



**L.A. CARE HEALTH PLAN
L.A. CARE COVERED™**

**PROVIDER MANUAL
2014**

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1.0 L.A. CARE

1.1 GENERAL INTRODUCTION

Committed to the promotion of accessible, high quality health care, L.A. Care Health Plan is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. With more than 1.2 million members in five product lines, L.A. Care is the nation's largest publicly operated health plan.

About this Provider Manual

This Provider Manual was specifically developed for providers participating in L.A. Care Health Plan's Covered California plans – called **L.A. Care Covered™**. This is L.A. Care's first "commercial" line of business, and one of six (6) Qualified Health Plans (QHPs) in Los Angeles County (region 15 & 16) certified by Covered California for participation in the 2014 Marketplace. L.A. Care Covered™ is offering benefit plans in all Metal Levels and the Minimum Coverage Plan (formerly the "Catastrophic Plan") in the Individual Marketplace. L.A. Care is not participating in the Small Business Health Option Program (SHOP) Marketplace.

This Provider Manual specifies eligibility and enrollment criteria that are unique to Covered California enrollees, as well as other specific Covered California requirements. Please note that the "Marketplace" and "Covered California" are used interchangeably throughout this Manual. Also contained in this Manual is general information, about such topics as credentialing and financial requirements that are applicable to other L.A. Care direct lines of business.

L.A. Care Covered™ must be re-certified by Covered California annually for continued participation in the Marketplace. Accordingly, this Provider Manual will be updated as needed to comply with re-certification requirements, or as otherwise required to comply with all contract, statutory and regulatory requirements.

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.

Responsibility of Participating Providers

L.A. Care Health Plan (L.A. Care) requires that its contracted medical groups, hospitals, ancillary providers and other Participating Physician Groups (PPGs) fulfill specified responsibilities. There is a segment entitled "Responsibility of Participating Providers" at the beginning of most sections of this manual that clarifies what functions, if any, are the responsibility of L.A. Care's contracted providers. Please read each of these sections carefully in order to determine what functions are the responsibilities of L.A. Care, and which are the responsibility of PPGs, hospitals, ancillary providers, or other participating providers.

Essential Community Providers

L.A. Care is required to maintain a network that includes a sufficient geographic distribution of essential community providers (“ECP”) that are available to provide reasonable and timely access to covered services to low-income populations in each geographic region where L.A. Care is certified as a Qualified Health Plan by Covered California. L.A. Care also encourages PPGs to contract with ECP providers for services for which it is responsible to the fullest extent possible.

For purposes of this Section, “sufficient geographic distribution” of ECPs is determined by Covered California based on a consideration of various factors, including:

- (i) the nature, type and distribution of L.A. Care’s ECP contracting arrangements;
- (ii) the balance of hospital and non-hospital ECPs in each geographic region
- (iii) the inclusion of at least 15% of entities in each applicable geographic region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) (“340B Entity”);
- (iv) the inclusion of at least one ECP hospital in each region;
- (v) the inclusion of Federally Qualified Health Centers, school-based health centers and county hospitals; and
- (vi) other factors as mutually agreed upon by Covered California and L.A. Care regarding the Plan’s ability to serve the low income population.

“Low-income populations” are defined as families living at or below 200% of Federal poverty level. ECPs must consist of participating entities in the following programs, or as may be revised by Covered California from time to time:

- (i) 340B participating entities, per the providers list as of November 9, 2012;
- (ii) California Disproportionate Share Hospital Program (DSH), per the Final DSH Eligibility List FY (CA DHCS 2011-12);
- (iii) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs;
- (iv) Community Clinic or health centers licensed as either a “community clinic” or “free clinic”, by the State under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code Section 1206; and
- (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program.

L.A. Care Enrollment Assistance Line

- If you have patients that you believe may be eligible for L.A. Care Covered[™], please refer them to L.A. Care at **1-855-222-4239**. TTY/TDD users should call **1-855-825-3166**.

1.2 L.A. CARE COVERED™ PLANS

“Marketplace” plans are part of the Patient Protection and Affordable Care Act (ACA) (also called Obamacare”), which was signed into law on March 23, 2010. ACA was designed to:

- Increase health care coverage
- Reduce health care cost and improve affordability
- Improve people’s health

Other health care improvements provided through ACA include the following:

- Guaranteed Coverage
- Standardized Benefits
- No Annual limits, no denial for pre-existing conditions
- Rates are not based on your health status
- Must provide coverage for dependent children up to age 26

“Marketplaces” are described as *“Virtual shopping malls where individuals/families and employers can purchase affordable health insurance.”*

California’s Health Insurance Marketplace, “**Covered California**” at www.coveredca.com, is a State-based, non-profit entity financed by fees levied on participating health plans. The goal of the Marketplace is to promote transparency, competition, price, and quality.

Covered California’s mission is to, *“Increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.”*

Covered California adopted the “triple aim” of achieving the following:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue the three dimensions of the “Triple Aim.”

Multiple Covered California insurance plans are offered in Los Angeles County. **L.A. Care Covered™** is the product name for the “Marketplace” plans offered by L.A. Care.

1.3 L.A. CARE DEPARTMENTAL CONTACT LIST

DEPARTMENT	NAME	EXTENSION
Capitation	Director	4236
Case Management	Case Management Nurse	Call: 1-877- 431-2273; Fax: 1-213-438-5034
Claims	Director For all claims for which L.A. Care is responsible, please mail to: L.A. Care Health Plan Attn: Claims Dept. P.O. Box 811580 Los Angeles, CA 90081	5727
Commercial & Group Plan Operations	Director	4187
Communications	Director	4142
Cultural & Linguistic Services	Director	4559
Eligibility Verification	Provider Information Line	1-866-LA-CARE6 1-866-522-2736
Encounter Data	Provider Information Line	1-866-LA-CARE6 1-866-522-2736
Health Education	Director	4559
Health Education	Manager	4524
Medical Management	Senior Director, Medical Management	4427
Medical Management	Director, Medical Management	4650
Medical Management	Manager, Utilization Management	4649
Member Services	Member Service Department	1-888-839-9909
Pharmacy	Director	4251
Prior Authorizations/ HOSPITAL ADMISSIONS	TOLL-FREE: 1-877-431-2273 FAX: (213) 438-5777 PPGs not delegated for extended Medical Management/Concurrent Review - L.A. Care Medical Management	

	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 (431-2273) FAX: (213) 438-5777	
Provider Credentialing, Performance and Certification	Director	4026
Provider Network Operations	Sr. Director Provider Network Operations	5730
Provider Relations	Manager	4138
Provider Information/Data Issues	Provider Information Line	1-866-LA-CARE6 1-866-522-2736
Provider Network Research & Analysis	Manager	4263
Quality Improvement	Sr. Director Quality Improvement	5744
Quality Improvement	Manager of Quality Improvement	4391
Regulatory Auditing & Compliance	Compliance Officer	4292
Sales & Marketing	Director	4575

Behavioral Health Hotline 877-344-2858

www.lacare.org/providers/resources/mentalhealth

L.A. Care Nurse Advice Line: 1-800-249-3619

24/7 Free Health Advice

Well Child Assessment Forms: L.A. Care Website

www.lacare.org/providers/resources/stayinghealthyforms

Health Education Services: 1-855-856-6943

<http://www.lacare.org/providers/resources/healtheducation>

Case Management: 1-877-431-2273

www.lacare.org/providers/commonquestions

Disease Management Programs: 1-800 LA-CARE6 or 1-866-522-2736

www.lacare.org/providers/commonquestions/qualityimprovementprogram

Clinical Practice Guidelines: L.A. Care Website

www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines

Preventive Health Guidelines: L.A. Care Website

www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines

1.4 GLOSSARY OF TERMS

ACRONYM OR WORD(s)	DEFINITION
AAP	American Academy of Pediatrics
ACA	The Patient Protection and Affordable Care Act (ACA). A law that provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act will expand access to high-quality affordable insurance and health care.
Advance Premium Tax Credits (APTC)	The payment of the tax credits authorized by 26 U.S.C. 26B and its implementing regulations, which are provided on an advance basis, to an individual enrolled in a Qualified Health Plan through Covered California in accordance with Section 1412 of the Affordable Care Act.
Ancillary Service	The following services are considered ancillary: ambulance transportation; durable medical equipment (DME) including but not limited to apnea monitor, artificial limbs, and hearing aids; home health care; prosthetic and orthodontic devices; and skilled nursing facilities.
BOG	Board of Governors

CalFresh Program	<p>The CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP), is a state program designed to put healthy and nutritious food on the table. The program issues monthly electronic benefits that can be used to buy most foods at many markets and food stores.</p> <p>The CalFresh Program helps to improve the health and well-being of qualified households and individuals by providing them a means to meet their nutritional needs.</p>
(CalHEERS)	<p>A project jointly sponsored by the California Marketplace and the Department of Health Care Services, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding the Marketplace and other State health care programs and assist Enrollees in the selection of a health plan. This is the “system of record” for all Covered California enrollees.</p>
CalWORKS Program	<p>A welfare program that gives cash aid and services to eligible and needy California families. The program serves all 58 counties in the state and is operated locally by county welfare departments. If a family has little or no cash and needs housing, food, utilities, clothing or medical care, they may be eligible to receive immediate short-term help. Families that apply and qualify for ongoing assistance receive money each month to help pay for housing, food and other necessary expenses</p>
CAP	Corrective Action Plans
CCS	<p>California Children’s Services – This program provides health care services to children with certain physical limitations and diseases whose families cannot afford all or part of the care</p>
Coinsurance	<p>A percentage of allowable charges that members must pay when covered services are received from a participating provider</p>

Co-payment	The amount a member is required to pay for certain covered services after meeting any applicable deductible
Cost-Sharing Subsidies	(Also called Cost-Sharing Reductions) the reductions in cost sharing for an eligible individual enrolled in a silver level plan through Covered California or for certain Native American Indians or Alaskan Natives enrolled in a Qualified Health Plan through Covered California.
Covered California	The California Health Benefit Marketplace, doing business as Covered California and an independent entity within the Government of the State of California
DDS	Developmental Disability Services
DMHC	Department of Managed Health Care
DOFR	Division of Financial Responsibility
Eligible/Eligibility	To meet certain requirements, in order to take part in or receive program benefits
Enrollment	The act of beginning participation in a benefit plan like L.A. Care Covered™
Essential Health Benefits (EHB)	Health care service categories that must be covered by certain plans and all Medicaid state plans starting in 2014. Health Plans must cover these benefits in order to be certified and offered in the Marketplace under contract with Covered California

Federal Poverty Level (FPL)	A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used by both government and private organizations to determine eligibility for certain programs and benefits. Covered California uses this measure to determine if you and your Enrolled Dependent(s), if any, qualify for a federal tax credit (which reduces your monthly premium) or for a federal cost-sharing subsidy (which reduces your cost-sharing out-of-pocket costs).
Grace Period	A specified time following the premium due date during which coverage remains in force and an Enrollee or Employer or other authorized person or entity may pay the premium without penalty
Habilitative Services	Medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment
HEDIS	Healthcare Effectiveness Data and Information Set
IBNR	Incurred But Not Reported
IPA	Independent Practice Association
L.A. Care	L.A. Care Health Plan (Local Initiative Health Authority for Los Angeles County)
L.A. Care Covered TM	The product name for the "Marketplace" plans offered by L.A.Care
MOU	Memorandum of Understanding
MRMIB	Managed Risk Medical Insurance Board
NCQA	National Committee for Quality Assurance

NAL	Nurse Advice Line
Open Enrollment Period	A designated period of time each year – usually a few months – during which insured individuals and their Enrolled Dependent(s) can make changes in health insurance coverage.
PCP	Primary Care Provider
PNRA	Provider Network Research & Analysis Unit
Premium	The monthly fee that an Enrollee (Member) must pay to L.A. Care for health coverage
QHP	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.
SED	Severely Emotionally Disturbed

1.5 WEB SITE INFORMATION AVAILABLE TO PROVIDERS

L.A. Care has information about many different topics that might be helpful to you on our Web site. It is a useful way to get information about L.A. Care and its processes. Please visit our provider Web site at www.lacare.org for information about L.A. Care's:

- Quality Improvement Program, including goals, processes and outcomes related to care and services
- Policy encouraging practitioners to freely communicate with patients about their treatment, including medication treatment options, regardless of benefit options
- Requirement that practitioners and facilities cooperate with QI activities; provide access to their medical records to the extent permitted by state and federal law; maintain confidentiality of member information and records; and allow L.A. Care to use performance data for quality improvement activities and public reporting to consumers
- Policy on notification of specialist termination
- Access standards
- Case Management services and how to refer patients
- Health education services and how to refer patients
- Disease Management Program information and how to refer patients
- Coordination of benefits
- Care services to members with special needs.
- Clinical Practice Guidelines, including ADHD and Depression
- Preventive Health Guidelines
- Medical record documentation standards; policies regarding confidentiality of medical records; policies for an organized medical record keeping system; standards for the availability of medical records at the practice site; and performance goals
- Utilization Management Medical Necessity Criteria including how to obtain or view a copy
- Policy prohibiting financial incentives for Medical Management decision-makers
- Instructions on how to contact staff if you have questions about Medical Management processes and the toll free number to call
- Instructions for triaging inbound calls specific to Medical Management cases/issues
- Availability of, and the process for, contacting a peer reviewer to discuss Medical Management decisions
- Policy on denial notices
- Policy regarding the appeals notification process
- Pharmaceutical management procedures and lists of pharmaceuticals included in the benefit plan

- Policy regarding your rights during the credentialing/recredentialing process including to review information and correct erroneous information submitted to support your credentialing application, as well as obtain information about the status of your application; and how to exercise these rights
- Member's Rights and Responsibilities
- Web-based Provider and Hospital Directory

If you would like paper copies of any of the information available on the website, please contact us at **1-866-LA-CARE6 (1-866-522-2736)**.

1.6 NOTICE TO PROVIDERS

L.A. Care has recently amended practitioner and provider contracts to encourage practitioners to freely communicate with patients about their treatment, including medication treatment options, regardless of benefit coverage limitations; and to require that practitioners and facilities:

- Cooperate with L.A. Care Quality Improvement activities
- Provide L.A. Care access to practitioner or facility medical records, to the extent permitted by state and federal law
- Maintain the confidentiality of member information and records
- Provider groups and practitioners will allow L.A. Care to use practitioner performance data for activities of the Health plan including, but not limited to, Quality Improvement activities, public reporting to consumers, preferred status designation in the networks, and reduced Member cost sharing.

The contract amendment also requires specialists and specialty group practices to provide timely notification to L.A. Care's members, who have been under the ongoing care of the terminating specialist, or an entire specialty group. Our contracts with specialists and specialty group practices outline which party is responsible for notifying those members affected by the termination prior to the effective date of termination. L.A. Care holds responsibility for notifying members affected by a termination of a provider unless this function is delegated by contract. You can find additional information regarding notification of specialist termination on L.A. Care's website at www.lacare.org.

If you would like paper copies of any of the above information, please contact us at **1-866-LA-CARE6 (1-866-522-2736)**.

2.0 MEMBERSHIP AND MEMBERSHIP SERVICES

This section covers membership and Member Services for L.A. Care Covered™. Topics include eligibility, enrollment and disenrollment, primary care provider assignment, and member rights and responsibilities.

2.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs) in the L.A. Care Covered™ network are responsible for adhering to the Member Services provisions and guidelines specified in this section.

L.A. Care Covered™ and its participating providers and vendors must not discriminate against an individual regarding eligibility or services in accordance with the Affordable Care Act Section 1557 (42 U.S.C. 18116), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*), the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or any other applicable State and Federal laws.

2.2 PLAN ELIGIBILITY

All subscribers who are determined eligible by the Marketplace, California Covered, can be enrolled in L.A. Care Covered™.

Some 780,000 individuals are subsidy eligible in L.A. County. L.A. Care Covered™ eligibility requirements are the following:

- U.S. Citizen or Lawfully Present Resident
- California Resident
- Household income above 100% of FPL
 - Financial assistance 100% - 400% FPL
 - Cannot be eligible for public coverage (i.e. Medi-Cal)
- Cannot have employer coverage unless
 - Person's share of premium exceeds 9.5% of household income
 - Coverage does not have an actuarial value of at least 60%

Any eligible person may purchase health care coverage through Covered California. People with incomes up to 400% of the Federal Poverty level (FPL) qualify for premium subsidy:

Are these 2014 Guidelines?

Family Size		Medi-Cal	Covered CA Premium Assistance
Income Level		0% – 138%	Up to 400% FPL
Adults	Individual	\$0 - \$15,856	\$15,857 – \$45,960

	Family of 4	\$0 – \$32,499	\$32,500 – \$94,200
Income Level		0% – 250%	Up to 400% FPL
Children	Individual	\$0 – \$28,725	\$28,726 – \$45,960
	Family of 4	\$0 – \$58,875	<ul style="list-style-type: none"> • \$94,200 Applicants have the right to appeal any: <ul style="list-style-type: none"> ○ Eligibility determination and redeterminations including timeliness of the determination ○ Determination of the amount of the premium assistance or cost-sharing reduction ○ Eligibility determination for an exemption to the requirement to have health insurance • Notice of appeal rights and instructions on how to file are included in any notice • Applicant or Enrollee can request an appeal within 90 days of the notice of eligibility determination • Covered California has 90 calendar days from the date of the appeal submission to settle the appeal

Eligibility is determined by the Marketplace via a streamlined process that requires less documentation and enables electronic verification using the CalHEERS system.

Eligibility timeframes are:

- Immediate if online and can be verified
- Within 10 calendar days from the date the Marketplace receives a paper application
- Written notification of determination within 5 business days
- For incomplete applications, applicants will have 90 calendar days from the date of the notice, or until the end of an enrollment period, whichever date is earlier, to provide the information needed to complete the application to the Marketplace

Eligibility Redetermination

Eligibility Redeterminations by Covered CA may happen if the following event(s) occur:

- New information reported by Enrollee or through semi-annual data matching process
- Reportable “Defined Life Events”

Defined life events, also known as special qualifying events, include the following:

- A qualified individual or dependent loses Minimum Essential Coverage (MEC)
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
- An individual who was not previously a citizen, a national, or a lawfully present individual gains such status
- A qualified individual's enrollment or non-enrollment in a Covered California Health Plan is unintentional, inadvertent or erroneous
- An Enrollee adequately demonstrates to Covered California that the Covered California Health Plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Enrollee
- An individual is determined newly eligible or newly ineligible for premium assistance or has a change in eligibility for a Cost Sharing Reduction, regardless of whether the individual is already enrolled in a Covered California Health Plan
- individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value
- A qualified individual or Enrollee gains access to Covered California Health Plans as a result of a permanent move

Individuals must enroll **within 60 days** of the life event.

In addition, an Annual Eligibility Redetermination by Covered CA occurs according to the following:

- Enrollee authorization to obtain tax information
- Pre-populated annual redetermination notice provided to Enrollee for validation

Eligibility Appeals

Applicants who are denied eligibility have the right to appeal. Please refer to Section 5.27 for the Appeals process.

Special Eligibility and Cost-sharing Standards for American Indians and Alaska Natives

There are special eligibility standards for American Indians and Alaska Natives under the Affordable Care Act. The Indian Health Care Improvement Act includes Native Americans and Alaskan Natives in its definition. The term applies to any individual who:

- Is a member of a federally recognized tribe by the United States Bureau of Indian Affairs (BIA) in the U.S. Department of the Interior
- First or second descendants of tribe members as described in the point above
- An Eskimo or Aleut or other Alaska Native
- Is considered by the Secretary of the Interior to be an Indian for any purpose
- Is determined to be an Indian by the Secretary of Health, Education and Welfare in collaboration with the Department of Health and Human Services

American Indians and Alaska Natives do not have to pay co-pays or cost-sharing if they:

- Expect to have a household income that does not exceed 300 percent of FPL for the benefit year for which coverage is requested
- Enroll in a Covered California Health Plan

If enrolled in a Covered California Health Plan, any cost sharing is eliminated if a service is provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contracted health services.

Exemptions, Enrollment Periods and Verification of Status

- American Indians and Alaska Natives are exempt from Individual Mandate penalties.
- American Indians and Alaska Natives may enroll outside of Open Enrollment periods and may change their coverage once a month.
- If an applicant attests that he or she is an American Indian or Alaska Native (or others as defined above), Covered California must verify status by verifying the attestation against available data sources.
- If data sources are not available or not reasonably compatible with the attestation, Covered California will notify the applicant. The applicant has 90 days to provide documentation. While this is happening, Covered California moves ahead with application and eligibility processing. If status can't be verified, Covered California uses the information provided by the applicant to make a decision about eligibility.

2.3 CONDITIONS OF ENROLLMENT

L.A. Care will enroll all subscribers referred by Covered California, or its contractor, on the specified date. Through a new enrollee welcome letter, L.A. Care will notify the enrollee of his/her enrollment status and effective date of coverage, pending receipt of the full premium payment. The enrollee will not be effectuated with L.A. Care Health Plan until first full (“binder”) payment is received. Once the binder payment is received by L.A. Care, the member will be sent a new ID card and Welcome Packet.

