care's Compliance Program is designed to ensure the provision of quality health care services to all L.A. Care Members, including Cal MediConnect Members. This is achieved through a variety of compliance activities that include the following:

- Communication and implementation of regulatory requirements
- Oversight and monitoring of delegated entities
- Training and education
- Fraud, waste, and abuse prevention, detection, and investigations
- Preserving Member rights concerning privacy and confidentiality
- Ongoing monitoring of quality health care services
- Education of Providers about Cal MediConnect program rules and other health care compliance requirements
- Oversight on written policies, procedures and standards of conduct
- Oversight on effective lines of communication
- Oversight on well-publicized disciplinary standards
- Oversight on procedures and systems for promptly responding to compliance issues

15.1 GOALS AND OBJECTIVES

The goal of L.A. Care's Compliance Program is to ensure that all L.A. Care Members receive appropriate and quality health care services through the Provider network in compliance with all applicable California and federal rules and regulations, as well as with L.A. Care contractual requirements.

L.A. Care's Compliance Program performs the following:

- Manages audits of Providers
- Provides oversight and ongoing monitoring of delegated responsibilities of L.A. Care's Provider network
- Requires the implementation of corrective actions by Providers to address deficiencies concerning providing health care services or L.A. Care performance standards
- Establishes policies and procedures to identify, investigate and resolve potential or actual Fraud, Waste and Abuse ("FWA") activities

- Establishes education/training opportunities and other available resources to assist Providers in complying with HIPAA requirements and with Member rights concerning privacy and confidentiality
- Establishes education/training opportunities and other available resources to assist Providers in complying with CMS MA-PD requirements
- Establishes education/training opportunities to assist Providers with compliance concerns and issues regarding Fraud, Waste and Abuse

15.2 AUTHORITY AND RESPONSIBILITY

L.A. Care's Compliance Program strives to ensure compliance with federal and California State rules and regulations affecting the administration of the Cal MediConnect program. This includes, but is not limited to, the following requirements as applicable to each Provider contracted with L.A. Care:

- Requirements set forth by CMS in the Medicare Managed Care Manual and other guidance or communications
- Rules and regulations promulgated by and for the DMHC and the DHCS
- All applicable federal rules and regulations that apply to the provision of health care services
- Federal and California State governing law and legal rulings
- Terms and conditions as set forth in L.A. Care's contracts with CMS and DHCS
- Requirements established by L.A. Care and implemented with the Provider as stated in the Provider's agreement with L.A. Care

15.3 DELEGATION OF COMPLIANCE AND AUDIT PROGRAM

L.A. Care does not delegate its Compliance Program responsibilities to a Provider. However, a Provider is required to comply with all CMS Compliance Program Effectiveness requirements.

L.A. Care staff works with Provider staff to administer compliance activities and implement corrective actions to rectify deficiencies. Provider staff is encouraged to work with L.A. Care compliance staff to ensure compliance with all L.A. Care performance standards.

15.4 AUDIT AND OVERSIGHT ACTIVITIES

To ensure that all L.A. Care Members receive appropriate health care services, L.A. Care staff performs an annual audit of the contract responsibilities and services that have been delegated by L.A. Care to a Provider. L.A. Care's audit program for delegated Providers includes, but is not limited to, the following activities:

- Annual onsite visit to delegated Providers to ensure that all delegated responsibilities and services comply with Cal MediConnect program requirements. The annual evaluation will be a comprehensive assessment of the delegate's performance, including compliance with applicable standards as well as the extent to which the delegate's activities promote L.A. Care's overall goals and objectives. If any problems or deficiencies are identified, the evaluation will specify any necessary corrective action and include procedures to ensure corrective action is implemented.

- Ad-hoc onsite visits to review Provider activities to ensure compliance with program requirements.
- Ongoing monitoring through review of periodic reports and data required as outlined in the delegation agreement.
- Review of all Provider books, records and information that may be necessary to demonstrate Provider's compliance with federal, California State, and L.A. Care contractual requirements. These records may include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and non-medical services rendered to Members, as well as any other information as reasonably requested by L.A. Care.

15.5 PARTICIPATING PHYSICIAN GROUP COMPLIANCE RESPONSIBILITIES

Providers must comply with Medicare and Medi-Cal laws, regulations, and CMS instructions. Providers also agree to audits and inspections by CMS, and/or its designees, and to cooperate, assist, and provide information as requested as well as maintain records (including records of education, training, and supporting documentation) for a minimum of 10 years or longer, as may be required by law.

Providers must ensure that all of their related entities, contractors, or subcontractors, and downstream entities involved in L.A. Care Cal MediConnect transactions maintain and provide access to all pertinent contracts, books, documents, papers and records (including records of education, training and supporting documentation) that are necessary for compliance with federal and state requirements.

Providers must require all of their related entities, contractors, subcontractors, and downstream entities to agree to comply with the following:

- Medicare and Medi-Cal laws, regulations, guidance, and CMS instructions
- Audits and inspections by CMS and/or its designees
- Cooperation, assistance, and information provided as requested

Providers must require its managers, officers and directors responsible for the administration or delivery of Part C or Part D benefits to sign a conflict of interest statement, attestation or certification, upon hire and annually thereafter, that certifies that the manager, officer or director is free from any conflict of interest in administering or delivering Part C and Part D benefits.

Upon contracting with a downstream entity and related entities, Providers must require a signed certification that these entities will require their managers, officers and directors responsible for the administration or delivery of Part C or Part D benefits to sign a conflict of interest statement, attestation or certification, upon hire and annually thereafter, that certifies that the manager, officer or director is free from any conflict of interest in administering or delivering Part C and Part D benefits.

Providers must conduct annual general and specialized compliance training for their employees. Providers must submit documentation of that general and specialized compliance training to L.A. Care's Compliance Officer annually.