2.4 MEMBER ENROLLMENT, ASSIGNMENT AND DISENROLLMENT

Covered California has a single, streamlined application to make it easy for eligible consumers to apply and enroll. The application is designed to both determine eligibility and collect the information necessary to:

- Purchase an L.A. Care CoveredTM plan, a Covered California health plan, at full cost
- Purchase an L.A. Care CoveredTM plan, a Covered California health plan, and qualify for premium assistance and Cost-Sharing Reductions (CSR, or cost-sharing subsidies)
- Enroll in Medi-Cal

The online application guides consumers through the eligibility process and determines all of their options. Consumers can complete applications themselves or work with a Certified Enrollment Counselor or Certified Insurance Agent.

The online application is the single, streamlined eligibility and enrollment system for all products and programs available through Covered California. The application is set up so that consumers input basic eligibility information. The application then shows the Covered California health plan options in which the applicant is eligible.

As part of the application and eligibility determination process, consumers will learn if they are eligible for a Covered California plan at full cost, a Covered California plan with premium assistance, CSR or Medi-Cal. Individuals interested in applying for L.A. Care CoveredTM plans can enroll and obtain free application assistance through the following resources:

1. Internet: www.coveredca.com
2. Phone:
 - L.A. Care Covered Plan Based Enroller (PBE) at (855) 222-4239.
 - Open Enrollment Extended Hours – 8 a.m. to 8 p.m. M-F and 8 a.m. to 6 p.m. Saturday
 - Interpretation services are available for more than 300 languages
 - Covered California Customer Call Center at (800) 300-1506.
 - Open Enrollment Extended Hours – 8 a.m. to 8 p.m. M-F and 8 a.m. to 6 p.m. Saturday
 - Closed on State holiday schedule: <http://www.calhr.ca.gov/employees/pages/state-holidays.aspx>
3. In person:
 - L.A. Care Family Resource Centers in Lynwood and Inglewood
 - Covered California Certified Enrollment Counselor (CEC). Call at (800) 300-1506 or go to www.CoveredCA.com for a list of CECs.
 - Covered California Certified Insurance Agent in the community
 - California Department of Public Social Services (DPSS) toll free at 1-877-481-1044
4. By mail or fax:
 - Covered California Customer Call Center at (888) 975-1142

L.A. Care has certified staff that are trained and certified to assist families with the L.A. Care Covered™ application process. Please have *potential* members call L.A. Care at **1-855-222-4239**, or Covered California at **1-800-300-1506**.

Applications can be downloaded from www.lacovered.org, www.CoveredCA.com, or <https://www.coveredca.com/individuals-and-families/index.html>

Covered California™ and the California Department of Health Care Services have introduced a Spanish-language enrollment application form, providing another path for residents to obtain quality, affordable health insurance.

The application, available now at www.coveredca.com/PDFs/English/paper_application/CA-SingleStream%20App%20Form%20SPA_91MAX.pdf, can be printed and completed in paper form.

Referrals to Non-Covered California Health Programs

The online application supports referrals to non-Covered California health programs. The online application asks, “Would anyone in the household like a referral to the local Health and Human Services Agency for any of the following programs: CalWORKS or CalFresh.” Consumers who answer yes will be provided the contact information for the nearest agency.

Member Enrollment

Covered CA will notify L.A. Care daily of each applicant who has:

- Completed an application
- Been verified as eligible
- Designated L.A. Care Covered™ as their QHP

The Marketplace will provide written notice to an applicant of any eligibility determination within five business days from the date of the eligibility determination.

Key Enrollment Dates:

<u>Event</u>	<u>Date(s)</u>
First Open Enrollment	October 1, 2013 through March 31, 2014
<i>Members enrolling October 1 – December 23, 2013 (Paper Applications Dec 28th)</i>	
Premiums due	Jan 15, 2013 (Up to each QHP)
Coverage begins	January 1, 2014
<i>Members enrolling after December 23, 2013</i>	
Premiums due	Four business days prior to first of month
Coverage begins	First of month following enrollment
<i>Members enrolling after March 31, 2014</i>	
Must have a defined life event	Must enroll within 60 days of life event

For future years, open enrollment periods will be:

- October 15 – December 7 only, with coverage effective after January 1.

As mentioned above, individuals are eligible to apply for coverage during the year if they meet certain criteria

Coverage Effective Dates

General coverage effective dates are:

Receipt of Notice	Coverage Effective
1 st and 15 th day of month	1 st day of the next subsequent month
16 th day through the last of the month	1 st day of the second month

Coverage dependent on receipt of payment

- 100% of the entire first month premium

Receipt of Payment	Coverage Effective
Due on or before the 4 th remaining business day of	1 st day of the next following month the month

For general future years' Open Enrollment:

- Coverage will be effective after January 1

For Defined Life Events:

Enrollment Date Based on Defined Life Event	Coverage Effective
1 st and 15 th of the month	First day of the following month
16 th and last day of the month	First day of the second following month
Birth, adoption or placement of adoption	On the date of birth, adoption or placement for adoption Note: any premium assistance and cost-sharing reductions are effective the first day of the following month.
Marriage	First day of the following month
Loss of minimum essential coverage	First day of the following month

ID Card and Welcome Packet

The member Identification Card and Welcome Packet will be mailed no later than 10 business days after receiving payment from the Enrollee. The required elements of the Welcome packet include the following:

- Welcome Letter
- Summary of benefits and coverage
- Pharmacy benefit information
- Nurse advice line information
- Other materials of benefit to the member that may be required by the Marketplace

Selection of Primary Care Physician

Upon receipt of the Enrollee file, L.A. Care Covered™ Member Services conduct calls to Enrollees to ask them to select a Primary Care Physician (PCP). Enrollees are also reminded to select their PCP in the “Notice to Acknowledge Enrollment” letter which is mailed shortly after receiving the enrollment file from Covered CA.

L.A. Care will auto assign a PCP to every L.A. Care Covered™ member if a L.A. Care was unable reach the member within the required timeframe or if the member failed to pre-select a PCP. The auto-assignment will be based on the following:

- Language needs of the member
- Distance from member residence (goal: within 10 miles)
- PCP specialty most appropriate for the member’s age

The PCP’s name and Medical Group will appear on the member’s Identification Card.

Change of Participating Physician Group (PPG) and/or Primary Care Physician (PCP) Member-Initiated Change

Members requesting to change to another PPG or PCP can do so by calling L.A. Care at 1-888-839-9909. The change will occur on the first of the following month, provided the request is received by Member Services by the 20th of the month.

Enrollee Terminations

Covered California may initiate the termination of an Enrollee's Covered California Health Plan coverage, and shall permit a Covered California Health Plan to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals in the following circumstances:

- The Enrollee is no longer eligible for coverage in a Covered California Health Plan through Covered California
- The Enrollee fails to pay premiums for coverage, and the three-month grace period required for individuals receiving Advance Premium Tax Credits (APTC) has been exhausted
- The Enrollee's coverage is rescinded for cause by L.A. Care Covered™
- L.A. Care Covered™ terminates or is decertified
- The Enrollee changes from L.A. Care Covered™ to another plan during an annual open enrollment period or special enrollment period.

In the case of termination of an Enrollee's coverage due to premium non-payment, L.A. Care Covered™ will:

- Provide the Enrollee, who is delinquent on premium payment, with notice of such payment delinquency
- Provide a grace period of three consecutive months if an Enrollee receiving APTC has previously paid at least one full month's premium during the benefit year
- The Marketplace will notify L.A. Care Covered™ within five (5) business days of any individual Enrollee termination.

Members may contact L.A. Care at **1-888-839-9909** to discuss enrollment and termination processes and options.

Grace Periods

Grace periods are a specified timeframe following the premium due date during which coverage remains in force, and during which the member must pay the premium without penalty for the first month coverage is retained. For the second and third months, coverage can be suspended, but not withdrawn. Upon payment in full, coverage is reinstated with no need for reapplication.

L.A. Care Covered™ reports information to the Marketplace regarding delinquent full or partial payments of premium owed by Enrollees as required by the Marketplace, based on consultation with L.A. Care Covered™. Grace periods are available to the following:

- Individuals receiving "advance payments of the premium tax credit" (APTC)
 - The individual must pay at least one full month's premium during the benefit year to qualify for a month of a three (3) month grace period
 - The individual retains coverage until the last day of the first month of a 3-month grace period
 - The individual is placed on suspended eligibility status during months 2 & 3 of the 3-month

grace period

- All other (non-APTC) members have a 30-day grace period if they fail to pay their monthly premium by the due date

A grace period of three consecutive months is provided to an Enrollee receiving APTC, who has previously paid at least one full month's premium during the benefit year.

For individuals receiving APTC, coverage will be terminated for an Enrollee's non-payment of premium as of the last day of the first month of a three-month grace period, as required under 45 C.F.R. 155.430(d)(4).

For individuals not receiving advance payments of the premium tax credit, coverage will be terminated on the last day of coverage established by grace periods under applicable State law, including requirements relating to Health and Safety Code § 1365 and Insurance Code § 10273.6

Grace Period Notices

Notice to Network Providers

- Written or telephonic notice to certain network providers is required within 15 calendar days of the start of the 2nd month of the grace period
- Certain providers are those providers who have submitted claims within the previous 2 months and the Enrollee's PCP
- Includes coverage status of member and possibility of pending claims

Notice to Members

- Notice of non-payment and cancellation consequences is required for the member
- Member remains responsible for payment of unpaid premiums during the grace period
- L.A. Care CoveredTM Reinstatement Rights: For Enrollees who are actively receiving APTC, and who have paid at least one month's premium in full, a three month grace period which begins on the first day of the first month allows the Enrollee to reinstate coverage by paying the entire outstanding amount of premium due by the last day of the third month.

Coverage during First Month: Enrollees in the 3-month grace period must be covered under their plan contract or policy only during the first month of unpaid premium.

Coverage Suspended during Second and Third Months: If an Enrollee who is receiving APTC has not paid all premium due by the end of the first month of the three-month grace period, plans must "suspend" coverage during the second and third months of the three-month grace period for eligible Enrollees. Once coverage is suspended, L.A. Care CoveredTM network providers are not obligated to provide covered services to an Enrollee while coverage is suspended. Enrollees may receive services from their providers, but are financially responsible for the cost of those services unless their coverage is reinstated on or before the end of the 3rd month of the grace period.

L.A. Care CoveredTM must meet state and federal notice requirements to Enrollees regarding payment due and overdue, prospective termination and the like for the above-stated timelines to apply.

L.A. Care CoveredTM must pay claims for covered services when coverage is in force during the first month of the grace period, even if premium is ultimately not paid for that month. Medically necessary services must be approved and covered when coverage is in force including during the first month of the grace period.

- Covered California Enrollees who are not actively receiving APTC are not subject to the three-month grace period; they are subject to state law grace period of “at least 30 days.” Enrollees who are eligible for APTC but elect not to receive it currently are not eligible for the three-month grace period.
- Enrollees who are not current with premium due and make a partial premium payment in an effort to restore coverage have not restored coverage and have not exited the three-month grace period unless the full outstanding amount is paid by the last day of the three-month period. L.A. Care Covered™ may retain payment for the first month of the grace period when coverage was in force but must return any overage if the Enrollee exhausts the grace period.
- Plans must continue to collect APTC for the entire three months of the grace period and may retain APTC received for the first month of the grace period. If the Enrollee’s grace period is exhausted, the plan must return APTC received for months two and three.
- An Enrollee who reinstates coverage returns to normal coverage status and could trigger another grace period during the plan year, if that Enrollee again fails to pay premium later in the year. The same timing and rules would apply to subsequent grace period(s).
- If an Enrollee receives care during the second and third months of the grace period and fails to reinstate coverage by paying the full premium due before the grace period is exhausted, the Enrollee assumes financial responsibility for the cost of that care.
- If an Enrollee receives care during the second and third months of the grace period and reinstates coverage by paying the full premium due, the Enrollee’s plan is responsible for payment for covered services received by the Enrollee during those two months. Enrollee owes applicable cost sharing, if any.

Termination Following Grace Period

At the end of the grace period, L.A. Care Covered™ can terminate the member’s coverage IF:

- The member has not paid all outstanding premiums in full
- All notice requirements have been met
- The termination effective date meets the regulatory requirements
- Notice to Covered CA has been provided

L.A. Care Covered™ will terminate coverage effective as of the first day of the second month.

L.A. Care Covered™ must provide a termination notice to the member within five business days from the date of the termination. The termination notice must include the reason for termination and the notice of appeals right.

Cancellation for nonpayment of premiums has many consequences, including, but not limited to, the following:

- Members remain responsible for payment of unpaid premiums during the 1st month of the grace period
- Members will be required to repay any premium tax credits provided received for 2nd and 3rd month of the grace period during which coverage was suspended
- Members will be unable to enroll themselves or any dependents on coverage due to the occurrence of any special enrollment events
- Members remain legally responsible for payment of any medical claims incurred during the 2nd and 3rd month of the grace period during which coverage was suspended

2.5 MEMBER IDENTIFICATION CARD

The L.A. Care member identification card provides a member's program name, language, date of birth, PPG name and phone numbers, PCP name, phone number and address, and pharmacy claims information.



2.6 ELIGIBILITY VERIFICATION

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

To verify member eligibility, providers can log on to www.lacarecovered.org on the "Member Sign-In" page, or call L.A. Care's Provider Information Line at 1-866-LA-CARE6 (1-866-522-2736).

2.7 SUMMARY OF BENEFITS & COVERAGE

The L.A. Care Covered™ Summary of Benefits and Coverage (SBC) matrix is sent to members upon enrollment and during the annual renewal thereafter. It provides members with a description of the scope of covered services, copayments and deductibles. Members are also provided information on how to access their Combined Subscriber Agreement and Evidence of Coverage (EOC) and Disclosure Document (Member Handbook) by logging in to www.lacarecovered.org, or by calling L.A. Care Health Plan's Member Services Department at 1-855-270-2327.

2.8 CO-PAYMENTS

There are member co-payments for most health care services and prescription drugs. For a complete listing, please refer to the Summary of Benefits for each Metal Level, attached hereto as **Exhibit 2**. For purposes of tracking co-payments, L.A. Care suggests that members keep all their co-payment receipts.

Monthly premiums depend on family income and family size. Most services have a small co-payment. No co-payment will be charged to children under 15 months of age for well-baby care, health examinations, or other office visits.

2.9 MEMBER'S RIGHTS AND RESPONSIBILITIES

L.A. Care members have specific rights and responsibilities that are fundamental to the provision and receipt of quality healthcare. Member rights and responsibilities are described in the L.A. Care Covered Member Handbook, as well as listed below.

Member Rights

Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy from your health plan's providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care. You have the right to be free from restraint (including physical and mechanical restraints and drugs), used as a means of coercion, discipline, convenience or retaliation.

Privacy and confidentiality. You have the right to have a private relationship with your provider and to have your medical record kept confidential. You also have the right to receive a copy of, amend and request corrections to your medical record. If you are a minor, you have the right to certain services that do not need your parent's okay.

Choice and involvement in your care. You have the right to receive information about your health plan, its services, its doctors and other providers. You have the right to choose your Primary Care Physician (doctor) from the doctors and clinics listed in your health plan's provider directory. You also have the right to get appointments within a reasonable amount of time. You have the right to talk with your doctor about any care your doctor provides or recommends, discuss all treatment options, and participate in making decisions about your care. You have the right to a second opinion. You have the right to talk candidly to your doctor about appropriate or medically necessary treatment options for your condition, regardless of the cost or what your benefits are. You have the right to information about treatment regardless of the cost or what your benefits are. You have the right to say "no" to treatment. You have a right to decide in advance how you want to be cared for in case you have a life-threatening illness or injury.

Receive timely customer service. You have the right to wait no more than 10 minutes to speak to a customer service representative during L.A. Care's normal business hours.

Voice your concerns. You have the right to complain about L.A. Care, the health plans and providers we work with, or the care you get without fear of losing your benefits. L.A. Care will help you with the process. If you don't agree with a decision, you have the right to appeal, which is to ask for a review of the decision. You have the right to disenroll from your health plan whenever you want.

Service outside of your health plan's provider network. You have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of your health plan's network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have the right to request an interpreter at no charge and not use a family member or a friend to translate for you. You have the right to get the Member Handbook and other information in another language or format.

Know your rights. You have the right to receive information about your rights and responsibilities. You have the right to make recommendations about these rights and responsibilities.

Member Responsibilities

Act courteously and respectfully. **You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.**

Give up-to-date, accurate and complete information. You are responsible for giving correct information and as much information as you can to all of your providers, and to L.A. Care. You are responsible for getting regular checkups and telling your doctor about health problems before they become serious.

Follow your doctor's advice and take part in your care. You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.

Use the Emergency Room only in an emergency. You are responsible for using the emergency room in cases of an emergency, or as directed by your doctor.

Report wrongdoing. You are responsible for reporting health care fraud and abuse or wrongdoing to L.A. Care. You can do this without giving your name by calling the L.A. Care's Compliance Helpline toll-free at 1-800-400-4889, go to www.lacare.ethicspoint.com, or by contacting any of the following:

The Office of Patient Advocate provides an overview of the health care industry
www.opa.ca.gov or 1.866.466.8900

California Department of Managed Health Care (DMHC) oversees HMOs and some PPOs
www.dmhc.ca.gov. or 1.888.466.2219

California Department of Insurance (CDI) handles complaints against PPOs
www.insurance.ca.gov. or 1.800.927.4357

Self-Reporting.

Consumers are required to self-report the following changes within 30 days:

Add a household member (birth, adoption, marriage, etc.	Change in income (employment)
Remove a household member	Change in income (self-employment)
Change in incarceration status	Change in income (other)
Change in health coverage	Change in income (tax deductions)
Change in citizenship/ immigration status	Miscellaneous information change
Change in household contact information	Tax information change
Change in name	Change in income type and deductions (newly eligible/ineligible for APTC)

2.10 NOTICE TO MEMBERS REGARDING CHANGE IN COVERED SERVICES

Members must be informed about any change in provision of services. L.A. Care must send written notification of any change to the member no less than sixty (60) days, or as soon as possible prior to the date of actual change. In case of an emergency, the notification period will be within fourteen (14) days prior to changes, or as soon as possible.

In the event that the change in covered services includes termination of a provider's contract; the member has a right to make an affirmative request for completion of services in the following situations:

- Acute condition (a serious and sudden condition that lasts a short time like a heart attack, pneumonia or appendicitis) — For the time the condition lasts
- Serious chronic (long-term) condition — For a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider
- Pregnancy — During the pregnancy and immediate postpartum care (six weeks after giving birth).
- Terminal illnesses/conditions — For the length of the illness
- Children ages birth to 36 months — For up to 12 months
- Surgery or other procedures authorized by L.A. Care as part of a documented course of treatment if the treatment was set to occur within 180 days of the time the doctor or hospital stops working with L.A. Care, or within 180 days of the time coverage began with L.A. Care

2.11 MEMBER GRIEVANCES

A grievance is any expression of dissatisfaction by an L.A. Care member. Any grievance that suggests a quality of care issue must be handled as a clinical grievance, and will be referred to L.A. Care's Member Services Department and Medical Management Department immediately.

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

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

Some examples of complaints about:

- The service or care received by the PCP or other providers
- The service or care received by the PCP doctor's medical group
- The service or care received by the pharmacy
- The service or care received by the hospital
- The service or care received by L.A. Care

How to File a Grievance

Members have many ways to file a grievance. They can do any of the following:

- Write, visit or call L.A. Care. You may also file a grievance online in English or in Spanish through L.A. Care's Website at: www.lacarecovered.org.
- Contact L.A. Care as listed below if they need a grievance form in a language other than Spanish or

English, or in another format (large print or audio).

L.A. Care Health Plan
Member Services Department
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017
1-855-270-2327 TTY/TDD: 1-855-576-1620
www.lacarecovered.org

- Fill out a grievance form at their doctor's office

L.A. Care can help members fill out the grievance form over the phone or in person. If the member needs interpreter services, L.A. Care will work with the member to make sure we can communicate with the member in a language they understand.

Members with hearing or speech loss may call L.A. Care's TTY telephone number for Member Services at 1-866-522-2731. Members may call the TTY/TDD Statewide access number at 1-888-877-5379 (Sprint), or 1-800-735-2922 voice (MCI). Members and providers can also dial 711 on their phones to call the California Relay Service directly.

Within five calendar days of receipt of a member grievance, L.A. Care will send a letter to the member stating that their grievance has been received and is in-process. Within 30 calendar days of receiving a grievance, L.A. Care will send the member a letter explaining how their grievance was resolved.

Filing a grievance does not affect a member's medical benefits. Members filing a grievance may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call L.A. Care's Member Services department at **1-855-270-2327 (TTY/TDD: 1-855-576-1620)**.

If a member does not agree with the outcome of their grievance:

If a member does not hear from L.A. Care within 30 calendar days, or they do not agree with the decision about their grievance, a grievance may be filed with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" section below.

How to file a grievance for health care services denied or delayed as not medically necessary:

If a member, or their provider, believes that a health care service has been wrongly denied, changed, or delayed by L.A. Care because it was found not medically necessary, the member may file a grievance. This is known as a disputed health care service.

Within five calendar days of receipt of a member grievance, L.A. Care will send a letter to the member stating that their grievance has been received and is in-process. The letter will also include the name of the person assigned to their grievance. Within 30 calendar days of receiving a grievance, L.A. Care will send the member a letter explaining how their grievance was resolved.

If a member does not agree with the outcome of their grievance for health care services denied or delayed as not medically necessary:

If a member does not hear from L.A. Care within 30 calendar days, or they do not agree with the decision about their grievance, a grievance may be filed with the Department of Managed Health Care (DMHC). For

information on how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section below.

How to File a Grievance for Urgent Cases

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

In urgent cases, members can request an “expedited review” of their grievances. Members will receive a call and/or a letter about their grievance within 24 hours. A decision will be made by L.A. Care within three calendar days (or 72 hours) from the day the grievance was received by L.A. Care.

Members have the right to file an urgent grievance with DMHC without filing a grievance with L.A. Care. For information on how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section below.

If a member does not agree with the outcome of their grievance for urgent cases

If a member is not contacted by L.A. Care within three calendar days (or 72 hours) of receipt of a member grievance, or they do not agree with the decision about their grievance, they may file a grievance with the Department of Managed Health Care (DMHC). For information on how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section below.

Independent Medical Review

Members may request an Independent Medical Review (IMR) from DMHC. Members have up to six months from the date of a denial from L.A. Care to file an IMR. Information on how to file an IMR will be included in the denial letter. Members may reach DMHC toll-free at **1-888-HMO-2219** or **1-888-466-2219**.

There are no fees to file an IMR. Members have the right to provide information to support their request for an IMR. A decision by the member not to take part in the IMR process, after the IMR application is submitted to DMHC, may cause a member to lose certain legal rights to pursue legal action against the plan.

When to File an Independent Medical Review (IMR)

Members may file an IMR if they meet the following requirements:

- Member’s practitioner states the member needs a health care service because it is medically necessary and it is denied
- Member received urgent or emergency services determined to be necessary and they were denied; or
- Members have seen a network practitioner for the diagnosis or treatment of the medical condition, even in the case that health care services were not recommended by the practitioner; or
- The disputed health care service is denied, changed or delayed by L.A. Care based, in whole or in part, by a decision that the health care service is not medically necessary; and/or
- Member has filed a grievance with L.A. Care and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days.

Before applying for an IMR, members must first submit their grievance through the L.A. Care grievance

process.

In special cases, the DMHC may not require members to follow the L.A. Care grievance process before filing an IMR. In these cases, the dispute will be submitted to a DMHC Medical Specialist if it is deemed eligible for an IMR. The specialist will make an independent decision whether the care received by the member is medically necessary. The member will receive a copy of the IMR decision from DMHC. If it is decided by DMHC that that the service is medically necessary, L.A. Care will provide the health care service.

Non-urgent cases

For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when a member's application and all related documents are received by DMHC.

Urgent cases

If the member's grievance is urgent and requires an expedited review, the member may bring it to DMHC's attention immediately, and the member will not be required to participate in the health plan grievance process. For urgent cases, the IMR decision must be made within three calendar days from the time the member's information is received by DMHC.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health

Independent Medical Review for Denials of Experimental/ Investigational Therapies

Members are also entitled to an Independent Medical Review, through the Department of Managed Health Care, when treatment determined to be experimental or investigational is denied by the health plan.

- L.A. Care will notify members in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- Members are not required to participate in L.A. Care Health Plan's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of treatment determined to be an experimental/ investigational therapy.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If a member has a grievance against L.A. Care Health Plan, they should first telephone L.A. Care Health Plan at 1-855-270-2327 (TTY for the hearing impaired at 1-855-576-1620) and use L.A. Care Health Plan's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to the member. If the member needs assistance with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by L.A. Care Health Plan, or a grievance that has remained unresolved for more than 30 days, they may call the DMHC for assistance. The

member may also be eligible for an Independent Medical Review (IMR). If the member's grievance is determined to be eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by the health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency and urgent medical services. The Department of Managed Health Care can be reached toll-free at **1-888-HMO-2219** to receive complaints regarding health plans. Hearing and speech impaired members may use the department's TTY line (1-877-688-9891) to contact DMHC. DMHC's complaint forms, IMR application forms and instructions can be obtained online at <http://www.hmohelp.ca.gov>.

L.A. Care Health Plan's grievance process and DMHC's complaint review process are part of several other dispute resolution procedures that may be available to the member. Failure of the member to use the above processes does not preclude their use of any other remedy provided by the law.

L.A. Care can help with interpreter services if the member speaks a language other than English. Member with hearing impairments may use the toll-free TTY/TDD numbers listed under "How to File a Grievance". With the member's written consent, the member's physician may also file an appeal on the member's behalf.

Members can file grievances by doing any of the following:

Write, visit or call L.A. Care:

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
1-888-839-9909
213-438-5748 (fax)

Complaints or Concerns

If the provider or member has a grievance against L.A. Care, please contact L.A. Care and follow the internal grievance process outlined above.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-839-9909 and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The DMHC also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877688-9891) for the hearing and speech impaired. The DMHC's internet website, <http://www.hmohelp.ca.gov>, has complaint forms, IMR application forms and instructions online.

Consumers can also contact the following entities with complaints or concerns:

The Office of Patient Advocate provides an overview of the health care industry
www.opa.ca.gov or 1.866.466.8900

California Department of Insurance (CDI) handles complaints against PPOs
www.insurance.ca.gov, or 1.800.927.4357

Maintenance of Member Grievance Records

L.A. Care will maintain all records related to member grievances for up to five (5) years after the active record has been closed.

3.0 ACCESS TO CARE

This section summarizes the access to care requirements for L.A. Care Participating Physician Groups (PPGs).

3.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

All providers are responsible for fulfilling the access standards below. L.A. Care monitors the ability of its members to access these services.

L.A. Care will disseminate age and gender specific preventive care guidelines on an annual basis.

PERFORMANCE STANDARDS REQUIRED BY COVERED CALIFORNIA	
Call Answer Timeliness	Expectation: 80% of calls answered 30 seconds
Processing ID Cards (L.A. Care)	Expectation: 99% sent within 10 business days of receiving complete and accurate enrollment information from the Marketplace and premium
Telephone Abandonment Rate	Expectation: No more than 3% of incoming calls in a calendar month
Initial Call Resolution	Expectation: 85% of Enrollee issues will be resolved within one (1) business day of receipt of the issue
Grievance Resolution	Expectation: 95% of Enrollee grievances resolved within 30 calendar days

3.2 L.A. CARE / PARTICIPATING PHYSICIAN GROUP ACCESS REQUIREMENTS

Accessibility Standards

L.A. Care	Member Services Department Call Service:	
	<ul style="list-style-type: none"> a. Speed of Telephone Answer: The maximum length of time for Member Service Department staff to answer the telephone b. Call Abandonment Rate 	<ul style="list-style-type: none"> • 90% of calls within 30 seconds • Not to exceed 3% in a calendar month
Primary Care Appt. Wait Times	<p>Preventive Exams: A periodic health evaluation for a member with no acute medical problem, including:</p> <ul style="list-style-type: none"> • Initial Health Assessment and Individual Education Behavioral Assessment (IHEBA) “Staying Healthy” 	<p>≤90 calendar days from when the member becomes eligible</p> <p>Members <18 months of age ≤60calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two</p>

	First Prenatal Visit	and under, whichever is less ≤14 calendar days of request
	Routine Preventive Health Examination	≤10 business days of request, not to exceed 30 calendar days
Primary Care Appt. Wait Times	EPSDT/CHDP*	≤10 business days of request, not to exceed 30 calendar days
	Routine Primary Care (Non-Urgent): Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment	≤10 calendar days of request
Urgent Care	Urgent Care: Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner	≤48 hours of request if no authorization is required ≤96 hours if prior authorization is required
Emergency Care	Emergency: 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
Office Wait Times	Office Waiting Room Time: The time after a scheduled medical appointment in which a patient is waiting to see a practitioner once in the office	Within 45 minutes of arrival
Speed to Answer (Practitioner Office)	Speed of Telephone Answer (Practitioner's Office): The maximum length of time for practitioner office staff to answer the phone	≤30 seconds
After Hours	After Hours Calls:	<ul style="list-style-type: none"> • Automated systems must provide emergency 911 instructions; and • 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, covering practitioner or offer a call-back from the PCP within 30 minutes • If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls • PPG staff: <ul style="list-style-type: none"> ○ Must have access to practitioner for both urgent and non-urgent calls
Call Return Time (PCP)	Call Return Time: The maximum length of time for a PCP or on-call practitioner to return a call after hours	≤30 minutes

SCP Care	Routine Specialty Care:	≤15 business days of request, not to exceed 30 calendar days
	Urgent Care: Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner	≤48 hours of request if no authorization is required ≤96 hours if prior authorization is required
Ancillary Care	Non-Emergent Ancillary Services	≤15 business days of request
Behavioral Health Care*	Routine Behavioral Health Care	≤10 business days of request, not to exceed 30 calendar days*
	Urgent Care	<48 hours of request
	Non-Life Threatening Emergency	<6 hours of request
	Emergency: 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
	Behavioral Health Telephone Responsiveness: <ul style="list-style-type: none"> • Quarterly average speed of answer for screening and triage calls • Quarterly average abandonment rate for screening and triage calls 	<30 seconds NTE 3%
AVAILABILITY STANDARDS		
Ratio of Providers to Members	Physician to Enrollee Ratio	1:1200
	PCP to Member Ratio	
	Provider to Extender Ratio* <ul style="list-style-type: none"> • Nurse Practitioners • Physician Assistants <p><i>*L.A. Care allows a provider an additional 1,000 members per extender up to a maximum of 5,000 members per PCP</i></p>	1:2000 1:4 1:4
	SCP to Member Ratio* <p><i>*Annually, L.A. Care identifies and assesses the OBG network along with the top four specialties based on the number of encounters for the 12 month period from October 1 through September 30 of the measurement year. Standards for provider to member ratios are determined based on utilization, need and trended data.</i></p>	1:5000
Ratio of	Ancillary Providers*	1:5000

Providers to Members cont'd	<i>Hospitals, Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgical Centers, Radiology Centers and Dialysis Centers</i>	
	Behavioral Health: <ul style="list-style-type: none"> • Psychiatrists/Behavioral Healthcare • Outpatient Mental Health Providers (Licensed Clinical Social Workers, Marriage and Family Therapists, etc.) • Psychologists • Inpatient Psychiatric Facilities and Residential Treatment Centers • Inpatient Substance Abuse Facilities and Residential Treatment Centers • Ambulatory Facilities 	<ul style="list-style-type: none"> • 1:5000 • 1:2000 • 1:2000 • 1:5000 • 1:10000 • 1:10000
Drive Distance	PCP	Within 10 miles/30 minutes of member residence
	SCP	Within 15 miles/30 minutes of member residence
	Behavioral Health <ul style="list-style-type: none"> • Psychiatrists/Behavioral Healthcare • Outpatient Mental Health Providers (Licensed Clinical Social Workers, Marriage and Family Therapists, etc.) • Psychologists • Inpatient Psychiatric Facilities and Residential Treatment Centers • Inpatient Substance Abuse Facilities and Residential Treatment Centers 	<ul style="list-style-type: none"> • Within 10 miles/20 minutes of member residence • 2 providers within 15 miles of member residence • 2 providers within 30 miles of member residence • 1 provider within 30 miles of member residence • 1 provider within 30 miles of member residence

<ul style="list-style-type: none"> • Ambulatory Facilities 	<ul style="list-style-type: none"> • 2 providers within 15 miles of member residence
<p>Ancillary Providers*</p> <p><i>Hospitals, Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgical Centers, Radiology Centers and Dialysis Centers</i></p>	<p>Within 15 miles/30 minutes of member residence</p>
<p>Pharmacies</p>	<p>Within 15 miles of member residence</p>

3.3 PCP MINIMUM SITE HOUR REQUIREMENTS

- PCP must be physically on site eight hours per week per site, with a maximum of four sites
- Each site must be available a minimum of 16 hours per week to see L.A. Care Members.

4.0 SCOPE OF BENEFITS

4.1 HEALTH BENEFITS

Member Handbooks (Evidence of Coverage) for the L.A. Care Covered™ plans are maintained by Commercial & Group Plan Operations and are made available electronically to all members on the member website and portal, as well as via hard copy upon request. The Benefits section of the handbook describes in detail the covered and non-covered services, procedures, and medical equipment for the L.A. Care Covered™ line of business. The Summary of Benefits section provides a detailed listing of all copayments, deductibles and other cost sharing information.

PPGs may access health benefit information or obtain a copy of any of the L.A. Care Covered™ plan benefit handbooks at the L.A. Care Website at www.lacarecovered.org.

Essential Benefits

ACA mandates the following “essential benefits:”

- Ambulatory patient services
- Emergency services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and Habilitative* services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

*Habilitative services are medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment.

Pediatric Dental

Covered California is working to embed pediatric dental in medical products in 2015. In 2014, coverage is provided through stand-alone plans offered by the following carriers:

- Anthem Blue Cross
- Blue Shield of California
- Delta Dental
- Liberty Dental
- Premier Access

Pediatric Vision is included in L.A. Care Covered™ benefits.

4.2 “METAL LEVEL” PLANS

Plans, and their prices, are tiered into four “metal” levels: Bronze, Silver, Gold, and Platinum. Prices of each level vary by age, zip code, household size and income (for premium assistance, and benefits). The Platinum

plan benefit level is the richest. “Minimum Coverage Plans,” available only to consumers under age 30, or with a waiver from Covered California, are the leanest benefits levels.

Assistance from the federal government -- premium subsidies – are available to help pay premiums for people between 100% and 400% of the Federal Poverty Level (FPL). Cost-sharing subsidies (also called Cost-Sharing reductions) are the reduction in cost sharing for an eligible individual enrolled in a Silver level plan, or for certain Native Americans or Alaskan Natives. Subsidized consumers have access to any plan, but they will be mostly concentrated in the Silver level plans.

L.A. Care Covered™ Plans and Benefits

	Platinum HMO	Gold HMO	Silver HMO	Silver 94 HMO	Silver 87 HMO	Silver 73 HMO	Bronze HMO ¹	Minimum Coverage HMO
BENEFITS								
Annual Deductible² (Ind./Family)	\$0	\$0	\$2,000/ \$4,000	\$0	\$500/ \$1,000	\$1,500/ \$3,000	\$5,000/ \$10,000	\$6,350/ \$12,700
Annual Out of Pocket Maximum (Ind./Family)	\$4,000/ \$8,000	\$6,350/ \$12,700	\$6,350/ \$12,700	\$2,250/ \$4,500	\$2,250/ \$4,500	\$5,200/ \$10,400	\$6,350/ \$12,700	\$6,350/ \$12,700
Annual Brand Name Rx Deductible	\$0	\$0	\$250/\$500	\$0	\$50/\$100	\$250/\$500	N/A	N/A
OFFICE VISITS								
Preventive Care Services including: prenatal visits, well child care, family planning	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Office Visits	\$20	\$30	\$45	\$3	\$15	\$40	\$60 (1st 3 visits)	\$0 (1st 3 visits)
Specialist Office Visits	\$40	\$50	\$65	\$5	\$20	\$50	\$70*	0%*
Mental Health/Substance Abuse Visits	\$20	\$30	\$45	\$3	\$15	\$40	\$60 (1st 3 visits) ³	\$0 (1st 3 visits)
URGENT AND EMERGENCY CARE								
Urgent Care Visit	\$40	\$60	\$90	\$6	\$30	\$80	\$120 (1st 3 visits)	\$0 (1st 3 visits)
Emergency Room⁴	\$150	\$250	\$250*	\$25	\$75*	\$250*	\$300*	0%*
INPATIENT SERVICES								
Inpatient Hospitalization	\$250/day ⁵	\$600/day	20%*	10%	15%*	20%*	30%*	0%*
Maternity	\$250/day	\$600/day	20%*	10%	15%*	20%*	30%*	0%*
OUTPATIENT SERVICES								
Outpatient Surgery	\$250	\$600	20%	10%	15%	20%	30%*	0%*
Lab Services	\$20	\$30	\$45	\$3	\$15	\$40	30%*	0%*
X-rays	\$40	\$50	\$65	\$5	\$20	\$50	30%*	0%*
PRESCRIPTION DRUGS								
Generic Rx	\$5	\$19	\$19	\$3	\$5	\$19	\$19*	0%*
Preferred Brand Rx	\$15	\$50	\$50**	\$5	\$15**	\$30**	\$50*	0%*
Non-Preferred Brand Rx	\$25	\$70	\$70**	\$10	\$25**	\$50**	\$75*	0%*
PEDIATRIC VISIONS⁶								

¹ Bronze and Minimum Coverage HMO have an integrated medical and Rx deductible

² Annual deductible included in annual out of pocket maximum

³ First 3 visits combined prior to deductible

⁴ Copay waived if member is admitted directly to the hospital

⁵ Copay is per day up to 4 days

*Subject to annual deductible

**Subject to brand Rx deductible

⁶ Applies to dependent children up through age 18

Vision exam, Glasses, Contacts	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Other benefits include but are not limited to:	Acupuncture, Ambulance, Hospice, Rehabilitation, Skilled Nursing Facility, Specialty Rx Note: This <i>Plans at a Glance</i> is intended to be a summary of benefits. Please review the L.A. Care Evidence of Coverage for a detailed description of all benefits, limitations and exclusions.							

L.A. Care Covered™ Portfolio

Native American plan options for consumers above and below 300 FPL*

Benefits	L.A. Care Covered Platinum HMO Native American	
	Participating Providers	Native American Providers
Annual Deductible	\$0	\$0
Annual Out of Pocket Maximum <small>(includes deductible)</small>	\$4,000/member \$8,000/family	45 \$0
Annual Brand Rx Deduct	\$0	\$0
Primary Care Office Visit	\$20	\$0

Benefits	L.A. Care Covered Native American 300
	Participating and Native American Providers
Annual Deductible	\$0
Annual Out of Pocket Maximum <small>(includes deductible)</small>	\$0
Annual Brand Rx Ded	\$0
Primary Care Office Visit	\$0

4.3 NURSE ADVICE LINE (1-800-249-3619)

L.A. Care provides, free of charge, a 24/7 nurse advice line (NAL). Providers are encouraged to promote the appropriate use of the NAL with their patients. The number is listed on the back side of the Member's ID Card. The NAL is intended to provide general health advice and information, and assist members in understanding their health concerns; medicines and health test results, and help members seek the appropriate level of care. The NAL line is staffed with RNs who follow MD reviewed algorithms when triaging symptomatic calls. An audio library of more than 1,000 easy to follow health topics is also provided through this service.

4.4 OTHER IMPORTANT NUMBERS

Hearing- or speech-impaired members can contact L.A. Care's Nurse Advice Line through the California Telecommunications Relay Service at 1-866-735-2929 (TTY) or 1-800-854-7784 (speech-to-speech).

5.0 UTILIZATION MANAGEMENT

This section summarizes L.A. Care Health Plan's (L.A. Care) Utilization Management (UM) Processes. UM functions/activities vary depending on specific contractual agreements with each contracted PPG, provider, and hospital. Please check your contract Division of Financial Responsibility (DOFR), or contact L.A. Care's Provider Information Line at 1-866-LA-CARE6, or Utilization Management at 1-877-431-2273.

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

L.A. Care's Utilization Management Department is staffed with professional registered, licensed vocational nurses and paraprofessionals who are available to assist the PPG and their providers with UM activities. These activities include, but are not limited to:

- Benefit clarification
- Referral management
- Coordination of care and services related to continuity of care previously received or care provided by a terminated provider
- Care coordination/case management
- Complex Case Management
- Education of PPG/providers on policies, procedures and legislative updates

5.1 GOAL AND

OBJECTIVES Goals

The goal of L.A. Care's Utilization Management Program is to ensure and facilitate the provision of appropriate medical and behavioral health care and services to L.A. Care members. The program is designed to monitor, evaluate, and support activities that continually improve access to, and quality of, medical care provided to L.A. Care Covered™ members.

Objectives

The Utilization Management Program's objectives are designed to provide mechanisms that assure the delivery of quality health care services and to optimize opportunities for process improvement through:

- Managing, evaluating, and monitoring the provision of healthcare services rendered to L.A. Care members to enhance access to, and provision of, appropriate services
- Facilitating communication and developing partnerships between, Participating Provider Groups, Providers, Practitioners, Members, and L.A. Care
- Developing and implementing programs to encourage preventive health behaviors that can ultimately improve quality outcomes
- Assisting PPGs, Providers, and Practitioners in providing ongoing medical care for members with chronic or catastrophic illness
- Developing and maintaining effective relationships with service providers available to L.A. Care members through commercial plans such as L.A. Care Covered™, as well as County, State, Federal, and other community-based programs to ensure optimal care coordination and service delivery
- Facilitating and ensuring continuity of care for L.A. Care members within and outside of L.A. Care's network

- Integration with Quality Improvement
 - The UM Program has a variety of quality operations processes in place to ensure quality of care service-oriented interventions are initiated and carried out. Linkage between the UM Program and the Quality Improvement (QI) Program is supported through committee representation by UM Program management and by presenting executive level summary of pertinent UM documents to the L.A. Care QOC Committee.
 - Additionally, UM integration with quality operations supports activities to capture utilization trends or patterns and is measured by, but not limited to:
 - IRR
 - Satisfaction with UM
 - Sentinel or adverse event reporting
 - Referral of identified potential quality issues for review to the QI Department for follow-up in accordance with established procedures
- Referral of identified potential quality issues for review to the QI Department for follow-up in accordance with established procedures
- Ensuring a process for UM that is effective and coordinated through Committees, work groups and task forces with the involvement and cooperation of experts in all fields of medicine, management, patient advocacy and other relevant fields.
- Providing leadership to PPGs, Providers, and Practitioners by developing and recommending changes and improvements in programs and processes resulting from collection and analysis of utilization data.
- Ensuring that UM decisions are made independent of financial incentives or obligations.
- Monitoring the provision of health assessments and basic medical case management to all members, PPGs, Providers, and Practitioners.