Provider must have written policies, procedures, and standards of conduct (code of conduct) that are detailed and specific, and that describe the operation of the Provider's compliance program. The policies, procedures and standards of conduct must meet the following requirements:

- Articulate the Provider's commitment to comply with all applicable federal and state standards
- Describe compliance expectations as embodied in the standards of conduct

- Implement the operation of the compliance program
- Provide guidance to employees and others on dealing with suspected, detected, or reported compliance issues
- Identify how to communicate compliance issues to appropriate compliance personnel
- Describe how suspected, detected or reported compliance issues are investigated and resolved by the Provider
- Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials
- Describe the Provider's expectations that all employees, downstream and related entities conduct themselves in an ethical manner and that issues of noncompliance and potential FWA be reported through appropriate mechanisms, addressed, and corrected.

A Provider's policies, procedures and standards of conduct must be distributed to the Provider's employees who support the Provider's Medicare business within 90 days of hire, when there are updates to the policies, and annually thereafter.

Providers are required to ensure that their policies, procedures, and standards of conduct are distributed to downstream and related entities' employees who support the Providers' Medicare business within 90 days of hire, when there are updates to the policies, and annually thereafter.

Providers must designate a compliance officer and a compliance committee who report directly and are accountable to the Provider's chief executive, the governing board, or other senior management. The compliance officer and compliance committee must periodically report directly to the governing board on the activities and status of the compliance program, and the board must be knowledgeable about the compliance program's operation and exercise reasonable oversight with respect to the implementation and effectiveness of the compliance programs. The compliance officer is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the DHCS and CMS contract.

Providers must establish, implement, and provide effective training and education for its employees (including the Compliance Officer, CEO, senior administrators or managers, and governing body members) as well as for downstream and related entities. Required Provider training and education includes the following elements:

- L.A. Care policies and procedures training, Model of Care training, and CMC program training within 30 working days of active status, and annually thereafter, for Provider employees (including the CEO, senior administrators or managers, and governing body members) and for downstream and related entities
- General compliance and FWA training within 90 days of hire/contracting, and annually thereafter, to Provider employees (including temporary workers, volunteers, the CEO, senior administrators or managers, and governing body members) and downstream and related entities
- Communication of general compliance information to downstream and related entities' employees
- Reviews and updates, if necessary, to the general compliance training whenever there are material changes in regulations, policy, or guidance, and at least once annually
- Federal and state standards and requirements education under CMS and DHCS contracts

Providers must establish and implement effective lines of communication, ensuring confidentiality between the Provider's compliance officer, members of the Provider's compliance committee, the Provider's employees, managers, and governing body, and the Provider's downstream and related entities. These lines of communication must be accessible to all and they must enable compliance issues to be reported via a method that is anonymous and in confidential good faith, as they are identified.

Provider lines of communication must include the following to be considered effective:

- Effective way(s) to communicate information from the Provider's compliance officer to others.
- Written standards of conduct and/or policies and procedures must require all employees, members of the governing body, and downstream and related entities to report compliance concerns and suspected or actual violations related to the Medicare program to L.A. Care and the Provider.
- System in place to receive, record, respond to, and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees, and downstream and related entities and their employees.
- Adopted, widely publicized, and enforced no-tolerance policy for retaliation or retribution against any employee or downstream and related entities who in good faith reports suspected FWA.
- Available reporting methods for compliance or FWA concerns as well as the non-retaliation policy publicized throughout the Provider's facilities.
- User friendly, easy to access and navigate reporting mechanisms that are available 24/7 for employees, members of the governing body, and downstream and related entities.

Providers must have well-publicized disciplinary standards, accomplished via implemented procedures that encourage good faith participation in the compliance program by all affected individuals.

Provider compliance includes compliance by the Provider's downstream and related entities. Providers must establish and implement an effective system for the routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits to evaluate the Provider's compliance with CMS requirements and the overall effectiveness of the compliance program. Provider compliance includes compliance by the Provider's downstream and related entities. A Provider's system for routine monitoring and identification of compliance risks must include all of the following to be considered effective:

- Monitoring and auditing work plan that addresses the risks associated with the Medicare Parts C and D benefits. The compliance officer and compliance committee are key participants in this process.
- Established and implemented policies and procedures to conduct a formal baseline assessment of the Provider's major compliance and FWA risk areas, such as through a risk assessment.
- Monitoring and auditing work plan that is based upon the results of the risk assessment.
- Work plan that includes a schedule that lists all of the monitoring and auditing activities for the calendar year.

- Compliance officer and compliance committee must ensure the implementation of an audit function to conduct oversight of the Provider’s operation and compliance program appropriate to the Provider’s size, scope and structure.
- Strategy to monitor and audit a Provider’s downstream and related entities to ensure that they comply with all applicable laws and regulations.
- Tracking and documentation of compliance efforts.
- Review of the DHHS OIG List of Excluded Individuals and Entities (“LEIE”), the GSA Excluded Parties Lists System (“EPLS”), and the Medi-Cal Suspended and Ineligible Provider List (“SIPL”) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or downstream and related entities, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

Providers must establish and implement procedures and a system for prompt response to compliance issues as they are raised. This includes investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce potential for recurrence, and ensuring ongoing compliance with CMS requirements. A Provider’s system for promptly responding to compliance issues must include all of the following:

- Timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medicare program noncompliance or potential FWA.
- Appropriate corrective actions in response to potential noncompliance or potential FWA.
- Certainty that Provider and downstream and related entities have corrected their deficiencies.
- Documented elements of corrective actions that address noncompliance or FWA committed by the Provider’s employee(s) or downstream and related entities and related ramifications if the Provider’s employee(s) or its downstream and related entities fail to satisfactorily implement the corrective action. Providers enforce effective correction through disciplinary measures, including employment or contract termination, if warranted.

Providers may self-report any potential FWA discovered at the Provider level, and potential fraud and abuse by downstream and related entities, as well as significant waste and significant incidents of Medicare program noncompliance to L.A. Care within 24 hours of identifying or being notified of the matter.