5.2 SCOPE OF SERVICE

The scope of L.A. Care Health Plan's Utilization Management Program includes all aspects of health care services delivered at all levels of care to L.A. Care Health Plan members. L.A. Care Health Plan offers a comprehensive health care delivery system along the continuum of care, including urgent and emergency services, ambulatory care, preventive services, hospital care, ancillary services, behavioral health (mental health and addiction medicine), home health care, hospice, rehabilitation services, skilled nursing services, and care delivered through selected waiver programs.

L.A. Care Health Plan administers the delivery of health care services to its members through different contractual agreements.

L.A. Care Health Plan's Programs are administered through different contractual arrangements with medical groups and Independent Provider Associations (IPAs), collectively called Participating Provider Groups (PPGs) which may include delegation of some or all UM functions.

L.A. Care and L.A. Care's PPGs shall provide or arrange for all medically necessary covered services for members.

If medically necessary services are not available within the L.A. Care PPG contracted networks, contracts are initiated on an individual basis to ensure availability of medically necessary care and services in accordance with benefit agreements.

At a minimum the UM Program includes the following:

- Assures that services which are medically necessary are delivered at the appropriate level of care, Including inpatient, outpatient, and the emergency room
- Assures that authorized services are consistent with the benefits provided by the Plan
- Provides a comprehensive analysis of care by identifying under- and over-utilization patterns by physicians and within the Plan
- Reviews care and identifies trends that positively and negatively impact the quality of care provided to the members
- Defines, monitors, and trends medical practice patterns impacting members' care
- Ensures that appropriate medical review guidelines are available and used by UM personnel
- Identifies, develops, revises, and implements appropriate policies, procedures, processes, and mechanisms for UM that can be used to evaluate medical necessity for requested services on a timely and regular basis
- Instructs all institutions, physicians, and other health care clinicians regarding the criteria used, the information sources employed, and the methods utilized in the approval and review processes
- Provides the health plan network with information related to effective mandated information system and communications for the monitoring, management, and planning of medical services
- Ensures that network institutions, physicians, and other health care clinicians provide services unless otherwise mandated by regulatory standards
- Determines if illness or injury is covered under other programs including third-party payers
- Ensures that guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate
- Facilitates consistent practice patterns among institutions, physicians, and other health care clinicians with L. A. Care Health Plan by offering feedback to the PPGs/Providers to assist in optimizing appropriate medical practice patterns.
- Provides case management services to ensure cost effective ongoing care at the appropriate level.
- Utilizes information in member and physician satisfaction surveys to develop quality improvement activities as appropriate.
- Conducts inter-rater reliability of physician and non-physician reviewers to assess determinations made as part of the UM process.
- Provides required reports.
- Ensures coordination and continuity of care for members.

Policy Prohibiting Financial Incentives for Utilization Management Decision-makers

Utilization Management decisions are based only on appropriateness of care and service and the existence of coverage. There are no rewards or incentives for practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for Utilization Management decision-makers to encourage decisions that would result in underutilization.

Required Reporting from UM

PPG UM Departments shall monitor, report, and address the following services to the appropriate committee structures. The services include, but are not limited to:

- Potentially fraudulent or abusive practices are referred to Regulatory Affairs and Compliance
- Potential under and over utilization are referred to the UM Director
- Coordination of care for results or facilitation are referred to the UM Director
- Opportunities for improvement are referred to the UM Director

- Breaches of adherence to confidentiality and HIPAA policies are referred to the HIPAA Compliance Officer
- Potential quality issues identified through UM activities are referred to the Quality Improvement department
- Barriers to accessibility and availability of services are referred to Provider Network Operations and Quality Improvement Departments, as appropriate

5.3 DELEGATION OF UTILIZATION MANAGEMENT

L.A. Care has a formal process by which specific Utilization Management functions are delegated to other organizations including PPGs, and ancillary vendors (**See PPGs Service Agreement — Delegation of UM Functions by NCQA UM Standards**).

L.A. Care evaluates all proposed delegates using a formal process that assesses the organization’s systems, processes and capabilities according to defined criteria. Utilization Management is not delegated until L.A. Care determines, in its sole judgment, that the delegate is capable of performing the delegated functions in a manner acceptable to L.A. Care. L.A. Care’s UM Delegation Standards and Oversight Monitoring Activities are described more fully in Addendum C.

The scope of delegation for each delegate is defined in a written delegation agreement. UM Delegation is defined in terms of:

- Standard Delegation
- Extended Delegation

Standard is defined as delegation to perform UM activities defined in the delegation agreement and noted in the PPG DOFR as “PPG Risk”. Extended delegation is defined as delegation to perform activities defined in the delegation agreement and noted in the PPG DOFR as “PPG Risk” and “Hospital Shared Risk Pool”.

The agreement also defines the oversight process and delegate reporting requirements. Delegates are not permitted to sub-delegate any functions without L.A. Care’s consent.

The ability for an organization to maintain its status as a delegate depends solely on the organization’s capacity, in L.A. Care’s judgment, to continue to perform in a manner consistent with the defined criteria.

Oversight of delegation includes periodic assessments throughout the year by designated staff based, in part, on review of required reports submitted by the delegate.

All delegates are formally reevaluated annually. The scope of the reevaluation may depend on the organization’s Knox-Keene or other regulatory status and NCQA accreditation or certification status and includes conducting oversight activities, reporting results, developing corrective action plans and monitoring progress in implementation of the corrective action plans.

L.A. Care is responsible for making sure that the delegated activities are performed in a manner consistent with the delegation agreement, L.A. Care criteria, and applicable regulatory requirements and accreditation standards. L.A. Care provides ongoing assistance, guidance, and oversight in furtherance of this goal. Should L.A. Care determine that an organization is not performing any portion of the delegated functions in a manner consistent with the delegation agreement, L.A. Care criteria, applicable regulatory requirements, or applicable accreditation standards L.A. Care may institute corrective action or revoke the delegation in whole or in part.

Non-compliance issues will be brought to the attention of the Compliance Officer for recommended actions. Non-compliance issues directly impacting member care will be brought to the attention of the Chief Medical Officer for recommendations which could include suspension of membership, up to and including immediate contract termination.

If L.A. Care Health Plan withholds or withdraws delegated status for Utilization Management from a PPG, L.A. Care Health Plan's Utilization Management department shall assume the level of UM activity appropriate to the new non-delegated PPG. L.A. Care Health Plan reserves the right to continue to delegate Utilization Management to the PPGs if they meet L.A. Care Health Plan's standards for delegation. L.A. Care Health Plan's Utilization Management department will provide consultation to the PPG and may actively participate with the PPG to assist the PPG to come into compliance with a UM delegated function prior to L.A. Care Health Plan's revocation of a UM delegated status.

UM DELEGATION STATUS

PPGs audited for UM delegation will be designated a delegation status after the due diligence review, annually and as a result of a supplemental or focused audit findings. Delegation status includes standard and extended delegation.

Standard is defined as delegation to perform UM activities defined in the delegation agreement and noted in the PPG DOFR as "PPG Risk". Extended delegation is defined as delegation to perform activities defined in the delegation agreement and noted in the PPG DOFR as "PPG Risk" and "Hospital Shared Risk Pool".

PPG delegation status may be impacted by PPGs contractual relationship with L.A. Care. All PPGs will be audited for compliance with the UM related regulatory requirements. Non-compliance may result in supplemental audits or focused audits to ensure compliance.

UM DELEGATION MONITORING AND OVERSIGHT

L.A. Care is responsible for evaluating PPG ability to perform the delegated activities including an initial review to assure that the PPG has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. UM Delegation monitoring shall be performed to ensure PPGs meet standards set forth by L.A. Care and regulatory body requirements. This includes the continuous monitoring, evaluation and approval of the delegated functions.

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

UM REPORTS

PPGs will submit utilization reports as defined in the delegation agreements, by secured portal exchange, e-mail or fax, from encounter data, claims data or department logs. A copy of the reporting requirements can be found in the PPG Contract.

L.A. Care Health Plan will utilize encounter data, summary reports, and supplemental reports provided by PPGs to track, trend, and report UM activities as required by the State. These reports, combined with information obtained

via site visits and audits, will be used to accomplish the UM oversight functions required by regulation and/or contract requirement. Some oversight reporting requires additional information be sent to the Delegation Oversight Unit for ongoing monitoring. L.A. Care reviews PPGs UM decision-making by auditing denial determinations on a periodic basis. Modification and Denial Notice of Action letters and medical records utilized in the modification or denial determination must be sent to the L.A. Care UM Department as defined in the PPG delegation agreements.

L.A. Care Health Plan will analyze the reports and present the results to the PPGs via the quarterly Oversight Response Communication. The goal of performing plan and group specific analysis is to monitor utilization activities, member access to care, and to validate and compare to community norms/ benchmarks. Any variance(s) or trends will be reviewed and discussed at the Utilization Management sub-committee and Committee meetings, and periodically at the Quality of Care and Internal Compliance Committees for recommendations.

UM DELEGATION OVERSIGHT AUDITS

Oversight for L.A. Care Health Plan's directly contracted PPGs are performed as prescribed in the UM Delegation Oversight Plan as approved by the UM Committee. Wherever possible these audits may be done in conjunction with other L.A. Care Health Plan departments to improve efficiencies and decrease duplication. The primary objective of the oversight audit is to ensure compliance with L.A. Care Health Plan's policies and procedures, standards of care, Local, State, and National regulatory requirements, and provisions of the purchaser contracts (e.g. SDHS, MRMIB, CHP). The oversight audit consists of document review and staff interviews to verify that policies/procedures/processes have been implemented and are being applied and complied with. This may include, but not be limited to, audits of case files and medical records. The oversight audits are conducted to ensure compliance with the following requirements:

- Annual approved Utilization Management Program, Work Plan, and Evaluation
- UM Policies/Procedures/Processes
- UM Administrative capacity, staffing resources
- UM Over/Under Utilization
- UM referral management
- UM Criteria and consistency of application of criteria
- Emergency Services and After Hours Authorizations
- UM sub-delegation activities
- UM Case Management, for Members identified by the HRA or CM program as "low" or "moderate" risk
- UM Care Coordination for in and out of network referrals/hospitals
- UM Care Coordination for Linked and Carved Out Services

SUPPLEMENTAL AUDITS

Focused supplemental audits, supplemental audit topics may be identified by the Utilization Management Committee, CMO, Medical Director, and/or as a mid-year assessment of new legislative implementation requirements or indicated as a consequence of findings from internal (e.g., performed by L.A. Care) or external (e.g. State or Federal) oversight/audit activity. The purpose of a supplemental audit is to capture more specific/detailed information that may not be captured through Encounter Data, Supplemental Reports or the annual oversight audit. The goal of the supplemental audit is to ensure compliance with L.A. Care Health Plan's Utilization Management department's policies and procedures, standards of care, regulatory requirements, and provisions of purchaser's contracts with a specific issue. The supplemental audit may consist of document review, file review and/or medical record review and staff interviews. Supplemental audits may be used to capture more specific or detailed information and/or to follow-up on identified deficiencies or areas of concern.

A sampling methodology, used to select member records, ensures a representative sample from the delegated entity for the supplemental audit.

Supplemental audit tools are scored according to the methodology approved by the UM Committee.

The supplemental audit may address any Utilization Management and coordination of care category as identified by L.A. Care Health Plan UM Program..

CONTINUOUS MONITORING ACTIVITIES

Continuous Monitoring Activities are used to further supplement the basic oversight activities of annual/focused audits and supplemental report submission review in order to provide more comprehensive and timely oversight in selected areas where episodic audits/review have not been adequate in ensuring compliance to regulations. A sampling methodology appropriate to each continuous monitoring activity is defined to ensure representative sampling, and approved by the UM Committee. Examples of continuous monitoring may include, but are not limited to:

- Referral Management – Timeliness and Clinical Decision Making
- Case Coordination Review for in and out of network referrals and hospitals
- Care Coordination for Linked and Carved Out Services Delegation Oversight Review
- Care Coordination for HRAs and care management services for low and moderate risk acuity levels

Continuous monitoring of unappealed denials

The L.A. Care UM Department reviews denials issued and submitted by the delegates. Delegated PPGs are required to submit all denial letters with any supporting documentation current to the denial or on schedule defined in L.A Care's Delegation Oversight Monitoring Policy

Plan and PPG denial letters are evaluated for compliance in the following areas:

- Timeliness of the decision-making and notification process
- Physician involvement in the decision making
- Clear and concise denial reason
- Appropriate information available for decision-making
- Documentation of criteria for medical necessity denials or benefit reference
- Appeal rights and process (***NOTE: Appeals process differs for members based on lines of business***)
- Appropriate template

If deficiencies are found in the initial review, the Plan or delegated PPGs are notified of the areas of deficiencies for immediate correction. Continued non-compliance issues are reported to the Internal Compliance Committee (ICC) for recommendations in corrective action planning or disciplinary action. Delegated Physician Group letters are also audited during the annual oversight audits. Corrective action plans are required for those PPGs with less than 90% compliance.

- PPGs with deficiencies or corrective action plans will be monitored according to L.A. Care policy.
- If a PPG remains non-compliant, the findings will be reported to the Delegation Oversight Committee for a decision regarding continued delegation.

The Plan will provide delegated PPGs with the approved CMS/DHCS or L.A. Care letter templates that need to be used, at least once every year or more often as the need arises. This is to ensure that the PPG are using standard regulatory approved language.

5.4 DE-DELEGATION

L.A. Care retains the right, based on quality issues to approve, suspend, and terminate delegated entities in situations where it has delegated UM decision making.

5.5 BENEFITS

Member Handbooks (Evidence of Coverage) for the L.A. Care Covered™ plans are maintained by Commercial & Group Plan Operations and are made available electronically to all members on the member website and portal, as well as via hard copy upon request. The Benefits section of the handbook describes in detail the covered and non-covered services, procedures, and medical equipment for the L.A. Care Covered™ line of business. The Summary of Benefits section provides a detailed listing of all copayments, deductibles and other cost sharing information.

Transition to Other Care When Benefits End

L.A. Care assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefit end.

5.6 NEW MEDICAL TECHNOLOGY

L.A. Care evaluates the inclusion of new technologies and new applications of existing technologies in the benefit plans. The Pharmacy and Therapeutics Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee and to the Quality Oversight Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices.

Members and providers may ask L.A. Care to review new technology. To request a new technology review or new use of an existing technology, the PPG may contact the UM Medical Director or UM Director at (877) 431-2273.

5.7 RESPONSIBILITY OF PARTICIPATING PROVIDERS

PPGs are responsible for primary (basic) medical case management, coordinating health care services, and referral management and authorization of services for which the PPG has financial responsibility, for members enrolled with their primary care physicians.

The PPG is responsible for notifying and obtaining authorization from L.A. Care's UM department for services which L.A. Care has financial responsibility. Please refer to the contract DOFR. Certain PPGs may have delegation for extended UM activities which all the PPG to review and coordinate services that a L.A. Care's financial responsibility. Please review your PPGs delegation status prior to making UM determinations.

The PPG agrees and is required to:

- Provide supportive care management/care coordination activities for the PCPs
- Make available to L.A. Care any requested data, documents and reports.
- Allow site visits, periodic attendance at UM meetings, evaluation and audits by L.A. Care or other agencies authorized by L.A. Care to conduct evaluations.
- Have representation and involvement in L.A. Care's UM committee meetings and other activities scheduled to enhance and/or improve the quality of health care services provided to L.A. Care's members.

5.8 AFTER HOURS AUTHORIZATION

PPGs must have a system in place for members to contact their Primary Care Physician after hours (24 hours, 7 days a week). This includes contacting the delegated UM Staff or physician covering for the PCP or PPG for resolution of expedited authorization requests and resolution of expedited authorization requests and hospital notifications.

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

L.A. Care Health Plan provides members and practitioners access to UM staff when they are seeking information regarding the Utilization Management process and the authorization of care.

- UM Staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
 - The toll free UM number at L.A. Care UM is (877) 431-2273.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff members identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- For telephone calls from Members and Providers regarding UM issues:
 - For Members: L.A. Care will accept collect calls from members and also provides the following toll free numbers (L.A. Care product specific member 800 toll free numbers)
 - TDD/TTY services for members who need them.
 - Language assistance for members to discuss UM issues.
 - For Practitioners: L.A. Care provides a Toll-free telephone number/L.A. Care's UM toll free provider 800 referral management: 1-877- 431-2273
- L.A. Care's Web Sites for members and providers provides the following information.
 - L.A. Care's processes for UM communication services that include:
 - Business hours during which UM staff are available.
 - Instructions for giving and getting specific information regarding a UM request.
 - Instructions for faxing or leaving a voice mail message outside of business hours, which also prompts members and practitioners to provide their contact information so that UM staff can respond back to them on a timely basis as appropriate
 - How to access language services
 - Resources for providers to download and use in their practice such as a C&L Provider Toolkit, interpreter request/refusal labels, patient language identification labels, translated signage, and the Employee Language Skills Self-Assessment Form.

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

5.9 UM REFERRAL MANAGEMENT REVIEW PROCESSES

Services Exempt from (Not Requiring) Prior Authorization (Pre-service Review)

- PPGs must provide, arrange for, or otherwise facilitate the following services, including appropriate coverage of costs without prior authorization as described in corresponding policies and procedures.
 - Emergency services (medical screening and stabilization) where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed and when an authorized representative, acting for L.A. Care, has authorized the provision of emergency services
 - Preventive health services for all ages including immunizations
 - Family Planning Services including outpatient abortions through an in-network family planning provider
 - Basic in-network prenatal care, including OB/GYN in-network referrals and consults.
 - Sensitive and confidential services and treatment, including but not limited to, services relating to sexual assault, pregnancy and pregnancy related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment)
 - Sexually Transmitted Disease (STD) treatment services in network including follow-up care
 - Confidential HIV counseling and testing services in network family planning provider

5.10 SERVICES REQUIRING PRIOR AUTHORIZATION

The delegation of certain UM activities affords flexibility for the PPG to establish internal prior authorization requirements. These requirements must be reviewed and approved by L.A. Care through the delegation process. Delegation status for UM is defined as 1) extended delegation, which allows PPGs to review and make decisions on services that are in the shared risk pool or 2) standard delegation which allows PPGs to make determinations in the PPG risk pool but must obtain prior authorization for defined services from L.A. Care.

There are services for which the PPG must submit a request/referral to L.A. Care for prior authorization, or notification concurrently with or retrospective of the services for authorization by L.A. Care. All referral requests submitted to L.A. Care will be responded to within the defined timeframes as follows:

- Routine – 5 working days from receipt of the information
- Expedited – 24-48 hours from the receipt of the request for service **(NOTE: LACC timeframe for expedited differs from other L.A. Care lines of business)**

Unless defined in the most recent L.A. Care PPG Auto Approval Listing, the services listed below, and any future updates dependent on delegation and DOFR, must first be authorized by L.A. Care's UM department, or its delegated entity:

- Certain pharmaceuticals (the pharmacy prior-authorization process can be found in the Pharmacy Manual)
- Durable Medical Equipment (DME)
- Home Health Services
- Hospice
- Non-Emergent/Non-Urgent Hospital admissions (see DOFR)
- Medical Supplies (not provided in physicians' offices)
- Most elective surgical and invasive diagnostic procedures (inpatient or outpatient facility component) (see DOFR)
- Orthotics & Prosthetics
- Physical/Occupational & Speech therapies (see DOFR)
- Rehabilitation services
- Transplant evaluation

UM SERVICES NOT DELEGATED TO PPGS:

(Unless the PPG is full risk or dual risk contracts)

Referrals for:

- Power Wheelchairs
Coagulation Factors (see pharmacy list)

Referral Management Processes are:

- Pre-Service Review (also called Prior Authorization, Pre-certification)
- Concurrent Review
- Post Service Review (service provided but no claim has been submitted)
- Retrospective Claim Review
- Second Opinion Review
- Reconsideration Review
- Independent Medical Review

NOTE: Referral requests submitted as expedited/urgent must meet the contract definition for urgent care. The Health and Safety code defines urgent services as:

Expedited (urgent) request means any request for medical care or treatment with respect to which the application of the time periods for making non urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the members medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Referrals submitted as such will be reviewed by L.A. Care clinical staff to ensure the service requested meets this definition. Referrals that DO NOT meet the definition will be modified to the appropriate determination status, i.e. routine, and processed accordingly. Members will be notified orally of the modification and the requestor will receive notification of the modification and given an opportunity to submit a reconsideration of the determination.