15.6 L.A. CARE’S PROGRAM INTEGRITY PLAN

L.A. Care recognizes the importance of preventing, detecting and investigating FWA. L.A. Care is committed to protecting and preserving the integrity and availability of health care resources for our Members, stakeholders, and business partners by maintaining a comprehensive program integrity plan (i.e. a Compliance Program). These responsibilities are delegated to the Program Integrity Unit – a subdivision of L.A. Care’s Compliance department that includes the Special Investigation Unit (“SIU”), whose mission is to maintain adherence to the program integrity plan to ensure the integrity of publicly funded programs.

15.6.1 The Role of the SIU in Program Integrity

The SIU is a team of L.A. Care personnel charged with investigating allegations of FWA, and facilitating all anti-fraud efforts at L.A. Care. The team consists of subject matter experts in Healthcare Fraud investigations and identification.

The goal of the SIU is to protect and preserve the integrity and availability of health care resources for L.A. Care Members, stakeholders and business partners by maintaining a comprehensive program integrity plan. Anti-fraud activities are coordinated between L.A. Care and its Providers and the first tier, downstream, and related entities (“FDRs”) of its Providers. The term “Provider” includes all health care practitioners and institutions or organizations that provide health care services or supplies.

15.6.2 Fraud, Waste and Abuse Defined

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/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.

15.6.3 Reporting Potentially Fraudulent Activities to L.A. Care

Under the terms of the L.A. Care contract, a Provider or its FDRs must report suspected cases of FWA. There are 4 ways that Providers and FDRs can report suspected FWA:

1. Through the Compliance Helpline

Call **800.400.4889** or file a report online at lacare.ethicspoint.com. The Compliance Helpline is available 24 hours a day, seven days a week and can be used by L.A. Care Board members, employees, contractors, Providers, Members and other interested persons to report all violations or suspected violations of law and/or the compliance program and/or questionable or unethical conduct or practices including, without limitation, the following:

- Incidents of FWA
- Criminal activity (fraud, kickback, embezzlement, theft, etc.)
- Conflict of interest issues
- Code of conduct violations

2. E-mail SIU Directly

Send an email to reportfraud@lacare.org

3. In Writing

Mail a written letter regarding potentially fraudulent activities to L.A. Care at:

L.A. Care Health Plan
Attn: Compliance Officer
Compliance Department
c/o Special Investigation Unit (SIU)
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

4. Call the Provider Inquiry Line:

If a potential FWA case cannot be reported by calling the phone numbers provided above, call L.A. Care's Provider Inquiry Line at **866.522.2736**.

15.6.4 Referral Requirements

Regardless of the method used to report FWA to L.A. Care, the following should be included:

- Name of Person Reporting Fraud or Abuse (optional, but highly recommended)
- Name, Address, License or Insurance ID of suspect (if known)
- Nature of Complaint
- Date of Incident(s)
- Supporting Documentation (optional)

15.6.5 Non-Retaliation

Neither L.A. Care nor any of its contracted entities, including PPGs, may retaliate against any employee, temporary employee, contractor or agent who, in good faith, reports suspected FWA, code of conduct violations, or any other compliance issues to L.A. Care, the contracted entity, or to a regulatory agency. Additionally, L.A. Care's contracted entities must require that its subcontractors abide by this non-retaliation policy.

15.6.6 Communication of L.A. Care's FWA Detection Efforts

L.A. Care uses various means to educate its Provider network and membership about its FWA detection efforts. Information about L.A. Care's FWA detection activities may be communicated in these ways: Provider bulletins; Provider mailings; Provider trainings; Member newsletters; New Member handbook and other sources, including L.A. Care's Regional Community Advisory Committee meetings.

15.6.7 Annual Fraud Waste and Abuse and General Compliance Training

All L.A. Care contracted Providers must ensure that all employees and contracted downstream and related entities participate and complete the Medicare Parts C and D Fraud, Waste, and Abuse and General Compliance Training within 90 days of hire/contracting and annually thereafter. All Medicare Providers must use the training materials provided by CMS; the materials can be accessed through the CMS Medicare Learning Network at

cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/

Providers that have met FWA certification standards through enrollment as a Medicare Provider are deemed to have met FWA training and educational requirements, but still must fulfill the general compliance training requirements.

All Providers are required to submit an executed FWA and General Compliance Awareness Attestation confirming their organization's compliance with this requirement.

15.7 ENFORCEMENT OF DISCIPLINARY STANDARDS

It is L.A. Care's expectation that Providers and their FDRs immediately report to L.A. Care any suspected compliance issues, such as noncompliant, unethical or illegal behavior. Such behavior may include, but is not limited to, falsifying diagnoses, claims, or other documents; refusal to cooperate with state or federal audits or investigations; and other behavior. Reports can be made directly to L.A. Care's Compliance Officer at **213.694.1250**, x 5729. Anonymous complaints of noncompliant, unethical, or illegal conduct may also be reported by calling L.A. Care's Compliance Helpline at **800.400.4889**. The Compliance Helpline is available 24/7. The Provider or FDR must also assist in the resolution of reported compliance issues.

L.A. Care will act on a timely, consistent, and effective basis when noncompliant or unethical behavior is found and reported to L.A. Care. L.A. Care's action will be appropriate to the seriousness of the violation. It may include de-delegation of a function, restriction of enrollment or assignment of Members, withholding capitation, instituting monetary sanctions, or terminating a contract. Refer to the PPGSA or other Provider Agreement for further details on these measures.

PPGs must ensure that they have established, implemented, and enforced disciplinary standards that are publicized to those entities with which it contracts.

It is L.A. Care's expectation that all Providers cooperate with L.A. Care's efforts to monitor compliance.

15.8 THE FEDERAL AND CALIFORNIA FALSE CLAIMS ACTS

The federal and California False Claims Acts are the government's primary weapon in the fight against health care fraud. The majority of funds recovered come from False Claims Acts suits or settlements. The False Claims Acts permit a person who learns of fraud against the government to file a lawsuit on behalf of the government against the person or business that committed the Fraud. If the action is successful, the person filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery. These persons are often referred to as whistleblowers.

For full details on the False Claims Acts and the protections available to whistleblowers, please see L.A. Care Policy RAC-013, "Federal and California False Claims Acts."

15.9 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

Providers who receive a misdirected communication from L.A. Care must immediately notify L.A. Care's Privacy Officer by calling **213.694.1250**, x 4186 or by emailing PrivacyOfficer@lacare.org. Providers should securely destroy, return to L.A. Care, or safely safeguard the misdirected communication.

As covered entities, L.A. Care expects all Providers to comply with applicable privacy and security requirements outlined by federal and state regulation and guidelines, including those set forth under the HIPAA Rules. A brief overview of some of these requirements is provided below, however, Providers are responsible for reviewing the actual HIPAA Rules or consult with their legal counsel to understand all applicable regulations and requirements.

15.9.1 Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information (“ePHI”) it creates, receives, maintains, or transmits. The Rule also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers, and other electronic devices.

The Security Rule is intended to be scalable. 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.

15.9.2 Privacy Rule

The Privacy Rule is intended to protect the privacy of all individually identifiable health information in the hands of covered entities, regardless of whether the information is transmitted or maintained on paper, electronically, or verbally. The Privacy Rule also gives Members a number of rights under HIPAA, including the following:

- Access their PHI
- Request a restriction on certain uses and disclosures of their PHI
- Request changes to their PHI
- Confidential communications
- Receive a list (or accounting) of when the covered entity disclosed PHI, with some exceptions (such as for treatment, payment, and health care operations)

In addition to these rights, the Privacy Rule includes requirements to formally notify Members of the covered entity’s privacy practices and to obtain a patient’s permission before using or disclosing their PHI with limited exceptions, as well as other requirements that address their proper use and disclosure of patient information.

15.9.3 Breach Notification Rule

If an impermissible acquisition, access, use or disclosure that compromises the security or privacy of PHI occurs, HIPAA’s Breach Notification Rule outlines the requirements for assessment and notification. While there are specific federal requirements that outline how to assess, who to notify, and the notification timelines, there may be other state and contractual standards that also apply. Providers are strongly encouraged to familiarize themselves with all applicable requirements and guidance.

15.9.4 Transaction and Code Sets Standards

According to CMS, electronic transactions are activities involving the transfer of healthcare information for specific purposes. The HIPAA regulations have identified certain standard transactions for Electronic Data Interchange (“EDI”) for the transmission of health care data. These transactions include the following:

- Claims and encounter information
- Payment and remittance advice
- Claims status
- Eligibility
- Enrollment and disenrollment
- Referrals and authorizations
- Coordination of benefits
- Premium payment

Providers who engage in one of the identified transactions electronically must comply with the standard for that transaction.

15.10 PRIVACY AND INFORMATION SECURITY RELATED RESOURCE AND WEBSITES

U.S. Department of Health & Human Services- Office of Civil Rights

hhs.gov/hipaa/index.html

Centers for Medicare & Medicaid Services (CMS)

cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/HIPAAAdministrativeSimplificationandACAFAQs.html

California Department of Justice, Office of the Attorney General

oag.ca.gov/privacy

California Department of Health Care Services

dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx

National Committee on Vital and Health Statistics

ncvhs.hhs.gov

National Institutes of Health

privacyruleandresearch.nih.gov

National Institute of Standards and Technology

nist.gov

Centers for Medicare and Medicaid Services Regulations & Guidance

cms.gov/home/regsguidance.asp

16.0 PHARMACY

16.1 OVERVIEW

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 practitioners and pharmacists ability to deliver optimal drug therapy to L.A. Care Members.

L.A. Care utilizes a closed formulary. Prescribing practitioners are requested to prescribe medications included in the formulary whenever possible. Formulary status and applicable utilization management edits such as prior authorization requirements, step-therapy, quality limits, and exceptions for drugs may be found on the L.A. Care website at calmediconnectla.org/providers/resources under the link, "Cal MediConnect Formulary."

16.2 ROLE OF THE PHARMACY BENEFIT MANAGER ("PBM")

L.A. Care contracts with Navitus Health Solutions (Navitus), a pharmacy benefit management vendor, to administer pharmacy benefits for its Members. Prescriptions of covered outpatient drugs may be filled at network pharmacies throughout Los Angeles County that are contracted with Navitus.

16.3 PHARMACY QUALITY AND OVERSIGHT COMMITTEE ("PQOC")

The PQOC Committee is responsible for oversight of the formulary development process administered by the contracted Pharmacy Benefit Manager ("PBM"). The PQOC's role is to review and evaluate new and existing drug therapies and establish formulary placement of these drugs. The PQOC also reviews new medical technologies or new applications of existing technologies and makes associated recommendations for benefit coverage, based on medical necessity.

Additionally, the PQOC provides a peer review forum for L.A. Care's clinical policies, Provider communication strategies, pharmaceutical quality programs/outcomes, and specialty drug distribution options. The PQOC meets quarterly to review the clinical objectives of the pharmacy benefit, including but not limited to the following:

- Formulary and utilization management positions
- Review and approval of policies and procedures
- Evaluation of outcomes for clinical programs
- Recommendations on communications to Providers and Members

L.A. Care encourages prescribing practitioners and pharmacists to provide suggestions and comments for consideration of formulary additions and changes.

Suggestions and comments may be made by completing the L.A. Care "Formulary Drug Review Request Form." This form is found on the L.A. Care website at

lacare.org/providers/provider-resources/pharmacy-services/medication-adherence/list-covered-drugs.