5.11 COORDINATION OF MEDICALLY NECESSARY SERVICES

The PCP is responsible for providing members with routine medical care and serves as the medical case manager within each managed care system. Referrals are made when services are medically necessary, outside the PCP's scope of practice, or when members are unresponsive to treatments, develop complications, or specialty services are needed. The PCP is responsible for making referrals and coordinating all medically necessary services required by the member. Pertinent summaries of the member's record should be transferred to the specialist by the PCP.

Outpatient Referrals and Specialty Referral Tracking

If the PCP determines that a member requires specialty services or examinations outside of the standard primary care, the provider must request for these services to be performed by appropriate contracted providers. The provider must ensure the following steps in coordinating such referrals:

- Submit a referral request to the PPG or the designated hospital physician to obtain authorization for those services.
- The PPG will process the request or contact the L.A. Care UM department to obtain authorization for the facility component of services needed, as appropriate.
- After obtaining the authorization(s),
 - PCP/PPG is responsible for notifying and referring the member to the appropriate specialist or facility.
 - The PCP, office staff, or member may arrange the referral appointment.
 - Note the referral in the member's medical record and attach any authorization paperwork.
 - Discuss the case with the member and the referral provider.
 - Receive reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider, or facility the member was referred to.)
 - Discuss the results of the referral, any plan for further treatment, and care coordination with the member, if needed.

Referrals should be tracked by the PCP's office and authorizing PPG for follow-up through a tickler file, log or

computerized tracking system. The log or tracking mechanism should note, at a minimum, the following for each referral:

- Member name and identification number
- Diagnosis
- Date of authorization request
- Date of authorization
- Date of appointment
- Date consult report received

Receipt of Specialist's Report

The PCP must ensure timely receipt of the specialist's report (e.g., use of tickler file). Reports for specialty consultations or procedures should be in the member's chart within a given timeframe, usually two (2) weeks. If the PCP has not received the specialist's report within the determined timeframe, the PCP should contact the specialist to obtain the report. For urgent and emergent cases, the specialist should initiate a telephone report to the PCP as soon as possible, and a written report should be received within two (2) weeks.

Member Eligibility Verification

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

Minimum Clinical Information for Review of UM Referral Requests

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When making a determination of coverage based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs as necessary.

Clinical information for making determinations of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:

- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

Timeliness Standards

Timeliness standards for decisions and notification of UM decisions are described for each line of business in the most current UM policies and procedures. Please contact LA Care for the most recent version of the policies and matrix.

For operational purposes, L.A. Care's timeliness standards for the initial start date of a referral are:

- Routine requests
 - Day of receipt of the request as "Day 0"
 - Day following receipt of the request as "Day 1"
- Expedited or Urgent requests (within 72 hours)
 - 24 hours is equivalent to one calendar day
 - 72 hours is considered as 3 calendar days.

Utilization Management Criteria

Approved UM Criteria are utilized for modifying, deferring, or denying requested services. PPGs are required to utilize evidence based criteria when making UM determinations.

L.A. Care requires that PPG UM Criteria be:

- Evidence-based Reviewed or developed, and adopted, with involvement from actively practicing health care providers.
- Consistent with sound clinical principles and processes.
- Evaluated at least annually and updated as necessary.

L.A. Care adopts and maintains approved UM Criteria.

UM criteria are used to determine medical necessity in the referral management Treatment Authorization Request (TAR) review process.

L.A. Care Approved Criteria and Application of UM Criteria

- UM Criteria used when determining medical necessity for a utilization review request in the following hierarchy order are:
 - Auto Auth Criteria as approved by the UM Committee; if Auto Auth Criteria do not apply; then
 - Other Utilization Management Committee Approved Criteria such as, but not limited to Synaxis Criteria, Medical/Nutritional Criteria, Pharmacy Therapeutics & New Technology Approved Criteria, etc; If other approved criteria do not apply, then
 - MCG Criteria (formally called Milliman Care Guidelines)
 - McKesson/Interqual
 - Apollo UM Criteria
 - Uptodate.com

However, in situations where two or more decision making criteria as listed above are available, MCG Criteria (formally called Milliman Care Guidelines) will be utilized as first choice. MCG Criteria are also to be used as the first choice in Appeals and other requested Clinical reviews.

- Definition of Medical Necessity (Product Line specific when the above criteria do not apply to a specific request for a UM decision) – Medical Necessity is a term for those services provided to treat an illness or injury according to established and accepted medical practice standards. Medically Necessary or Medical Necessity means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:
 - Consistent with nationally accepted standards of medical practice:
 - “Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
 - For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
 - Because nationally developed procedures for applying criteria, particularly those for lengths of hospital stay, are often designed for “uncomplicated” patients and for a complete delivery system, they may not be appropriate for patients with complications or for a

delivery system with insufficient alternatives to inpatient care.

Therefore, L.A. Care considers at least the following when applying criteria to a given individual:

- age
 - comorbidities
 - complications
 - progress of treatment
 - psychosocial needs
 - home environment, when applicable
- L.A. Care also considers characteristics of the local delivery system available for specific members, such as, but not limited to:
 - availability of contracted hospitals within the network and other hospitals out of network
 - availability of contracted specialists and specialty centers
 - availability of non-contracted specialists and specialty centers which may be contracted through a one-time MOU for a specific member for unusual specialty services
 - availability of skilled nursing facilities, subacute care facilities or home care in the service area to support the patient after hospital discharge
 - coverage of benefits for skilled nursing facilities, subacute care facilities or home care where needed
 - local hospital's ability to provide all recommended services within the estimated length of stay
 - If none of the approved UM Criteria meet the member's medically necessary service needs, even when considering the member's individual needs, and/or the characteristics of the local delivery system, then the physician reviewer considers other alternatives, such as:
 - approving higher levels of care within the local area
 - making arrangements to send the member out-of-the local network or out-of-Plan for the needed services
 - arranging for case discussion with a local physician consultant or a physician consultant from the contracted vendor
 - assembling a panel of independent experts to identify other possible alternatives
 - Ultimately the physician reviewer makes a UM decision in a timely manner that will meet the member's individual medically necessary needs. In these instances, the physician reviewer makes the determination in a manner which is consistent with L.A. Care's Utilization Management Principles.

Continuing Coverage of Services for Covered California Enrollees and New enrollees:

When a newly enrolled member joins a L.A. Care contracted PPG or a PPG's physician and/or specialist leaves the Plan either voluntarily or involuntarily Members assigned to them may require continuity of care services. To be eligible for "Continuity of Care" (COC) services the member must request the service. Requests can be made by phone, in writing or by fax.

New Enrollees may request to receive continuity of care by a non-participating provider, if at the time of the Members enrollment the Member was receiving services from that provider.

Continuing medical services for Covered California members who request continued access, and the provider agrees and has been treating the member for:

- Acute condition - For the duration of the condition.

- Serious chronic (long term) condition – For a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider.
- Pregnancy – includes the rest of the pregnancy and immediate postpartum care.
- Terminal illnesses/conditions - For the length of the illness.
- Children from birth to age 36 months – For up to 12 months.
- Surgery or other procedure that has been authorized by the plan as part of a documented course of treatment.

L.A. Care requires the terminated provider whose services are continued beyond the contract termination date to:

- Agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
- If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, L.A. Care is not required to continue the provider's services beyond the contract termination date.
- Unless otherwise agreed by the terminated provider and L.A. Care or by the individual provider and the provider group, the services rendered will be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider.
- Neither L.A. Care nor its delegated provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates.

L.A. Care requires a nonparticipating provider whose services are continued for a newly covered enrollee to:

- Agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
- If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.
- Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered will be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider.
- Neither L.A. Care or its delegated provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates

Members are responsible for any amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the L.A. Care or its delegated provider group.

Timeframes for continuity of care services are:

Acute Condition (for example, pneumonia)	As long as the condition lasts
Serious Chronic Condition (for example, severe diabetes or heart disease)	No more than 12 months. Usually until you complete a period of treatment and your doctor can safely transfer your care to another doctor

Pregnancy	During Pregnancy and immediately after the delivery (the post-partum period)
Terminal Illness	As long as the person lives
Care of a Child 0- 36 months	For up to 12 months
An already scheduled surgery or other procedure (for example, knee surgery or colonoscopy)	The surgery or procedure must be scheduled to happen within 180 days of your doctor or hospital leaving your health plan
Mental Health Acute Condition	90 days or though the acute period of illness

PPGs are responsible for the initial review of continuity of care for new enrollees or for members assigned to a terminated provider. PPGs must assess the enrollees request or assess the UM referral management system to identify Members currently schedule with or who may have open authorizations with a terminated provider.

PPGs will be responsible for negotiating any Letter of Agreements/Intent (LOA/LOI) to validate contract terms as well as ensuring if necessary, a quality assessment is performed validating there is no quality of care issue with the provider, i.e. 805 Reports, Office of Inspector General Reports, Hot Sheet etc.

- PPGs are responsible for ensuring care coordination Member’s requesting continuity of care to ensure care needs are met and the member is safely transitioned to a network provider upon the completion of the identified and approved treatment plan. In instances where there is a facility component to the continuity of care requests, PPGs are responsible for notification to L.A. Care UM Department to ensure the appropriate facility authorizations and necessary LOA/LOI are in place.

5.12 PPG UM CRITERIA

- PPGs must review or adopt specific evidence based UM criteria to be used for decision making.
 - L.A. Care reserves the right to review the PPGs criteria on an annual basis to ensure that PPGs are using evidence based criteria and the most current available versions of the evidence based criteria.

Criteria for use in L.A. Care review of Appeals and other requested Clinical Reviews (e.g. Clinical Grievance Review, PQI’s, etc.)

- MCG Criteria (formally called Milliman Care Guidelines) are used by L.A. Care as the first choice in review of Appeals and other requested Clinical reviews (e.g. Clinical Grievance Review, PQIs, etc.).
- Assessment of Consistency of UM Decisions

- PPGs are required to ensure that UM criteria be applied in a consistent and appropriate manner by physician and non-physician UM staff based on available medical information and the needs of individual Members.
- L.A. Care’s requirements for PPG Inter-rater Reliability (IRR)
 - At least annually, PPGs are required to ensure that consistency and appropriateness with which health care professionals involved in utilization review apply criteria in decision making is evaluated and reported.
 - The assessment of IRRs applies only to determinations made as part of a UM process. A primary care practitioner's referral of a member to a specialist, when the referral does not require prior authorization, is not considered a UM determination.
 - Opportunities to improve consistency in the application of criteria are acted upon, as appropriate.
 - Require IRR Methodologies use Statistically Valid Samples:
 - 5 percent or 50 of its UM determination files, whichever is less; or
 - NCQA “8/30 methodology” or a valid sampling of hypothetical cases
- L.A. Care reserves the right to review the PPGs IRR on an annual basis to ensure that PPGs are using required IRR Methodology with statistically valid samples.

Access to and Disclosure of UM Criteria and UM Policies/Procedures and Processes

UM criteria and UM procedures and processes are available to L.A. Care practitioners, providers, members and their representatives, and the public upon request. To obtain a copy of any L.A. Care UM criteria, UM policies/procedure and UM processes, practitioners, providers, members and their representatives, and the public may contact the L.A. Care Member Services Department at **1-888-839-9909**, or the L.A. Care UM Department at **1-877-431-2273** and ask to speak with the UM Director or UM Manager to make the request.

PPGs shall make information available so that practitioners, providers, members, member representatives, and the public know how to request the PPG’s UM criteria, UM policies/procedures and UM processes.

PPGs shall maintain logs for requests of UM Criteria, and report the number and types of UM Criteria requests annually to their UM Committees.

Use of Board Certified Consultant to assist in making UM Decisions based on Medical Necessity and covered Medical Benefits

- L.A. Care provides a description of guidelines for the use of Board Certified Consultants to assist in making UM decisions based on medical necessity, covered medical benefits as defined in the member's Evidence of Coverage (EOC), and care or services that could be considered either covered or non-covered, depending on the circumstances.
- L.A. Care has access to a broad range of contracted medical, pharmaceutical, and behavioral health practitioners in various specialties and subspecialties in Los Angeles County available for verbal and written consultation.
- L.A. Care also maintains a contract with an outside vendor for various services, including use of Board Certified Consultants, who are available for review upon request.
 - If the Board Certified Consultant is from the contracted vendor that L.A. Care uses to obtain the services of a Board Certified Consultants (i.e. non-L.A. Care physician/peer reviewer), the consultant shall provide advice that the UM Medical Director/peer reviewer considers in making his/her UM decision.

- Non-L.A. Care consultants cannot make a denial decision

Requests for Authorization (Referrals) to L.A. Care's UM Department

Requests for Authorization (Referrals) may be submitted on paper, by phone, or electronically. All requests must be submitted on a L.A. Care Referral Form and include the following information:

- Requesting provider
- Patient's name, date of birth, address, phone number, and social security number
- Confirmation of current L.A. Care eligibility
- Patient's diagnosis and medical history supportive to the service requested
- Supportive medical records needed to make a determination
- Appropriate coding (using current coding specifications such as, CPT, ICD procedure, and/or HCPCS codes), and identification of services requested
- Identification of requested provider of service, including name, type of provider, location and provider's phone number

Notification Process for UM Decisions (*See L.A. Care UM Timeliness Matrix*)

Notifications of UM decisions are made in accordance with all current regulatory requirements as described for each line of business in the most current UM Policies and Procedures. For PPGs delegated to perform UM functions, the PPG is responsible for member and provider notifications.

PPGs are required to notify members and providers of UM determinations related to approvals, modifications, deferrals (pending) or denials.

Providers should be notified of determinations by phone within 24 hours of the determination. The written determination must be mailed to the Member and Provider within two (2) business days of the determination.

For services that are the financial responsibility of the PPGs hospital shared risk pool or L.A. Care:

- PPGs with Standard Delegation
 - PPG managing an outpatient referral and using a contracted L.A. Care facility, PPG UM Department is responsible for notifying the member, the requesting provider, the rendering provider and the PCP.
 - When PPG must utilize a non-L.A. Care facility, PPG will pend the determination and route the request to L.A. Care's UM Department for review/determination. **NOTE:** Decision-making timeframe is within the 5 business days of receipt of the information necessary to make the information:
 - Upon final determination, L.A. Care will notify the PPG UM Department, of the determination and
 - PPG UM Department is responsible for notifying the member, the requesting provider, the rendering provider and the PCP.
 - For requests with insufficient information to make the determination AND additional information is necessary to make an appropriate determination, the PPG will issue a deferral notification. The deferral must be communicated, completed before the 5th calendar day of receipt of the request and approved by the Member and Provider; the notification must include the reason for the delay and a date the request will be completed (must be within the 14 calendar days of the request), the L.A. Care UM Department will notify the PPG UM Department and the member.

- PPGs with Extended Delegation
 - PPG is responsible for processing the request, notifying the appropriate providers and documentation of notification to the providers and members as defined in the **L.A. Care UM Timeliness matrix**
 - PPG will notify LA Care as defined in the PPG contract agreements (i.e. electronic file exchange or Excel file logs).

L.A. Care's CAP Deduct Process

For PPGs with standard delegation, should a PPG authorize a service that is L.A. Care's financial responsibility according to the DOFR, L.A. Care will honor the authorization request and pay the claim, but as defined in the PPG Service Agreement, services are subject to capitation deduction from the PPG's monthly capitation (See PPG contract Section 1.22 E). L.A. Care will notify the PPG and L.A. Care's Provider Network Operations Department when determination is made that a service is eligible for CAP deduct.

Use of Out of Network Providers

L.A. Care requires the use of the L.A. Care contracted network. As LA Care Covered members may have additional out-of-pocket expenses for Out of Network Providers, PPGs should verify Member Benefits prior to arranging Out-Of Network, non-emergency services. For service needs that cannot be met within the network and that are in the shared risk pool or L.A. Care's risk, PPGs must contact L.A. Care UM Department for assistance. L.A. Care staff will maintain a process to facilitate those Memorandum's of Understanding between L.A. Care and the Out of Network Provider.

If a PPG continuously utilizes out of network services without notification to L.A. Care, L.A. Care will honor the authorization request and pay the claim, but as defined in the PPG Service Agreement, services are subject to capitation deduction from the PPG's monthly capitation.

Rescission or Modification of an Authorization after a Service has been provided is not allowed PPG shall not rescind or modify an authorization after the provider renders the health care service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract, or when the PPG did not make an accurate determination of the member's eligibility.

Delay, Denial, Modification, and Termination Determinations/Notice of Action Letters

PPGs are required to utilize the most recent version of the template UM Notice of Action Letters (NOA's) specific to the product line. Copies of the template letters are provided to the PPGs, or may be obtained by contacting the L.A. Care UM Department.

Unusual Specialty Services

L.A. Care and its PPGs/PCP must arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within network, when determined Medically Necessary.

Services Received in an Alternative Care Setting

The PCP should receive a report with findings, recommended treatment and results of the treatment for services performed outside of the PCP's office. The provider must also receive emergency department

reports and hospital discharge summaries and other information documenting services provided.

Home health care agencies submit treatment plans to the PCP after an authorized evaluation visit and every 30 days afterward for review of continued home care and authorization.

The PCP should also receive reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action.

Reference to Basis of UM Determination

The following are included in a UM Notice of Action Letter:

- Clear, concise documentation and communication of the reasons for the determination, so that Members and Practitioners receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.
- A reference to the UM Criteria, citation (when applicable), or benefit provision on which the decision is based.
- Information about how the member, upon request, can obtain a copy of the actual UM Criteria or benefit provision on which the decision was based.

Contacting the Peer Reviewer (Reconsideration)

All UM Notice of Action correspondences sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer in order to allow the requesting practitioner the opportunity to discuss issues or concerns regarding the decision.

A requesting practitioner may call L.A. Care, or the delegate making the decision to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer, or may write to supply additional information for the physician (or peer) reviewer.

To file a reconsideration of a UM determination, the reconsideration must be filed by the requesting practitioner within 24 hours of the notice of action.

If a requesting practitioner would like to discuss a denial/modification decision made by a L.A. Care physician (or peer) reviewer, please call L.A. Care's UM Department at **1-877-431-2273**.

- L.A. Care's UM Department responds to reconsideration requests within one (1) business day of the receipt of the requesting practitioner telephone call or written request.
- If the physician (or peer) reviewer reverses the original UM determination based on the discussion with, or additional information provided by the requesting practitioner, the case will be closed.
- If reconsideration does not resolve a difference of opinion, and the previous UM determination remains or a modification results, or the requesting practitioner does not request reconsideration, the requesting practitioner may submit a request for review through the appropriate practitioner dispute processes or may appeal on behalf of the member, if appropriate.

Practitioner Appeal Processes--How to Dispute an Adverse Determination Process for Filing a Formal Appeal

If a requesting practitioner believes that a determination is not correct, he/she has the right to appeal the decision on behalf of the member by filing a grievance with L.A. Care Health Plan. The requesting practitioner

should submit a copy of the member's denial notice and a brief explanation of his/her concern with any other relevant information to the address below:

L.A. Care Health Plan
Attn: Appeals and Grievance Unit
P.O. Box 811610
Los Angeles, CA 90081
1-888-839-9909
FAX 1-213-438-5748

Pre-service Review (Prior Authorization)

Pre-service Review or Prior Authorization, the formal process requiring a health care provider to obtain advance approval for coverage of specific services or procedures, allows for benefit determination, determination of medical necessity and clinical appropriateness, level of care assessment, assignment of the length of stay for inpatient admissions, appropriate facility placement prior to the delivery of service, and identification of the intensity of case management that may be needed for optimal patient outcomes.

- **24 hour Access to Pre-service Review (Prior Authorization)**
A Physician with an active unrestricted California license is available 24 hours a day to review requests for post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department, if necessary.
- **Services Requiring Pre-service Review (Prior Authorization)**
L.A. Care develops, reviews, and approves at least annually, lists of auto pay and auto authorization. Any procedure, treatment, or service not on these lists requires prior authorization. L.A. Care communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization. PPGs may obtain a copy of the L.A. Care list by contacting the L.A. Care Oversight and Compliance Specialist at (877) 431-2273.
- **Prior Authorization Specialty Referral Tracking Systems**
PPGs are required to maintain a system to track and monitor specialty referrals requiring prior authorization. The system tracks the decision (authorization, denial, deferral, modification, and termination) and the timeliness of the decision. L.A Care ensures that all contracting health care practitioners are aware of the referral processes and tracking procedures.
- **UM Services Types** include:
 - **Pre-service – Urgent** is an expedited authorization in which the provider indicates or determines that following the standard timeframe could jeopardize the member's life or health or ability to attain, maintain or regain maximum function. These determinations are made as expeditiously as the member's health condition requires and not more than within 24-48 hours after receipt of the request for the service
 - **NOTE:** Service types identified by the PPG Staff as Pre-Service Urgent may be reviewed for appropriateness by the L.A. Care UM Medical Director. PPG will be contacted if a request is determined by the Medical Director not to meet the definition of urgent, and advised that the requested service will be revised to reflect a routine request. Providers who disagree with the revision may contact L.A. Care at **(877) 431-2273**.
 - **Pre-service – Routine** is a standard request for services not otherwise exempt or expedited, reviewed within five working days from the date of the receipt, or less, and is consistent with urgency of the member's medical condition.