16.4 SUPPLEMENTAL DRUG COVERAGE

Medi-Cal will pay for certain *medically necessary* drugs not covered under Medicare Part D when they are prescribed by a participating licensed practitioner acting within the scope of his or her licensure, are listed on L.A. Care's Drug Formulary, and are filled at a participating pharmacy. Drugs commonly covered under the supplemental drug coverage include, but are not limited to the following:

- Cough/cold medications
- Over-the-counter medications (except for insulin & syringes which are covered by Medicare Part D)
- Prescription vitamins and minerals

16.5 DRUG EXCLUSIONS

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include the following:

- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for erectile dysfunction

16.6 FORMULARY UTILIZATION MANAGEMENT

16.6.1 Prior Authorization

Prior Authorization (“PA”) requirements apply to certain medications to promote appropriate utilization, treatment, and step-therapy protocols, actively “risk manage” drugs with serious side effects and influence the process of managing costs. Drugs with a prior authorization requirement are designated on the formulary with a “PA” indicator.

The PBM processes pharmacy PAs for L.A. Care. The PA criteria and the length of the PA approval follow CMS regulations.

A response from the PBM regarding a PA request may include a notice of action letter in the form of an approval, denial or a request for additional information to make a determination of medical necessity. Expedited PA requests may be made by a prescribing Provider when there is a serious risk to the patient's life, limb or rehabilitation.

Prescribers may access information regarding the formulary and the specific PA criteria and forms online at navitus.com, under the “Prescribers” section, or have Navitus Customer Care fax them to the prescriber's office. Prescribers will need their National Provider Number (“NPI”) to access this portal. Drugs requiring PAs and forms may also be found on the L.A. Care website at calmediconnectla.org/members/part-d-prescription-drugs.

Prescribing Providers may also call Navitus Customer Care at **844.268.9785** for additional information on the coverage determination process for Cal MediConnect Members.

16.6.2 Step-Therapy

Step Therapy is administered to promote the appropriate utilization of certain drugs and to mitigate costs when there are multiple effective drugs to treat a medical condition. Step Therapy drugs are designated on the formulary with an “ST” indicator. Drugs listed as Step Therapy require one or more “prerequisite” first step drugs to be tried before progressing to the second step drug.

When a prescription for a Step Therapy drug is filled at the dispensing pharmacy, the pharmacy benefits claims processor will search past claims for the first step drugs. If medically necessary, a Step Therapy drug can be obtained without first trying the first step drug by submitting a completed PA form with documentation of the medical need for consideration.

Each request will be reviewed on an individual Member need. Procedures and timeframes will follow our PA process. The following basic guidelines are used to authorize a second step drug:

- The use of the first step drug is contraindicated in the patient
- The first step drug is not suited for the present patient care need, and the drug selected is required for patient safety
- The use of the first step drug may provoke an underlying condition, which would be detrimental to patient care

16.6.3 Quantity Limits

L.A. Care has identified a select number of medications that are subject to quantity limits. A quantity limit establishes the maximum amount of medication that L.A. Care will cover within a defined period of time. If a Member has a medical condition that requires a medication quantity that exceeds our limit, a written request on a PA form will be required, with documentation of medical need, for consideration. Procedures and timeframes will follow the PA process.

16.6.4 Non-Formulary Agents

Any generic or proprietary drug name not found in the L.A. Care formulary listing or in published formulary updates will be considered a non-formulary drug. Coverage for non-formulary agents may be requested by a prescribing Provider using the PA process described above. Each request will be reviewed according to individual patient need. Approval will be given if a documented medical need exists. The following basic guidelines are used:

- The use of formulary drugs would be less effective or harmful for the patient
- The patient has failed an appropriate trial of formulary alternatives
- The choices available in the formulary are not suited for the present patient care need, and the drug selected is required for patient safety
- The use of a formulary drug may provoke an underlying condition, which would be detrimental to patient care

To request or submit a PA, and for questions regarding a specific PA request or the PA process, please contact the following:

- **Telephone:**

- a. Navitus Customer Care at **844.268.9785** for Cal MediConnect. Provide all necessary information required.
- b. L.A. Care Health Plan Provider Line at **866.522.2736**, 24 hours a day, 7 days a week, including holidays.

- **Fax:**

- a. Providers may fax fully completed and signed PA forms to Navitus Health Solutions, 24 hours a day, 7 days a week at 855.878.9207 for Cal MediConnect Members.

Navitus will provide an authorization number specific for the medical need for all approved requests. Denied requests may be appealed on behalf of the Member (please see Appeals and Grievance below). The prescriber must provide information to support the appeal on the basis of medical necessity.

16.7 APPEALS AND GRIEVANCES

If a prescribing Provider would like to discuss a decision for a PA denial with a clinical reviewer, please call Navitus Health Solutions at **844.268.9785** for Cal MediConnect..

If you believe that this determination is not correct, you have the right to appeal the decision on behalf of the Member by filing an appeal with L.A. Care. For additional information on appeals on behalf of a Member, please call L.A. Care at **866.522.2736**. You may also submit a copy of the denial notice and a brief explanation of your concern with any other relevant information to the address below or fax it to L.A. Care at 213.438.5748.

L.A. Care Health Plan
Attn: Appeals and Grievance Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017

For questions related to the formulary, prior authorizations, step-therapy, quantity limits, or therapeutic interchange, please call Navitus at **844.268.9785** for Cal MediConnect.

16.8 TRANSITION POLICY

In some cases, we can provide Members with a temporary supply of a drug when the drug is not on the formulary or when use is restricted. This gives Members time to talk with their Provider about a formulary alternative and/or gives Providers time to submit an exception to coverage request.

To receive a temporary supply of a drug, Members must meet the two rules below.

1. The drug the Member has been taking meets any of the following criteria:
 - Is no longer on our Drug List; or
 - Was never on our Drug List; or
 - Is now limited in some way.

2. The Member must be in one of these situations:

- Is new to the plan and does not live in a long-term care facility –
 - o We will cover a supply of the drug one time only during the first 90 days of membership in the plan. This supply will be for an approved month’s supply, or less if the prescription is written for fewer days. Members must fill the prescription at a network pharmacy.
- Is new to the plan and lives in a long-term care facility –
 - o We will cover a supply of the drug during the first 90 days of membership in the plan. This supply will be up to an approved month’s supply consistent with the dispensing increment, or less if your prescription is written for fewer days.

For more information, please contact L.A. Care’s Provider Solution Center at **866.522.2736** 24 hours a day, 7 days a week, including holidays, or visit our website at calmedconnectla.org/members/part-d-prescription-drugs.

16.9 GENERIC SUBSTITUTION

When available, L.A. Care policy, while not precluding or supplanting any State statutes, is that FDA-approved generic drugs are to be used in all situations, unless otherwise specifically indicated. Brand name drugs may be prescribed as a covered benefit; however, Members may be responsible for the cost difference between the brand name drug and the generic substitution.

All drugs that are or become available generically are subject to review for inclusion in the formulary. Drug products approved for generic substitution are reviewed and updated periodically based on the evaluation of clinical literature and available pharmacokinetic principles of the drug products. If a prescribing Provider determines that there is a medical need for the brand name equivalent that is not covered in lieu of an approved formulary generic substitution, a request for coverage may be made using the PA process.

Some changes to the Drug List will happen immediately, for example, when a new generic drug becomes available.

How to Use the Formulary – FDA-approved generic drug product names are presented in lower case letters in the formulary. The common proprietary (branded) name is capitalized next to the generic name in parenthesis. Drugs that come only in brand name formulations are listed by the proprietary (branded) name.

To view a copy of our formulary and for more information about covered brand name and generic equivalent drugs, quantity limits and step-therapy medication list, please go to our website at calmedconnectla.org.

16.10 TIERS/COPAYMENT FOR 2019

Tier 1 – Generic drugs

Tier 2 – Brand drugs

Tier 3 – Non-Medicare prescription drugs

Tier 4 – Non-Medicare over-the-counter (“OTC”) drugs

TIER	Copayment
1	\$0
2	\$0 - \$8.50
3	\$0
4	\$0

16.11 ADDITIONAL PHARMACY SERVICES

16.11.1 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. Starting on May 1st, 2018, mail order service is provided by Kroger Mail Order Pharmacy. Additional information can be found by visiting calmediconnectla.org/members/part-d-prescription-drugs.

Kroger Mail Order Pharmacy accepts new written prescriptions from Members by mail or new prescriptions sent by prescribers directly to Kroger Mail Order Pharmacy by phone or fax at the following numbers:

- Kroger Mail Order Pharmacy Fax: **1-800-723-9023**
- Kroger Mail Order Pharmacy Telephone: **1-800-552-6694**
- Kroger Mail Order Mailing Address:

(Via USPS)
PPS Prescription Services
P.O. Box 2718
Portland, OR 97208-2718

(Via FedEx/UPS)
3500 SE 26th Ave.
Portland, OR 97202

Prescriptions will arrive in 14 days.

Please remember to write up to a 90 day-supply with valid instructions and refills for prescriptions. We recommend a 30-day supplemental prescription that may be filled at a retail pharmacy to ensure Members have medication while the initial order is being processed.

If our Cal MediConnect Members need mail order registration forms, please contact the L.A. Care Provider Line at **866.522.2736** or visit our website at calmediconnectla.org/members/part-d-prescription-drugs for more information.

16.11.2 Medication Therapy Management Programs

L.A. Care is making strides towards identifying and improving adherence among Cal MediConnect Members with chronic medications such as those for diabetes, cholesterol, and/or hypertension. Along with direct outreach to Members, L.A. Care is also distributing, via Navitus, Prescriber Scorecards to Providers prescribing these therapies. A letter and supplemental table offer details regarding medication adherence of all Members under a respective Provider's care. This data is derived from frequency of medication claims processed by the Member's pharmacy. With this information, Providers are able to quickly identify L.A. Care Members that may need additional counseling in continuing with regular administration of their chronic medications. It is only with the involvement of Providers in this initiative that L.A. Care can work towards truly improving the well-being and quality of care for all Cal MediConnect Members.

16.11.3 Medication Therapy Management Programs

L.A. Care Cal MediConnect Plan has contracted with SinfoniaRx® to offer Medication Therapy Management (“MTM”) services to all L.A. Care Cal MediConnect Plan Members who meet specific criteria. We hope you will encourage your patients to utilize the MTM program so that we can help manage their medications. Participation is voluntary and the service provided is free of charge.

To qualify for L.A. Care Cal MediConnect’s MTM program, Members must meet ALL of the following criteria:

- 1) 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-Asthma
 - Respiratory Disease-Chronic Obstructive Pulmonary Disease (“COPD”)
 - Hepatitis C
- 2) Take at least eight (8) covered Part D medications.
- 3) Are likely to have medication costs of covered Part D medications greater than \$4,044 per year.

For questions regarding our MTM program, please contact L.A. Care’s Provider Solution Center at **866.522.2736** or visit our website at calmediconnectla.org/members/part-d-prescription-drugs.

16.11.4 Opioid Overutilization Monitoring

As part of its clinical programs, opioid overutilization is reviewed by L.A. Care and Navitus to reduce potentially inappropriate and harmful use. Patient specific reports are generated when criteria are met during a predefined time period, and the reports are supplied to the appropriate Providers.

The information shared with Providers enables clinical interventions deemed necessary by the Provider to address opioid overutilization. Additionally, the program implements improved Drug Utilization Review (“DUR”) controls including the following:

- Safety controls at the pharmacy during dispensing (e.g. preventing unsafe daily doses of acetaminophen and opioids, identifying members who have had a concomitant fill of an opioid and benzodiazepine medication)
- Improved use of formulary management (e.g. step therapy, quantity limits)
- Concurrent and retrospective DUR programs and case management

Beginning in 2019, L.A. Care will implement a new drug management program (“DMP”) called the Opioid Home Program for our Cal MediConnect Members. Potential at-risk Members are identified when the following opioid overutilization criteria are met:

- The Member has received prescriptions for opioid medications with an average daily morphine milligram equivalent (“MME”) greater than or equal to ninety (90) mg for any duration during the most recent six (6) months; AND
- One of the following:
 - o The Member received prescriptions for opioid medications from three (3) or more providers within the past six (6) months AND filled prescriptions for opioid medications at three (3) or more pharmacies within the past six (6) months, OR
 - o The Member received prescriptions for opioid medications from five (5) or more providers within the past six (6) months.