- **Concurrent review of authorization** is an authorization for treatment regimen already in place, reviewed within five working days or less, and is consistent with urgency of the member’s medical condition
 - **NOTE:** This does not include inpatient concurrent review; pre-service inpatient concurrent review of service must be responded to within 24 hours of the request
 - **Post Service** – service has occurred without prior authorization; determination within 30 calendar days of the request; no claim has been submitted with the request
 - **Retrospective Claim review**– service has occurred without prior authorization and request is submitted with a claim; determination is made within 30 calendar days of the request or the regulatory requirement for claims processing.
- UM determinations are made in accordance with the standard regulatory requirements for referral management and include:
 - Approve
 - Denied
 - Modified
 - Denial
 - Pended (Delayed/Deferred)

Concurrent Review/In-patient Hospital Care

Concurrent Review is the assessment used to determine medical necessity or clinical appropriateness of services as the services are being rendered. Concurrent review is used for the assessment of the need for continued inpatient or ongoing ambulatory care. Concurrent review is generally conducted telephonically, but may also occur on site.

Concurrent review includes, but is not limited to:

- Verifying medical necessity
- Determining approximate length of stay
- Determining appropriate level or intensity of service and setting of care
- Ensuring access to ancillary care
- Determining and/or changing the level of case management, when appropriate
- Initiating timely discharge planning activities

Unless defined in the L.A. Care/PPGs delegation agreement as “extended”, PPGs with “standard delegation” are not delegated to perform concurrent review.

Hospital inpatient care may be pre-planned/ pre-authorized (elective), urgent or emergency admissions. The PCP is responsible for obtaining required pre-authorizations for elective inpatient care from the PPG. The PCP must notify the PPG of an emergency admission. **Unless delegated for the management of admissions and concurrent review, the PPG must notify L.A. Care of all inpatient admissions.**

While a member is hospitalized, the PCP must:

- Maintain access to a physician to manage the member while in the hospital; this can be arranged through a hospitalist network or contracting with the attending/admitting hospitalist providing care to the member.

- Coordinate, with the assistance of UM staff, care for members admitted to out of network facilities for emergency care, or other reasons. After determination of the appropriateness of an emergency admission and a transfer assessment is made, the member will either be transferred to a network facility or care will be continuously monitored at the initial facility of admission until discharge, or a transfer is appropriate.
- Respond to the concurrent review process, including level of care, length of stay, and medical necessary elements, when he/she acts as the attending physician or works in conjunction with the attending physician for a hospital stay.
- Assist with discharge planning by ordering and requesting authorization for appropriate elements of discharge.

Inpatient Concurrent Review

Inpatient concurrent review is usually a coordinated effort between L.A. Care and the PPG. Once notified, L.A. Care's UM staff or its delegate's will perform telephonic reviews with the hospital staff.

- Inpatient concurrent review will begin within one (1) day of notification of the admission and include an assessment of the appropriateness of the level of acute care by using accepted criteria.
- Concurrent review will be conducted periodically on or before the dates assigned at the end of the initial review and each subsequent review. For the applicable timeframes, see the most recent version of the UM Timeliness Decision Matrix.
- Concurrent review includes an evaluation of the following:
 - Appropriateness of acute admission
 - Plan of treatment
 - Level of care
 - Intensity of services/treatment
 - Severity of illness
 - Quality of care
 - Discharge planning/Transition of care

These reviews will be conducted utilizing accepted guidelines for acute levels of care, such as intensity of service and severity of illness criteria, MCG Guidelines, or other guidelines and criteria developed and/or approved by L.A. Care.

PPGs may perform the management of hospital admissions by way of a hospitalist program, or retain the services of a hospitalist. At all times, the hospitalist will facilitate care with L.A. Care UM staff or its delegate. Members in a hospital setting for greater than 10 days must be reported to L.A. Care's UM Department Manager, or the PPGs assigned performance team member for assistance in care coordination.

Concurrent quality issues noted during utilization review will be documented and reported to the PPG, L.A. Care's UM Medical Director and Quality Improvement department. When appropriate, quality issues will be discussed with the attending physician by the UM medical staff for appropriate intervention. Depending on the urgency or gravity of the situation, discussion of the issues may also be necessary with L.A. Care's Senior Executive Administration.

Utilization review concurrent focus will be proactive, and UM/Case Management levels of focus will be employed as appropriate.

L.A. Care will coordinate continued monitoring and management of concurrent reviews. Whenever possible, L.A. Care will transfer members admitted to non-contracted hospitals or hospitals where the PPG does not have hospital services, to an in-network hospital.

Admissions to non-contracted hospitals– hospitals are reimbursed based on the most recent contracting methodology and require a one-time agreement (MOU). **For PPGs with extended delegation to manage hospital admissions through the shared risk pool, PPG must notify LA Care’s UM Department immediately to initiate the MOU process.**

Discharge Planning

CCS

- Members under the age of 21 years and who have conditions eligible for services through CCS, L.A. Care will ensure timely referrals are made to and for CCS specialists, hospitals and specialty centers.
 - Providers must follow the most recent CCS Numbered Letter instructions on referral to CCS paneled hospitals using CCS paneled physicians. Providers are referred to the DHCS website for full instructions: <http://www.dhcs.ca.gov/Services/CCS/Pages/default.aspx>
- For members admitted to non-CCS paneled facility, L.A. Care and its delegates will ensure timely referrals are made to CCS and CCS staff informed of the member’s stability for transfer as needed. Once stable, L.A. Care or its delegates will obtain approval to transfer to an appropriate CCS-paneled center.
- L.A. Care and its delegates will ensure, the cases where CCS is pending a determination, L.A Care will approve medically necessary services as needed. Authorization documentation will evidence appropriate decision-making pending the final CCS decisions; decisions will not be held pending CCS final decisions. Once the CCS decision is made, the authorization/referral will be updated in the appropriate information system to reflect the decision and the CCS Service Authorization Referral (SAR)

Discharge Planning/ Transition of Care

L.A. Care UM staff or delegates will begin discharge planning within 24 hours of notification of admission and will facilitate the involvement of a multidisciplinary team of providers, care coordinators, and others as appropriate. Patient and family engagement will occur as appropriate, throughout the stay to assure appropriate discharge plans are in place.

Discharge plans will be based on member clinical condition, treatment requirements, the family situation, available benefits and community resources. The discharge plan will be consistent with the member’s existing care plan and will be added to the ICP. PPG Medical Directors should contact the attending physicians for a peer to peer review of the cases which fall out of standard care guidelines. In cases where the PPG and the attending physician do not agree on the continued plan of care, the PPG Medical Director may consult with L.A. Care’s Medical Director for assistance.

PPGs must maintain a process to manage discharges through a Transition of Care (TOC) program. The TOC program should evaluate members at the time of the admission to identify members at “high risk” for an adverse transition. PPGs may utilize a screener to identify the most appropriate interventions for the program. If the PPG does not have a program, they should contact L.A. Care to discuss alternative options for meeting the responsibility. At risk members may be identified by the following:

- Re-admission within 30 days of discharge

- Chronic behavioral health conditions
- Members in complex case management/high care coordination
- Admissions with a projected long length of stay (greater than 10 days)
- Complex medical diagnosis/conditions
- Complex social conditions (homelessness, lack of family support)
- History of inappropriate utilization of care setting (i.e., frequent ER visits)

The minimum requirements of a TOC program include, but are not limited to:

- Robust communication process for Stakeholders including the member, care team and provider
- Timely care management process
- Ability to perform medication reconciliation
- Ability to facilitate access to needed care
- Ability to perform in-home evaluations, as needed
- Ability to coordinate home and community based services and community resources
- Ability to meet reporting and monitoring requirements timely

PPGs may utilize a screener to identify the most appropriate interventions for the program. If the PPG does not have a program, they should contact L.A. Care to discuss alternative options for meeting the responsibility.

PPGs will be assessed to ensure the TOC program meets the minimum requirements. The policy of L.A. Care is that all PPGs have a TOC which supports appropriate coordination of care in a member-center manner that is cost effective.

Emergency Notification of Admission

PPGs that do not have extended delegation must report all elective and emergency inpatient admissions to L.A. Care's UM department within 24 hours of the admission. These notifications may occur by calling in or faxing the patient's admission face sheet to the following:

1-877-452-CARE (1-877-452-2273)
Fax: 213-438-5777

Maternity Length of Stay

L.A. Care and/or PPGs shall have procedures in place that require members who deliver vaginally, or by caesarean section, to be provided appropriate maternity benefits as required by the Newborn and Mother Health Act of 1997. Prior authorization is not required for these benefits as follows:

- Post-partum stay of 48 hours following normal vaginal delivery
- Post-partum stay of 96 hours following caesarean section delivery

Decisions to discharge mothers/newborns earlier than 48 or 96 hours post-delivery are to be made by the treating physician in consultation with the mother and must include appropriate documentation for follow-up plans in the member's medical record.

When the mother/newborn are discharged prior to 48 hours for vaginal delivery/96 hours for cesarean section delivery, L.A. Care and/or PPGs shall cover a post discharge follow-up visit, when agreed to by the mother and ordered by the treating physician. A post discharge follow up visit must occur between 21 and 56 days after delivery.

The treating physician, in consultation with the mother, shall determine whether the visit will occur at home by a home health nurse or whether the member shall see the physician in the physician's office.

The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physician assessments.

L.A. Care's PCPs and OB/GYN providers are expected to provide written notification of these maternity benefits to members during prenatal care.

L.A. Care shall provide written notification of these maternity benefits to members through the EOC.

Post Service

Post Service (Retrospective Review) is the assessment of the appropriateness of medical services after the services have been provided. Post Service Review is conducted when there has been no notification or request for review prior to services being rendered. Decisions are based on medical necessity and appropriateness of care using UM Criteria and the member's benefit structure.

Post Service Review includes, but is not limited to:

- Reviewing for medical necessity and clinical appropriateness of services in those instances where authorization was not obtained. These services are usually related to the urgency of the care provided.
- Reviewing for eligibility and benefit coverage.

Retrospective Claim Review

Retrospective Claim Review is the assessment of the appropriateness of medical services related to a provider/facility claim. Retrospective Review is conducted in collaboration with the Claims Department and subject to the review timelines associated with the Claims Department. Decisions are based on medical necessity and appropriateness of care using UM Criteria and the member's benefit structure.

Retrospective Claim Review includes, but is not limited to:

- Reviewing for medical necessity and clinical appropriateness of services in those instances where authorization was not obtained.
- Reviewing for eligibility and benefit coverage at the time of service.

5.13 SECOND OPINION PROCESS

The second opinion program provides members and providers with the ability to validate the need for specific procedures. The use of screening criteria will be employed in addition to securing a second physician consult,

when necessary. Second opinions will be rendered by an appropriately qualified health care professional identified as a primary care physician or a specialist who is acting within his or her scope of practice, and who possesses clinical background, including training and expertise related to the particular illness, disease, condition or conditions associated with the request for a second opinion. Second opinions shall be provided to L.A. Care Covered members. Members shall not be responsible for costs beyond their applicable co-pay for second opinions approved by L.A. Care or the delegated PPG.

PPGs shall maintain policies to ensure second opinion request will be processed in accordance with the state regulatory requirements. PPGs requiring assistance in locating a specialist for assistance in processing requests for second opinions may contact the L.A. Care UM Department.

5.14 STANDING REFERRAL PROCESS

PPGs must maintain a process for a Member with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling to receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinating the Member's health care.

A standing referral is a referral made by the PCP for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis. A member may request a standing referral to a specialist through his/her PCP or through a participating specialist. The standing referral request will be made in collaboration with the PCP, the treating specialist, and the L.A. Care Medical Director or the delegate. If a treatment plan is necessary in the course of care and is approved by L.A. Care, in consultation with the PCP, specialist and member, a referral shall be made in accordance with the recommended treatment plan. A treatment plan may be deemed unnecessary if L.A. Care approves a current standing referral to a specialist. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member.

Standing referrals do not require L.A. Care, or its delegates, to refer to a specialist who, or to a specialty care center that, is not employed under contract with L.A. Care or the delegate to provide health care services to members unless there is not a specialist within the network that is appropriate to provide treatment to members as determined by the PCP and in collaboration with the L.A. Care Medical Director, or their designee, as documented in the treatment plan.

L.A. Care Health Plan maintains a referral management process and may delegate the referral management process to delegated entities.

PPGs shall maintain policies and procedures for referral management that include review of standing referrals for members, who require specialty care or treatment for a medical condition or disease, that is life threatening, degenerative, or disabling.

Authorization and Referral Processes

Authorization determinations for specialty referral/services shall be processed in accordance with L.A. Care's and/or its delegated entities' policies and procedures for referral management within required time frames for standing referrals, as described in this procedure.

Services shall be authorized as medically necessary for proposed treatment identified as part of the member's care treatment plan utilizing established criteria and consistent with benefit coverage.

Once a determination is made, the referral shall be made to the Specialist within four (4) business days of the date the proposed treatment plan, if any, is submitted to the physician reviewer.

The duration of a standing referral authorization shall not exceed one year at a time, but may be renewed for periods of up to one year, if medically appropriate.

Credentialing Requirements

The specialty provider/special care center shall be credentialed by, and contracted with, L.A. Care or its delegated entities' network to provide the needed services.

If standing referrals are made to providers who are not contracted with L.A. Care or its delegated entities' network, L.A. Care and/or its delegated entities shall make arrangements with that provider for credentialing prior to services rendered, appropriate care coordination, and timely and appropriate reimbursement.

In approving a standing referral, in-network or out-of-network, L.A. Care and PPGs delegated for UM will take into account the ability of the member to travel to the provider. PPGs can request assistance from L.A. Care in locating a specialist.

HIV/AIDS Referrals

When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, PPGs shall refer the member to an HIV/AIDS specialist.

When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the member's health care, who is infected with HIV/AIDS, PPGs shall refer the member to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician if:

- the nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
- the nurse practitioner or physician meets the qualifications specified in the state regulations; and
- the nurse practitioner or physician assistant and the provider's supervising HIV/AIDS specialist have the capacity to see an additional patient

Care Coordination

The PCP shall retain responsibility for basic case management/coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PPGs contract with L.A. Care.

Requests for standing referrals will be processed in accordance with state regulatory requirements

5.15 TUBERCULOSIS TREATMENT SERVICES PROVIDED BY PRIMARY CARE PROVIDER

PPGs shall have established programs for ensuring that basic care for tuberculosis is provided to members at

the primary care provider level through basic case management services.

PPGs shall ensure that primary care providers provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention to include, but not limited to:

- TB screening
- TB diagnosis
- TB treatment
- TB follow-up

PPGs shall ensure that primary care providers coordinate with Local Health Departments.

5.16 CERVICAL CANCER SCREENING

PPGs shall have procedures to provide for Cervical Cancer Screening, a covered preventive health benefit for L.A. Care Health Plan members.

The coverage for an annual Cervical Cancer Screening test shall include the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration, upon the referral of the member's health care provider (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee).

PPGs shall ensure that routine referral processes are followed when the member requests a human papillomavirus (HPV) screening test, in addition to the conventional Pap test, that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

5.17 MATERNAL HEALTH

All preconception and prenatal visits are covered by L.A. Care. Maternity care includes:

Prenatal visits

Postpartum Care

Ambulatory Care

Diagnostic and genetic testing including, but not limited to 1) Alpha fetoprotein testing; 2)

Screening for gestational diabetes

Nutritional Counseling, breastfeeding support, and supplies and counseling

L.A. Care and its PPGs must complete a comprehensive risk assessment tool for all pregnant female Members that is comparable to the American College of Obstetrics and Gynecology standard and Comprehensive Perinatal Services Program (CPSP) standards.

The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.

The risk assessment tools shall be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be

documented in the medical record.

Standard Obstetrical Record Elements

Standard Obstetrical record elements shall be included in the obstetric, nutritional, psychosocial and educational examination of pregnant members and the most current guidelines of the American College of Obstetrics and Gynecology (ACOG),

Referral to Specialists

L.A. Care and its PPGs are responsible for ensuring that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

Pregnant women that are at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals.

Specialists may include, but are not limited to:

- Cardiologists
- Psychiatrists
- Internists
- Infectious Disease
- Geneticists
- Specialty High-Risk Obstetricians
- Oncologists
- Endocrinologists

Examples of these referral types and protocols may include, but are not limited to:

- Diabetes
- Hypertension
- Hepatitis
- HIV+
- Genetic Problems
- Epilepsy or Neurological Disorder
- Renal Disease
- Alcohol or Drug Abuse
- Maternal Cardiac Disorders
- Thyroid or Other Endocrine Disorders
- Epilepsy or Neurological Disorder

Common Pregnancy Conditions/Issues Requiring Multidisciplinary Management

Pregnant Members exhibiting any of the following representative conditions/ issues will have interventions and referrals developed utilizing the Nutrition (N), Psychosocial (PS), or Health Education (HE) protocols:

- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Fear of physicians, hospitals, and medical personnel (HE)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- Housing and transportation problems (PS)

- Domestic violence (PS)
- No previous contact with health care systems (HE)
- Multiple gestation (HE), (PS), (N)
- Need for bed rest during pregnancy (PS), (HE)
- Previous receipt of unfriendly health care services (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)

Common Postpartum Conditions/Issues Requiring Multidisciplinary Management:

- Postpartum blues, postpartum depression (PS)
- Housing, food, transportation problems (PS)
- Lack of basic parenting skills and role models (HE)
- Breastfeeding difficulties (HE)
- Sexual pain/difficulties (HE)
- Severe anemia (N)

5.18 MAJOR ORGAN TRANSPLANTS

Major organ transplants are covered benefits as outlined in the member's Summary of Benefits including those medically necessary organ transplants and bone marrow transplants, which are not experimental or investigative in nature. Major organ transplant referrals are subject to L.A. Care's prior authorization process and the physician reviewer determination is based on the physician's review of medical necessity.

When a member is identified as a potential major organ transplant candidate, delegates must notify L.A. Care's Care Management Department/Transplant Unit to ensure the members is managed and referred to an approved transplant center. Transplant request will be managed using the most recent regulatory requirements, evidence-based guidelines or criteria. For members under the age of 21, L.A. Care will coordinate services with the California Children's Services Program (CCS) for consideration.

Information to be provided to the L.A. Care Health Plan's Care Manager includes, but is not limited to:

- Referral of the member for transplant evaluation.
- If an evaluation has occurred, include the evaluation and all pertinent documentation supporting member is a candidate for major organ transplant
- Major organ transplant is authorized by the CCS Program

Transplantation services are defined in the member's handbook and include, but are not limited to:

- Evaluations
- Pre-transplant diagnostic work-ups
- Organ procurement and donation related services for actual or potential donors (whether or not they are Members) in accord with the established guidelines

For covered services, L.A. Care and its PPGs are responsible for providing all medically necessary covered services. Members may be responsible for cost sharing if the service provided were not related to the transplant.

L.A. Care maintains policies and procedures on organ, blood and tissue transplantation. PPGs must notify L.A. Care of all members being referred for transplantation services.

For more information about transplantation services or to make a referral, call the L.A. Care UM Department at 1-877-431-2273 and ask to speak with a Case Manager/Transplant Services or complete a **CM REFERRAL FORM** AND SUBMIT VIA FAX # **(213) 438-5077**.

5.19 CASE MANAGEMENT

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

Care Management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members' health care across the care continuum. It includes empowering members to exercise their options and access the services appropriate to meet their individual health needs, using communication, education and available resources to promote quality outcomes and optimize health care benefits.

L.A. Care's Care Management Program includes four levels:

- Basic Care Management
- Care Coordination
- Complex Care Management
- Targeted Care Management

Basic Care Management

The Primary Care Physician (PCP) is responsible for Basic Care Management for his/her assigned members. The PCP is responsible for ensuring that members receive an initial screening and health assessment, which initiates Basic Medical Care Management.

The PCP conducts the initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and carved out services, as needed, based on the member's individual treatment plan. The PPG supports the member and PCP through the referral management process. Members whose care management needs do not exceed basic case management are considered low risk and care management activities such as follow up on Health Risk Assessment results (as applicable). PPGs are responsible for developing, updating the Individualized Care Plan (ICP) and organizing an Interdisciplinary Care Team (ICT) and as applicable to the LOB.

Care Coordination

L.A. Care's Care Management Program is a member advocacy program designed and administered to assure that the member's healthcare services are coordinated with a focus on continuity, quality and efficiency in order to produce optimal outcomes. Members who are Low and Moderate Risk level primarily receive care coordination and care management services through the PPG CM staff. These activities include review of the HRA results, completing and updating the ICP as well as organizing the ICT as warranted and as applicable to the LOB.