After case management review by L.A. Care clinical staff, which includes outreach to the Member’s opioid prescribing Provider(s) to obtain clinical information, the Member will be locked into a Pharmacy Home and/or Provider Home if he or she is determined to be an At-risk Member. An agreement is required with the pharmacy and prescriber before locking the Member into his or her Pharmacy Home and/or Provider Home. The Member will receive all opioid or benzodiazepine medications from his or her Pharmacy Home and/or Provider Home for a duration of 12 months. Members will receive a letter explaining the limitations in advance. The DMP may not apply if the Member:

- Has certain medical conditions, such as cancer; or
- Is getting hospice care; or
- Lives in a long-term care facility.

Also starting January 1, 2019, various opioid point-of-sale (“POS”) Drug Utilization Review safety edits will be put into place in order to further help prevent and combat prescription opioid overuse, such as the following:

- Morphine Milligram Equivalent, also referred to as “Care Coordination Edit.”
- Concurrent Use of Opioids and Benzodiazepines.
- Long-Acting Opioid Duplicate Therapy.
- Initial Opioid Fill, which limits an opioid prescription for opioid-naïve Member to a 7-day supply.

Proactive steps to minimize disruption:

- Submit Prior Authorization (PA)/Coverage Determination (CD) for chronic pain patients.
- Educate patients and staff regarding new opioid safety measures.
- Communicate with dispensing pharmacists, as needed, for the care coordination edit.

16.12 E-PRESCRIBING/ELECTRONIC HEALTH RECORDS

L.A. Care strongly encourages all prescribing practitioners to adopt e-prescribing and electronic health records. E-prescribing allows Providers to do the following:

- Enhance formulary compliance
- Verify alternatives and generic substitutions
- Check drug quantity limits
- Avoid drug-drug interactions/medication errors
- Improve patient safety (reduce adverse drug events)

Please visit the HITEC-LA website at hitecla.org for information to assist with adopting E-Prescribing/EHRs.

16.13 PHARMACY LOCATIONS

16.13.1 Improving Member health and providing the best possible service and convenient access to safe and cost-effective medication is important to L.A. Care. A large number of pharmacies are available to Members across Los Angeles County. The network includes most major chain drug stores, retailers, grocers and community pharmacies. To search the pharmacy network, please visit calmediconnectla.org/members/pharmacy-locator.

Physicians and pharmacies are highly encouraged to direct any suggestions, comments, or formulary additions to L.A. Care via email to Pharmacyandformulary@lacare.org or by mail to the following address:

L.A. Care Health Plan
ATTENTION: Senior Director, Enterprise Pharmacy
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

17.0 MANAGED LONG TERM SERVICES AND SUPPORTS (“MLTSS”)

17.1 MLTSS OVERVIEW

MLTSS refers to a wide range of services that support Members living independently in the community. This includes In-Home Supportive Services (“IHSS”), Community-Based Adult Services (“CBAS”), Multipurpose Senior Services Program (“MSSP”), and Long Term Care (“LTC”) provided in skilled nursing facilities. A more detailed description of these programs is in the following sections.

L.A. Care is responsible for coordinating access to and overseeing MLTSS services for Members. L.A. Care’s MLTSS Department uses a Member-centered care model designed to help Members find the right combination of services to help them reside safely in their homes or in a long term care facility. The MLTSS Department also works closely with L.A. Care’s Social Services Department who assists with referrals to community-based services to assist Members achieve this goal.

L.A. Care’s MLTSS Department contact information is as follows:

- Email MLTSS@lacare.org
- Call 855.427.1223
- Fax 213.438.4866

(Please note: ALL emails containing member PHI must be securely encrypted.)

Managed Long Term Services and Supports: A Resource for Physicians

L.A. Care’s MLTSS Department serves as an important resource for Members and their physicians. Physicians should contact the MLTSS Department when they identify a Member who meets any of the following criteria:

- Qualifies for nursing home placement, but wants to stay home
- Has a condition that indicates a possible need for MLTSS in the future
- Needs social supports or caregiver support
- Needs assistance with Activities of Daily Living (“ADLs”) such as walking, bathing, dressing, toileting, brushing teeth, and eating
- Needs assistance with Instrumental Activities of Daily Living (“IADLs”) such as cooking, driving, using the phone or computer, shopping, keeping track of finances, and managing medication
- Receives MLTSS services, but has unmet needs
- Experiences difficulty with a particular MLTSS service
- Is preparing to transition into long term care *or* from long term care into the community

L.A. Care's MLTSS Department provides a variety of support and expertise to Members and their physicians, including, but not limited to:

- Assisting Members in finding the right combination of services through assessment and staff expertise
- Coordinating access to MLTSS services, including both L.A. Care benefits and community services and supports
- Providing oversight and education of MLTSS services
- Acting as MLTSS subject matter experts on care teams
- Facilitating participation of MLTSS Providers on care teams
- Working with MLTSS organizations to design and implement system and process improvements

17.2 IN-HOME SUPPORTIVE SERVICES (“IHSS”)

IHSS is a state entitlement program that pays for homecare services enabling seniors and individuals with disabilities (including children) to remain safely in their own homes and avoid institutionalization. Members who qualify hire their own IHSS caregiver to assist with personal care services, including the following:

- Bathing, grooming, dressing, and feeding
- Domestic services (e.g. cooking, house cleaning, and laundry)
- Protective supervision for individuals with mental impairment
- Paramedical services such as assistance with medications and bowel and bladder care
- Other services such as accompaniment to medical appointments

To qualify for IHSS, a Member must be a legal resident of California, living in his/her own home, receiving (or eligible to receive) Supplemental Security Income/State Supplemental Payment (“SSI/SSP”) or Medi-Cal benefits, and 65 years of age or older, legally blind, or disabled by Social Security standards. The Member must also submit a Health Care Certification Form (SOC 873) signed by a licensed health care professional indicating that they need assistance to stay living at home. This form is provided to Members when they begin the application process.

17.2.1 Accessing IHSS

IHSS Program eligibility and service authorizations are determined by the Los Angeles County Department of Public Social Services (“DPSS”). Once approved for services, a Member is responsible for hiring, training and supervising the IHSS caregiver. L.A. Care can assist Members with the following:

- Coordinating and navigating the IHSS assessment and re-assessment process
- Connecting the Member to resources that can assist with locating a homecare worker
- Resolving IHSS-related issues
- Navigating the DPSS grievance and appeals processes
- Coordinating IHSS benefits with other health plan benefits

Physicians may refer Members to either the L.A. County IHSS Application Hotline at **888.944.4477** or to L.A. Care's MLTSS Department at **855.427.1223**. The physician may also assist with completion of required IHSS forms and provide Members with other documentation to support their need for IHSS. Members who have questions about their IHSS may also be referred to the MLTSS Department for assistance.

17.3 COMMUNITY BASED ADULT SERVICES ("CBAS")

CBAS is a facility-based program that Members can attend during the day for assistance with their daily needs. CBAS centers provide core services such as the following:

- Skilled nursing and medication management
- Social services
- Physical, occupational, and speech therapies
- Personal care
- Family/caregiver training and support

CBAS centers also provide mental health/psychiatric services, registered dietitian services, meals, and transportation to and from a Member's residence.

To qualify for CBAS, Members must be over 18 years of age and certified for nursing home placement or have other specialized disabilities or health conditions, such as organic, acquired, or traumatic brain injury, chronic mental illness, Alzheimer's disease, mild cognitive impairment, dementia, or a developmental disability.

17.3.1 Accessing CBAS Services

Members must be assessed for program eligibility using the state mandated CBAS Eligibility Determination Tool ("CEDT"). To request a CEDT assessment, the Member should be referred to a CBAS center of their choice. Alternately, the PCP or Member may also contact the MLTSS Department at **855.427.1223**. A MLTSS Nurse Specialist will contact the Member, discuss the service and provide a list of CBAS centers near the Member's home. CBAS services must be ordered by the Member's PCP. The CBAS center will request a medical history and physical and an order for CBAS from the Member's PCP required for program enrollment.

17.4 MULTIPURPOSE SENIOR SERVICES PROGRAM ("MSSP")

MSSP is a Medi-Cal 1915 (c) Home and Community-Based Waiver Program. Local MSSP sites provide social and health care management for frail elderly Members who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail Members. Members eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and be certified or certifiable for placement in a nursing facility.

Services provided by MSSP include: adult day care / support center, housing assistance, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services.

MLTSS staff will also work with Members who do not meet MSSP eligibility requirements and their care teams to identify alternative services.

17.4.1 Accessing MSSP Services

L.A. Care contracts with six (6) MSSP Providers who are responsible for determining program eligibility. If a Member is eligible, but placed on a wait list due to the limited amount of slots available under the waiver, the MLTSS Department will work with the Member, MSSP Provider, and other community-based Providers to ensure the Member receives assistance via other services and programs.

A physician who believes a Member might benefit from MSSP services should refer the Member to L.A. Care's MLTSS Department.

17.6 LONG TERM CARE ("LTC")

LTC is the provision of medical, social and personal care services in either an institution or private home. Most LTC services are provided in skilled nursing facilities ("SNFs"). The primary purpose of LTC is to assist the Member in activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparing special diets and supervision of medication that can usually be self-administered.

To qualify for LTC, Members must meet all of the following criteria:

- Be a Medi-Cal beneficiary;
- Require 24-hour long or short-term medical care; and
- Eligible to receive services in a Skilled Nursing Facility.

Additional criteria for LTC may be found in state regulations under Title 22, CCR, Section 51335.

17.6.1 Accessing LTC

Referrals for LTC can come from a PCP, Discharge Planner, Family Caregiver or Interdisciplinary Care Team ("ICT"). A PCP who believes a Member needs LTC should write an order to admit under Custodial Level of Care and must include a completed LTC Custodial Referral Form and submit it to L.A. Care's Utilization Management Department for review. This form can be accessed on the Provider Portal at calmediconnectla.org/providers/resources.

Once the LTC referral and physician order for Custodial Care have been received, L.A. Care will notify the referral source of the LTC referral outcome within five (5) business days for routine situations and 72 hours for urgent situations.

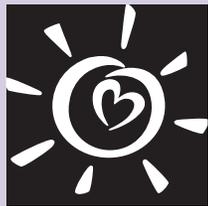
L.A. Care's MLTSS Department assists Members with LTC by monitoring Member progress, assisting with transitions outside of LTC, and coordinating LTC services with other health plan benefits. L.A. Care's LTC Nurse Specialist will support the assigned physician with facilitation and coordination of care needs. L.A. Care's LTC Nurse Specialist will also conduct regular onsite or telephonic clinical review of Members in Skilled Nursing Facilities.

17.7 CARE PLAN OPTIONS (“CPO”)

Under Cal Medi-Connect, LA Care may offer CPO services to Members with the goals of helping to keep them safely in his or her own community, thereby preventing costly and unnecessary hospitalization or prolonged care in institutional settings.

Care Plan Option services are those long term services and supports or home and community-based services that might be delivered under a waiver including, for example, respite care (both in-home and out of home), additional personal care, chore type services, habilitation nutrition, home maintenance, minor home or environment adaptation and other services which could include Personal Emergency Response systems (“PERS”), assistive technology, and in-home skilled nursing care.

CPO services are designed to be provided in addition to, and not in lieu of required benefits, which includes CBAS, IHSS, MSSP and LTC.



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