Care coordination by Care Managers or designated staff is provided for members needing assistance in coordinating their health care services. This service includes members who may have opted out of complex care management but have continuing coordination of health care needs. These include, but are not limited to, members assigned to or receiving:

- Out of Area/Network services
- Hospital discharge follow up calls

Developing the ICP

The HRA is the basis for the Care Plan, supplemented with Member information provided during care management planning to identify any necessary assistance and accommodations, including:

- Educational material on conditions and care options
- Information on how family members and social supports can be involved in care planning, as member chooses
- Self-directed care options and assistance available
- Information on accessing available LTSS, including IHSS services if applicable
- Available treatment options, supports, and/or alternative courses of care
- Ability to opt out of the Care Planning process

Members and their Caregivers must be engaged to actively design their care plans initially and at re-assessments by:

- Empowering members to identify successes or change self-directed goals based on their condition
- Applying health coaching techniques

If telephonic outreach is unsuccessful in monitoring/ re-assessing the CP, Care Managers may present options to ICT, such as continued telephonic outreach or schedule face-to face assessments.

The member has the ability to opt out or decline involvement in the ICP process:

- Explain the care planning process to the member, emphasizing the importance of member participation
- The member will be asked at the beginning of each encounter if he/she chooses to participate, which will be **documented** in the care plan record
- Agreement with the ICP is **documented** in the member record
- Include member appointed ICT members in care planning process (e.g. Caregiver

Developing Care Plan Goals

Prioritized goals consider the member/caregiver goals, preferences and desired level of involvement in the ICP. Goals should be “SMART” - **S**pecific, **M**easurable, **A**ctionable, **R**ealistic, **T**ime-bound. A full description of developing SMART goals is provided in L.A. Care policy UM 158 Complex Case Management. Care Plans must document the identification and management of barriers to member goals:

- Understanding the member’s condition and treatment
- Desire to participate in the case management plan
- Belief that their participating will improve their health
- Financial or transportation limitation that may hinder participating in care
- Mental and physical capacity

Care plans must also contain an assessment of goals and progress (documented as ongoing process). In addition to the member’s self-reported outcomes and health data to assess if member goals are being met. This includes but is not limited to:

- Utilization data
- Preventive health outcomes
- HRAs (annual)
- Pharmacy data

ICT DOCUMENTATION EXAMPLE:

ICT convened for Mr. Smith on 3/23/14 at 1500.

ICT focus: Review Moderate Risk HRA/Preliminary Care Plan Results

- 1) Needs assistance with shopping
- 2) Needs food resources
- 3) Has 3 chronic conditions

4) Takes 5 or more medications daily ICT Members Include:

PPG CM _____-Lead/attended
L.A. Care CM _____-attended
Mr. Smith-declined invite to PCP _____-attended
L.A. Care LTSS staff _____-attended

Plan: L.A. Care LTSS staff will assist member with IHSS process and food resources. PPG CM will assist with referral to available disease management programs and provide medication reconciliation. PPG CM will call member to update on ICT plan, update care plan with follow up schedule and offer care plan to be mailed.

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

Timing of the ICP

The ICP will be reviewed and revised (at a minimum):

- At least annually
- Upon notification of change in member status
-

The ICP is reviewed during ICT meetings and in accordance with scheduled follow-up on member goals.

Update frequency may change in response to routine and non-routine reviews and revisions, including required updates when members are not meeting their ICP goals. The ICP should be developed within 30 days of HRA.

Individualized Care Team

The member's ICT should be comprised of appropriate staff to meet the needs identified during the care plan discussions. Composition of ICT based on identified needs (e.g., PCP, Specialist, PPG CM, and Social Worker). Member or Members designated representative should be invited to participate in the ICT as feasible. ICT lead team members are responsible for documenting the operation detail and communication (meeting dates-phone call and follow up).

ICT activities/outcome should be shared documentation (dissemination of ICT reports to all stakeholders).

At a minimum the ICT meeting minutes require:

- the date of meeting
- names and roles of attendees
- fact that Member or representative was invited
- topics discussed
- any revision to the care plan

The documentation of care plan revision may be at a high level (e.g., "revised priority of goals", or "added goal for weight management"). The actual changes will be documented in the Care Plan.

How an ICT is Assembled

ICT documentation can occur in several ways:

- **Informal:** Involving the Care Manager, member and single discipline (ex. PCP, Registered Dietician, Social Worker)
- **Formal:** Structured large meeting format with multiple disciplines prepared to contribute

Whether it is informal or formal, it is essential to document “ICT Convened”. This documentation is based on the documented need for ICT (e.g. Review HRA results, multiple issues need coordination)

The Lead ICT member identifies members who need to participate (e.g. PCP, PPG CM) and is responsible for setting up meeting date, time, mode (ex. conference call) as well as sending invitations to all, including member

Complex Care Management

L.A. Care Health Plan retains the responsibility for case management and **does not** delegate complex case management to the PPGs.

The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The program incorporates the dynamic processes of individualized screening, assessment, problem identification, care planning, intervention, monitoring and evaluation. The Care Management Program uses an interdisciplinary collaborative team approach comprised of patient care management and education through experienced licensed professionals in collaboration with the Primary Care Physician and community and state specific resources. The team may be comprise of Medical Directors, RN Care Managers, Clinical Pharmacists, social workers and non-clinical support staff Coordinators, Primary or Specialty Care Providers and Behavioral Health Specialists.

The team works closely with contracted practitioners and agencies in the identification, assessment and implementation of appropriate health care management interventions for eligible children and adults with special health care needs, including the provision of care coordination for specialty and state waiver programs.

Complex Care Management is provided for members with extensive utilization of medical services or those having chronic or immediate medical needs requiring more management than is normally provided through the Basic Care Management. Complex Care Management is a collaborative process between the member, Primary Care Provider, an RN Care Manager and Interdisciplinary Care Team (ICT) who provides assistance in planning, coordinating, and monitoring options and services to meet the Member’s health care needs.

L.A. Care’s Care Management team is responsible for working collaboratively with all members of the health care team including the PCP, hospital discharge planners, specialty practitioners, ancillary providers, community and state resource staff. The Care Managers, in concert with the health care team, focus on coordinating care and services for members whose needs include preventive services, ongoing medical care, rehabilitation services, home health and hospice care, and/or require extensive coordination of services related to linked and carved out services or the coordination and/or transfer of care when “carved-out” services are denied.

Care Managers assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs of these members across the continuum. The essential functions of the Care Manager include:

- Assessment
- Care Planning

- Interventions
- Coordination and Implementation
- Monitoring/Evaluation
- Facilitation
- Advocacy

L.A. Care’s Care Managers provide the care management activities for the complex and High Risk members which includes reviewing HRA results, completing the ICP with the member and ICT and organizing and leading the ICT. Communication with the PPG and PCP is an important component in the collaborative process and interdisciplinary approach.

Referrals to Complex Case Management

Members may be referred for complex case management by:

- Disease Management (DM) program referrals
Referrals are received from the DM program upon identification of complex needs according to specified CCM program criteria.
- Discharge planner referrals
Referrals to the CCM program may be made during the discharge planning process when real or potential complex needs are identified. These referrals may be made by hospital discharge planners or Social Workers involved in the discharge planning process.
- L.A. Care UM (UM Staff) referrals
Referrals to CCM are made by UM staff when complex needs are identified. This may occur during multidisciplinary conferences or during the concurrent review process.
- Member or caregiver referral
Members or caregivers are provided with materials containing instructions on how to self-refer and/or access Complex Care Management
- Practitioner referrals
Contracted Practitioners are provided information on how to refer for Complex Care Management. Referrals for case management or care coordination may be faxed to (213) 438-5034. A copy of the referral form can be found in Attachment C.
- Other referrals including, but not limited to:
 - L.A. Care Health Plan Medical Director Referrals
 - PPG Medical Director(s) referrals
 - External Service Partners referrals

Identifying Members for Care Management

Multiple sources are used to identify members who may be a higher risk for adverse outcomes or transitions from their usual environment to needing a higher level of care. L.A. Care uses multiple data sources to identify members that are eligible for the program but no yet referred.

These data sources include, but are not limited to:

- Claims and Encounter Data
- Pharmacy Data
- Laboratory Data, when available

- Behavioral Health Joint Operations Report
- PPG Supplemental Reports
 - Catastrophic Medical Condition (e.g. Genetic conditions, Neoplasms, organ/tissue transplants, multiple trauma)
 - Chronic Illness (e.g. Asthma, Diabetes, Chronic Kidney Disease, HIV/AIDS)
- Data provided by purchasers
- Hospital Utilization
 - Hospital discharge data
 - Hospital Length of Stay (LOS) exceeding 10 days
 - Readmission Reports
 - Skilled Nursing facility (SNF), rehabilitation admissions
 - Acute Rehabilitation admissions
- Ambulatory Care Utilization Reports
 - Emergency Room utilization
 - Nurse Advice Line Reports/ER Referrals
- Referral Management Reports
 - Precertification Data
 - Prior Authorization Data
 - High-technology home care requiring greater than two weeks duration of home care
 - Long Term Care referrals and monitoring logs
 - Non-adherence with treatment plan

Complex Case Management services and how to refer patients

For more information about complex case management, or to make a referral, call the L.A. Care UM Department at 1-877-431-2273 and ask to speak with a Case Manager or complete a **CM REFERRAL FORM** AND SUBMIT VIA FAX # **(213) 438-5077**.

Targeted Care Management

Targeted Care Management (TCM) assists Members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, Targeted Care Management is available as a carve-out Medi-Cal benefit through the State of California, Los Angeles County Public Health Department and their contractors as specified in Title 22, Section 51351. The Care Managers are responsible for identifying members that may be eligible for TCM services and must refer members, as appropriate, for the provision of TCM services. TCM services are integrated into the overall care plan, as a barometer for measuring disease progression and cost of care. State and county TCM services may include, but is not limited to, Pediatric and adult partial hospitalization programs (i.e. adult day health care centers, pediatric day care centers, MSSP, AIDS Wavier Programs, community based in-home operation services)

L.A. Care is responsible for co-management of the member's health care needs with the TCM providers, providing preventive health services and for determining the medical necessity of diagnostic and treatment services. The TCM services will serve to supplement care where needed to keep the member safe within their community based setting.

Targeted Case Management services and how to refer patients

For more information about targeted case management, or to make a referral, call the L.A. Care UM Department at 1-877-431-2273 and ask to speak with a Case Manager or complete a **CM REFERRAL FORM** AND

SUBMIT VIA FAX # (213) 438-5077

5.20 HOSPICE CARE SERVICES

Hospice Care Services are available to all L.A. Care members. Members and their families shall be fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. For individuals who have elected hospice care, continuity of medical care shall be arranged, including maintaining established patient-provider relationships to the greatest extent possible. Hospice services are covered when all of the following requirements are met:

- A participating provide has diagnosed the member with a terminal illness and determines life expectancy to be 12 months or less,
- The covered service are provided in network,
- The services are provided by a participating licensed hospice agency and,
- The services are necessary for the palliation and management of your terminal illness and related conditions

L.A. Care and the PPGs shall cover the cost of all hospice care provided as defined by the DOFR. PPGs are also responsible for all medical care not related to the terminal conditions.

5.21 L.A. CARE APPEALS PROCESS

L.A. Care does not delegate the appeal process to PPGs. The PPG must ensure that a timely appeal process is operational and ensure the submission of appeals to L.A. Care. Requests for appeals received by the PPG must be routed to the LA Care Member Services Grievance and Appeals Unit within 24 hours of receipt at:

**L.A. Care Health Plan
Attn: Appeals and Grievance Unit
P.O. Box 811610
Los Angeles, CA 90081 1-888-
839-9909
FAX 1-213-438-5748**

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

- If the group's reconsideration process results in a denial, deferral, and/or modification with which the provider is still dissatisfied, the provider may request a formal appeal to L.A. Care for a higher level review.
- Members and providers may also appeal L.A. Care's decision to modify or deny a service request (this does not apply to the retrospective claims review/provider dispute resolution process). The appeal request is reviewed by a physician or physician consultant not involved in the prior determination.
- Member requested appeals may be initiated orally or in writing. Members (and Providers on behalf of Members) have the right to appeal an adverse utilization review determination.
- Members have the right to be represented by anyone they choose when they appeal an adverse determination, including an attorney, and have that representative act on their behalf at all levels of the appeal. They can name a relative, friend, advocate, doctor, or someone else to act for them.

Others may also be authorized under State law to act for them.

- L.A. Care has a full and fair process for resolving member disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. The process for filing an appeal is made available to the member in writing through the member handbook (evidence of coverage), the L.A. Care Web site, and to the provider through the Provider Manual, and policies and procedures.
- Appeal Procedures provide for:
 - Allowance of least 180 days for L.A. Care Covered™ members after notification of the denial for the member to file an appeal.
 - Acknowledgement of the receipt of the appeal within five (5) calendar days (Acknowledgement upon receipt by phone, if expedited).
 - Documentation of the substance of the appeal and any actions taken.
 - Full investigation of the substance of the appeal, including any aspects of clinical care involved.
 - The opportunity for the member to submit written comments, documents or other information relating to the appeal.
 - An authorized representative to act on behalf of the member.
 - The appointment of a new person to review the appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
 - The appointment of at least one person to review the appeal, who is a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment.
 - Notification of the decision of the appeal to the member within 30 calendar days of receipt of the request, or 72 hours if expedited.
 - Providing to the member upon request, access to and copies of all documents relevant to the member's appeal.
 - Notification to the member about further appeal rights.
 - Members who have disagreement with the appeal decision, and wish to appeal further, have the right to contact and file a grievance with the Department of Managed Health Care (DMHC), or to request an Independent Medical Review (IMR).

Standard Review

- Upon receipt of a standard appeal, the Appeals and Grievance Nurse Specialist will immediately investigate and inform the Chief Medical Officer/physician designee.
- An acknowledgment letter will be sent to the member or provider acting on behalf of the member within five (5) business days. The letter will include information regarding the appeals process.
- The acknowledgment shall advise the complainant of the following:
 - That the grievance has been received.
 - The date of receipt.
 - The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance
- 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 (same or similar qualification*).
- If the physician reviewer determines he/she is qualified, he/she will make a resolution/disposition determination. (same or similar qualification)

- 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. (same or similar qualification)
- A determination will be made within thirty (30) calendar days from receipt of the appeal and information necessary to make a determination.
- Written notification of determination will be sent within two (2) business days of the determination. The notification will include:
 - Final determination
 - A statement setting forth the specific medical and scientific reasons for the determination, and a description of alternative treatments, supplies, and/or services as appropriate
 - Reasons other than medical necessity (e.g., non-covered benefits, etc.) will include the statement of benefit structure
 - Instructions for appealing further to the Department of Managed Health Care (DMHC) will include DMHC's address and toll-free telephone number, as applicable
 - The phone number and extension of L.A. Care's physician reviewer

Expedited Review

- A member or provider may request an expedited reconsideration of any decision to deny or modify a requested service if waiting thirty (30) calendar days for a standard appeal determination may be detrimental to the Enrollee's life or health, including but not limited to, severe pain, potential loss of life, limb or major bodily function. In the case of an expedited appeal, the decision to approve, modify, or deny requests by a provider prior to, or concurrent with, the provision of healthcare services to members, will be made in a timely manner that is appropriate for the nature of the member's condition and not to exceed 72 hours after the plan's receipt of the information.
- Upon receipt of an expedited request, the Grievance and Appeals Nurse specialist will immediately investigate and inform the physician reviewer.
- The physician reviewer will review the expedited appeal request and determine if he/she is qualified to make a determination on the clinical issues of the case (same or similar qualification*).
- If the physician reviewer determines he/she is not qualified, he/she will consult with another qualified professional prior to making a determination (same or similar qualification*).
- 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 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the appeal determination. The notification will include:
 - The final determination
 - A statement setting forth the specific medical and scientific reasons for the determination, and a description of alternative treatments, supplies, and/or services as appropriate
 - Reasons other than medical necessity (e.g., non-covered benefits etc.) will include the statement of benefit structure
 - Instructions for appealing further to the Department of Managed Health Care (DMHC), to include DMHC's address and toll free telephone number, as applicable
 - The phone number and extension of the L.A. Care physician reviewer

Determinations that cannot be completed within the thirty (30) calendar days for standard appeals, or within

72 hours for expedited appeals, must be forwarded to DMHC for final resolution.

NOTE*: Same specialty is defined as a practitioner with similar credentials AND licensure as those who typically treat the condition or health problem in question in the appeal. A similar specialty refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems. Depending on the type of case, as same or similar specialist, may be a physician, behavioral health care practitioner, chiropractor, dentist, physical therapist or other type of practitioner as appropriate.

5.22 ELIGIBILITY APPEALS

There is a Covered California (Marketplace) Appeals process for Enrollees who disagree with any of the following:

- Eligibility determination for Covered California Health Plan
- Determination of the amount of the premium assistance or cost-sharing reduction
- Annual re-determination of eligibility
- Eligibility determination for an exemption to the requirement to have health insurance related to claims based on hardship, religious beliefs, being a member of the ministry, incarceration or being an American Indian or Alaska Native.

The process has the following steps:

- Enrollees have 90 calendar days from the notice date of the determination to submit an appeal
- Covered California has 90 calendar days from the date the appeal is submitted to study and settle the appeal. The 90 day timeframe is dependent on federal regulators providing a response to Covered California. During this time, Covered California will:
 - Work closely with the Enrollee to resolve the issue informally
 - Hold a formal hearing process to settle the appeal if the appeal is not resolved informally
 - Enrollees who are not satisfied with the decision can appeal directly to the U.S. Department of Health and Human Services, or to any of the agencies below

The Office of Patient Advocate provides an overview of the health care industry
www.opa.ca.gov, or 1.866.466.8900.

California Department of Managed Health Care (DMHC) oversees HMOs and some PPOs
www.dmhc.ca.gov, or 1.888.466.2219.

California Department of Insurance (CDI) handles complaints against PPOs
www.insurance.ca.gov, or 1.800.927.4357

5.23 INDEPENDENT MEDICAL REVIEW (IMR)

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 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.

5.24 INITIAL AND PERIODIC HEALTH

ASSESSMENTS Adults

PPGs are responsible for maintaining and disseminating to its Provider Network, protocols and High Risk Categories by adult age groupings based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) for use in determining the provision of clinical preventive services to asymptomatic, health adult Members (age 21 and older).

High risk individuals are defined as individuals whose family history and/or life style indicates a high tendency towards disease, or who belong to a group (socioeconomic, cultural, or otherwise) which exhibits a higher tendency toward a disease.

L.A. Care CoveredTM will provide lists of new member Enrollees to the PPGs on a monthly basis. PPGs shall have processes in place to ensure the provision of an IHA (complete history and physical examination) to each new adult member (over age 21) within 90 calendar days that:

- Includes a health education behavioral assessment, Staying Healthy Assessment (SHA) using an age appropriate approved assessment tool. A copy of the SHA is available at www.lacare.org
- Makes arrangements for any needed follow-up services that reflect the findings or risk factors discovered during the IHA and SHA
- Documents the member's completed IHA and SHA tool in the members' medical record and makes available during subsequent preventive health visits
- PPGs shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented
 - Documented attempts that demonstrate unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement
 - For follow-up on missed and broken appointment documentation requirements see Section: Coordination of Medically Necessary Services

When New Member's Health does not indicate any Urgency for an IHA (based on previous medical records if available):

- If the PCP has access to a new L.A. Care member's medical records from a previous Plan or other PCP, and those records indicate that the member has had an IHA within the previous 12 months, and the examination provides evidence that there is no urgency for an IHA, then the visit can be waived until the next periodic visit is due.
- For members whose health status does not indicate urgency, and if conducting the assessment as part of the first visit is not feasible, the PCP must contact the member within 90 days after the member's first medical visit to schedule an initial health assessment appointment.

PPGs shall ensure that the performance of the initial complete history and physician exam for adults in compliance with L.A. Care's age appropriate preventive health guidelines, CDC or the most recent USPSTF recommendations, includes, but is not limited to:

- Blood pressure.
- Height and weight.
- Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over.
- Clinical breast examination for women.
- Mammogram for women.
- Pap smear (or arrangements made for performance) on all women determined to be sexually active
- Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for Chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age.
- Screening for TB risk factors, including a Mantoux skin test on all persons determined to be at high risk.
- Health education behavioral risk assessment.

Children

L.A. Care Covered™ will provide lists of new member Enrollees to the PPGs on a monthly basis. PPGs shall have processes in place to ensure the provision of an IHA (complete history and physical examination and SHA) to each new member under age 21 in required timeframes as follows:

- For members under the age of 18 months, PPGs are responsible to cover and ensure the provision of an IHA within 90 days following the date of enrollment.
- For members 18 months of age and older upon enrollment, PPGs are responsible to ensure an IHA is performed with 90 days of enrollment.
- PPGs shall cover and ensure the provision of an IHA (complete history and physical examination and SHA) to each new member under age 21 as follows:
 - The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age
 - Includes a SHA using an age appropriate approved assessment tool
 - Arrangements are made for any needed follow-up services that reflect the findings or risk factors discovered during the IHA and SHA
 - Document the members' completed IHA and SHA in the members' medical record and to be made available during subsequent preventive health visits
 - PPGs shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented
 - Documented attempts that demonstrate PPGs unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement

5.25 ADULT PREVENTIVE SERVICES

PPGs shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members.

PPGs shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members (age 21 and older).

As a result of the IHA or other examinations, discovery of risk factors or disease conditions will determine the

need for further follow-up, diagnostic, and/or treatment services.

In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the adult IHA described above shall be provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

PPGs shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the finding or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. PPGs shall ensure that these services are initiated as soon as possible, but no later than 60 days following discovery of a problem requiring follow up.

Immunizations for Adults

PPGs are responsible for ensuring all adults are fully immunized and shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations and L.A. Care Preventive Health Guidelines (see L.A. Care Website/Provider Resources/Clinical Practice Guidelines).

In addition, PPGs shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the finding of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

5.26 CHILDREN'S PREVENTIVE SERVICES

PPGs shall provide preventive health visits for all members less than twenty-one (21) years of age at times specified by the most recent AAP periodicity schedule.

PPGs shall provide, as part of the periodic preventive visit, all age specific assessments and services required and the age specific health education behavioral assessment, as necessary.

Where a request is made for children's preventive services by the member, the member's parent or guardian, an appointment shall be made for the member to be examined within two weeks of the request.

At each non-emergency Primary Care encounter with members under the age of twenty-one (21) years, the member (if an emancipated minor) or the parent(s) or guardian of the member shall be advised of the children's preventive services due and available from PPGs, if the member has not received children's preventive services in accordance with preventive standards for children of the member's age.

Documentation shall be entered in the member's medical record which shall indicate the receipt of children's preventive services, or proof of voluntary refusal of these services in the form of a signed statement by the member (if an emancipated minor) or the parent(s) or guardian of the member. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

Immunizations

PPGs shall ensure that all children receive necessary immunizations at the time of any health care visit.

PPGs shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP).

Documented attempts that demonstrate L.A. Care's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement.

If immunizations cannot be given at the time of the visit, the member must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made.

Appropriate documentation shall be entered in the member's medical record that indicates all attempts to provide immunizations.

A receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statement by the member (if an emancipated minor) or the parent(s), or guardian of the member, shall be entered in the member's medical record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

Upon federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, PPGs shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within 60 calendar days of the vaccine's approval date.

Blood Lead Screens

PPGs shall cover and ensure the provision of a blood lead screening test to members at ages one (1) and two (2) in accordance with American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.

PPGs shall document and appropriately follow up on blood lead screening test results. PPGs shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide test.

If the blood lead screen test is refused by the member, proof of voluntary refusal of the test in the form of a signed statement by the member (if an emancipated minor), or the parent(s) or guardian of the member, shall be documented in the member's medical record.

If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

Documented attempts that demonstrate a PPG's unsuccessful efforts to provide the blood lead screen test shall be considered sufficient in meeting this requirement.

Screening for Chlamydia

PPGs shall screen all females less than 21 years of age, who have been determined to be sexually active, for Chlamydia.

Follow up of positive results must be documented in the member's medical record.

PPGs shall make reasonable attempts to contact appropriately identified members and provide screening for Chlamydia.

- All attempts shall be documented.
- Documented attempts that demonstrate PPGs unsuccessful efforts to contact a member and screen for Chlamydia shall be considered sufficient in meeting this requirement.
- If the member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the member (if an emancipated minor) or parent(s), or guardian of the member, shall be documented in the member's medical record.
- If the responsible party refuses to sign this statement, the refusal shall be noted in the member's

medical record.

Human Papillomavirus (HPV) shots: CDC recommends HPV vaccination for preteen girls ages 13 through 26, and for boys ages 13 through 21, to prevent cervical cancer and genital warts.

5.27 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

PPGs must maintain a program for Children with Special Health Care Needs, which includes, but is not limited to, the following:

- L.A. Care mails a health risk assessment to all newly enrolled members. The assessment assists in identifying members with health conditions that may need assistance in care coordination including the identification of Children with Special Health Care Needs.
- The outcomes of the health risk assessment are routed to the assigned PCP and delegated PPG to coordinate medically necessary care.
- Members identified as CSHCN are referred to the Care Management Program for assistance in care coordination
 - The PPGs/PCPs are responsible for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as PCP, standing referrals, or other methods as defined by regulatory and L.A. Care policy requirements.
- L.A. Care's PPGs/PCPs are responsible for ensuring that each Child with Special Health Care Needs, receives a comprehensive assessment of health and related needs and that all medically necessary follow-up services are documented in the medical record, including needed referrals. The comprehensive assessment should be completed at the time of the Initial Health Assessment and periodically thereafter.
- L.A. Care has an established case management/ care coordination Care Management Program for Children with Special Health Care Needs that includes the coordination with other agencies, which provide services for children with special health care need (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency)
- L.A. Care monitors and identifies opportunities for improving the quality and appropriateness of care for children with special health care needs through established quality processes:
 - HEDIS results
 - Utilization Reports (e.g. IHA, Hospitalizations, ER, Ambulatory Care)
 - Potential Quality of Care Issues (PQIs)
 - Grievance and Appeals
 - Member and Provider Satisfaction Surveys

5.28 DISEASE MANAGEMENT

L.A. Care does not delegate disease management to the PPGs/PCPs.

The Centers for Medicare and Medicaid Services defines disease management as a “system of coordinated health care interventions and communication for populations with conditions in which patient self-care is substantial”. Disease Management supports the provider-patient relationship and treatment plan while emphasizing prevention and self-management.

L.A. Care offers a variety of disease management programs which focus on the development, implementation

and evaluation of a system of coordinated health care interventions and communication for members with chronic conditions and individuals that care for them. Using a multi-disciplinary approach, members are identified, stratified, assessed and care plans are developed to assist members and their families with navigating the managed care system and managing their chronic conditions. Programs may include:

- Self-management support
- Education and materials
- Community referrals
- Care coordination

Providers or members may contact L.A. Care Member Services to inquire about the available programs.

5.29 BEHAVIORAL HEALTH SERVICES (Described in further detail in Attachment B)

Behavioral Health Services

L.A. Care Health Plan is responsible for behavioral health services for L.A. Care Covered™. The behavioral health aspects of the UM program are described in a separate UM program description and in policies/procedures developed by L.A. Care's contracted behavioral health vendor, and approved by L.A. Care. L.B.

The plan has contracted with Beacon Health Strategies, LLC and College Health IPA to administer the delivery of behavioral health and substance use services for LA Care members. While Beacon is the contracted administrative service provider with the Health Plan, College Health IPA will render all utilization management determinations.

For certain diagnoses, as defined in the L.A. Care Covered™ benefit structure, the Los Angeles County Department of Mental Health may assume responsibility. In these instances, the Behavioral Health vendor, Beacon Health Strategies, coordinates and ensures continuity of care.

All behavioral health referrals are to be reviewed through Beacon Health Strategies in coordination with College Health IPA:

- Beacon Health Strategies performs medical review on all referrals for behavioral health services, including but not limited to, outpatient, inpatient, day residential care, and will coordinate the requested services as necessary.
- Beacon Health Strategies, following medical review, provides and/or coordinates care to facilitate authorization of medically necessary mental health services and/or substance abuse services, including pharmacy, laboratory, and ancillary services provided to a member who has experienced family dysfunction and/or trauma, to the extent that such services are required as a course of treatment for the health and recovery of the child and the family members.

Behavioral Health Services include chemical dependency and mental health services. L.A. Care Health Plan provides these services through Beacon Health Strategies.

- For referring your patients to receive any Behavioral Health Services you may directly call **(877)-344-2858, Option 6, then Option 3** to speak with a Beacon representative, 24/7.
- For Crisis Intervention, please call **(877)-344-2858, Option 6, then Option 3** to speak with a Beacon representative, 24/7.

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

Chemical Dependency Services

Inpatient Detoxification

L.A. Care Health Plan covers hospitalization in a participating hospital only for medical management of withdrawal symptoms, including room and board, participating physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient Chemical Dependency Care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

Additional covered services include:

- Individual chemical dependency evaluation and treatment
- Group chemical dependency

L.A. Care Health Plan covers methadone maintenance treatment for all Enrollees when medically necessary at a licensed treatment center approved by the Medical Group.

Transitional Residential Recovery Services

L.A. Care Health Plan cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. These settings provide counseling and support services in a structured environment.

Chemical Dependency Services Exclusion

Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this “Chemical Dependency Services” section

Mental Health Care

L.A. Care Health Plan covers Services specified in this “Mental Health Care” section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder." For example, the DSM identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

“Mental Disorders” include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa

- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the DSM, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
 - as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
 - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
 - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Inpatient Mental Health Services

L.A. Care Health Plan covers inpatient psychiatric hospitalization in a participating hospital. Coverage includes room and board, drugs, and Services of participating physicians and other providers who are licensed health care professionals acting within the scope of their license.

Outpatient Mental Health Services

We cover the following Services when provided by participating physicians or other participating providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug

therapy Additional covered services include:

- Individual mental health evaluation and treatment
- Group mental health treatment

Behavioral Health Treatment for Autism and Pervasive Developmental Disorders

Behavioral Health Treatment for members with Autism or Pervasive Developmental Disorders is covered when prescribed by a Physician or licensed psychologist who is a Plan Provider and the treatment is provided under a treatment plan prescribed by a Participating Provider. Behavioral Health Treatment must be prior authorized and obtained from Participating Providers.

Behavioral Health Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

“Behavioral Health Treatment” is defined as follows: Professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Exclusions and Limitations

- Alternative Therapies, unless the treatment is prescribed by a licensed physician and surgeon or by a licensed psychologist as Behavioral Health Treatment for pervasive developmental disorder or autism, and such treatment is provided pursuant to a treatment plan administered by qualified autism providers.
- Biofeedback, unless the treatment is prescribed by a licensed physician and surgeon or by a licensed psychologist as Behavioral Health Treatment for pervasive developmental disorder or autism, and such treatment is provided pursuant to a treatment plan administered by qualified autism providers.
- Non-skilled care that can be performed safely and effectively by family members (whether or not such family members are available to provide such services) or persons without licensure certification or the presence of a supervising licensed nurse, except for authorized homemaker services for hospice care, and except for Behavioral Health Treatment that is provided by a Qualified Autism Service Professional or Qualified Autism Service Paraprofessional for the treatment of pervasive developmental disorders or autism.

Intensive Psychiatric Treatment Programs

We cover **at no charge** the following intensive psychiatric treatment programs at a participating facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

5.30 VISION SERVICES

L.A. Care CoveredTM provides certain vision benefits for children, including eye exams and eyeglasses.

5.31 DENTAL SERVICES

Dental benefits are not covered under L.A. Care CoveredTM. Covered California is working to embed pediatric dental in medical plans in 2015.

CARE COORDINATION WITH COMMUNITY AGENCIES AND SERVICES Coordination of Care and Services with Community Agencies

Care Managers are available to assist members, who may need or who are receiving services from out of plan providers and/or programs, in order to ensure coordinated service delivery and efficient and effective joint case management. However, the coordination of care and services remains the responsibility of each member’s PCP. PPG’s and the member’s PCP will monitor the following:

5.33.1 Member referral to and/or utilization of special programs and services

- 5.33.2 Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- 5.33.3 Routine medical care, including providing the necessary preventive medical care and services
- 5.33.4 Provision of Initial Health Assessments and completion of the age-specific Individual Health Education and Behavioral Assessment (IHEBA)

PPGs and PCPs are encouraged to make referrals to local health departments, mental health programs and regional centers.

Out-of-Plan Case Management and Coordination of Care for Community Agency Services

L.A. Care shall implement procedures to identify individuals, who may need or who are receiving services from out of plan providers and/or programs, in order to ensure coordinated service delivery and efficient and effective joint case management.

Linked community agencies have defined roles and responsibilities to ensure coordination of care for members. In most instances, the agency, not L.A. Care, is financially responsible for the linked services.

5.32 CALIFORNIA CHILDREN SERVICES (CCS)

Services provided by the CCS program are not covered under the L.A. Care Covered™ contract.

Upon adequate diagnostic evidence that a Member under 21 years of age may have a CCS eligible condition, L.A. Care and/or its PPGs shall refer the member to the local CCS office for determination of eligibility.

L.A. Care and/or its PPGs shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:

- Ensure that L.A. Care and/or its PPGs' providers perform appropriate baseline health assessments and diagnostic evaluations which provide the sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition;
- Assure that contracting providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within L.A. Care and/or its PPGs' network; and only from the date of referral;
- Enable initial referrals of members with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program;
- Ensure that L.A. Care and/or its PPGs continue to provide all Medically Necessary Covered Services to the member until CCS eligibility is confirmed;
- Ensure that, once eligibility for the CCS program is established for a member, L.A. Care and/or its PPGs shall continue to provide all Medically Necessary Covered Services (primary care and preventive services that are not related to the CCS eligible conditions), that are not authorized by CCS, and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

If the local CCS program does not approve eligibility, L.A. Care and/or its PPGs remain responsible for the

provision of all Medically Necessary Covered Services to the member. If the local CCS program denies authorization for any service, L.A. Care and/or its PPGs remain responsible for obtaining the covered service, if it is medically necessary and paying for the service if it has been provided.

Identification

Identify and track current and new Enrollees with potential and/or eligible CCS conditions.

Eligibility

L.A. Care Health Plan shall be responsible for generating and distributing, to its PPGs and the member's PCP, lists received from CCS of L.A. Care members identified as being eligible or authorized to receive CCS services.

L.A. Care will send these lists to its PPGs and to the member's PCP on a monthly basis.

L.A. Care and/or its PPGs will notify the member's PCP, and will work with the local CCS office to ensure the member is receiving appropriate medical care and that coordination of care is documented in the member's medical records.

L.A. Care and/or its PPGs will undertake regular activities, such as review of encounter data necessary to identify members with potential CCS conditions and assure appropriate referrals to CCS.

Referral

Members (parent/guardian) may self-refer to CCS.

L.A. Care will make available to its PPGs; a list of CCS paneled providers and facilities as received from the local and/or State CCS program office.

PCP or specialist may refer to CCS paneled provider or CCS local program using the L.A. Care, and/or its delegated provider's, referral process or refer the member directly to CCS.

L.A. Care and/or its PPGs are required to provide to PCPs, information on CCS paneled providers and facilities including mechanism for accessing specific provider facility contact information for referral.

The CCS program authorizes payments to L.A. Care and/or its delegated provider's network physicians who currently are identified CCS panel providers. CCS may for services to non-CCS paneled providers in the event of an emergency and the member cannot be safely transitioned to a CCS paneled network, provider or facility.

L.A. Care and/or its PPGs shall submit information to the CCS program on all providers who have provided services to a member thought to have a CCS eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by L.A. Care and/or its PPGs, or a L.A. Care and/or its delegated provider's network physician, via telephone, FAX, or mail. In an emergency admission, L.A. Care and/or its PPGs, or L.A. Care and/or its PPGs' network physician shall be allowed until the next business day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

L.A. Care will ensure that the member and provider manuals document the CCS referral options and processes.

Coordination of Care

L.A. Care and/or its PPGs shall:

- Designate a CCS coordinator (liaison) to interface with a designated L.A. Care CCS Coordinator, the CCS office, CCS panel provider, the member's family or guardian.
- Implement procedures to ensure confidential transfer of medical documentation between the PCP and CCS paneled providers in compliance with all federal and state regulations
- Ensure that the PCP provides basic case management for the member and assures appropriate referrals for members with potential and/or eligible CCS conditions
- Make available CCS Program referral forms to all member families/guardians and PCP offices
- Continue to provide case management of all services (primary and specialty care) until eligibility has been established with the CCS program

CCS program case management is responsible for the CCS eligible condition and authorizes medically necessary care.

L.A. Care and/or its PPGs must continue to provide primary care case management, coordination of services, and health care service other than those required for the CCS condition and keep active CCS case logs. For inpatient admissions CCS referrals, authorization for inpatient hospital stays is limited to the time of eligibility for the CCS program. It is recommended that the L.A. Care and/or its PPGs or designated CCS coordinator continue to track the hospitalization in collaboration with the CCS Case Manager.

L.A. Care's PPGs are capitated to provide services not unrelated to the treatment of the CCS eligible condition.

Dispute Resolution

L.A. Care and/or its PPGs need to have a mechanism in place to resolve disputes between the PCP or Specialist and the CCS program office.

In the absence of a resolution, L.A. Care and/or its PPGs Liaison will notify L.A. Care UM of all unresolved disputes regarding CCS services.

All dispute resolutions must be resolved within 30 calendar days.

L.A. Care and/or its PPGs are required to provide any medically necessary special services during the time of dispute resolution.

L.A. Care will facilitate any unresolved disputes.

Disagreements with regards to CCS program eligibility, payments for the treatment of services of the CCS eligible condition and associated or complicated conditions must be resolved cooperatively between L.A. Care and the county CCS program.

If the dispute is not resolved at the local level, L.A. Care must notify the county CCS program must notify the State CCS Regional Office. The State Children's Medical Services (CMS) program will ultimately render a joint decision if the problem is not resolved at the lower level.

Training and Education

L.A. Care and/or its PPGs will develop and implement training programs for PPGs, PCPs, and L.A. Care Staff.

L.A. Care will ensure that provider manuals and the member enrollment materials outline information describing CCS benefits and eligibility.

5.33 DEVELOPMENTAL DISABILITIES SERVICES (DDS)

Members may be eligible to receive services from the Regional Centers if services needed are not available within the L.A. Care network.

L.A. Care and its PPGs must maintain policies, procedures, and processes in place to address the following: identification, diagnosis, referral, and tracking of members with potential and eligible DDS conditions for the provision of all screening, preventive, medically necessary, and therapeutic services.

L.A. Care and its PPGs will utilize network providers for diagnosis and treatment of members with developmental disabilities

L.A. Care and its PPGs will refer members with developmental disabilities to the Regional Centers for those non-medical services such as respite, out-of-home placement, supportive living, etc. for members with substantial disabilities if such services are needed.

PPGs will:

- Maintain mechanisms to support the identification of members with eligible and potential DDS conditions and use the list of members with potential and eligible DDS conditions generated by L.A. Care Health Plan and any additional information generated by L.A. Care to facilitate the provision of basic case management and coordination of care by the PCP.
- Be responsible for tracking the identified potential and eligible DDS members and the services provided to them to assure coordination and continuity of care.
- Notify PCPs of potential and eligible DDS members and work with the PCPs and the local Regional Centers to ensure these members continue to receive preventive and medically necessary care and that coordination of care is documented in member medical records.

PCPs will:

Be responsible for basic case management and coordination of care for members with potential and eligible DDS conditions.

Eligibility

L.A. Care will verify member eligibility and send the list of members with potential and eligible DDS conditions to the PPGs via secure PPG FTP sites.

Referral

Members (parent/guardian) may self-refer to the Regional Centers for confirmation of Regional Center eligibility criteria. A current listing of the local Regional Centers is available at www.lacare.org or www.dds.cahwnet.gov

The PCP or specialist should refer potential and eligible members directly to the Regional Center and are encouraged to include the specific member information in the referral matching Regional Center eligibility criteria.

PPGs must:

- Implement procedures to ensure confidential transfer of medical documentation to and from the PCP to Regional Centers in compliance with all federal and state regulations.
- Establish procedures to support the identification and management of problems with the PCP, Regional Centers, and L.A. Care.
- Ensure that the PCP maintains the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

PCPs must:

Maintain the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

Attachment A

L.A. Care UM Timeliness Standards

(Based on Current California Regulatory Requirements and NCQA Standards)

		Notification Timeline	
Type of Request	Decision	Initial Notification	Written Notification
<u>EMERGENCY CARE</u>	No prior authorization required; follow the reasonable lay person standard to determine that the presenting complaint might be an emergency.	N/A	N/A
<u>POST- STABILIZATION FOLLOWING MEDICAL SCREENING IN THE EMERGENCY ROOM</u>	Decision Timeframe: Within 30 minutes of request or the requested service is deemed approved	Practitioner: For approvals: within 30 minutes of request, (if after hours a tracking number is provided authorizing the requested service and follow-up the next business day with an authorization number.) For denials/ modifications: verbal notification within 30 minutes of requests and fax (with confirmation) or electronic notification to the requesting practitioner the same day of the denial decision	Practitioner: <u>Written Notification:</u> For approvals: If no response within the required 30 minutes, the requested service is deemed approved. (If after hours, a tracking number is provided authorizing the requested service and follow-up the next business day with an authorization number.) <u>Practitioner and Member For denials/modifications:</u> written notification to requesting practitioner and member deposited with the United States Postal Service in time for pick-up same day

<p><u>PRE-SERVICE URGENT Expedited Request.</u> <u>An Expedited Request</u> means any request for medical care or treatment with respect to which the application of the time periods for making non urgent care determinations:</p> <ul style="list-style-type: none"> • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to server pain that cannot be adequately managed without the care or treatment that is the subject of the request. 	<p><u>Decision timeframe:</u> In a timely fashion appropriate to the member's condition not to exceed 72 hours after receipt of the initial request.</p>	<p><u>Practitioner and Member:</u> <u>Initial Notification of Decision:</u> Verbal notification to requesting practitioner and member as soon as the decision is made not to exceed 72 hours after receipt of the original request.</p>	<p><u>Practitioner and Member: Written Notification for denials/ modifications,</u> written notification to requesting practitioner and member as the member's health condition requires and no later than 72 hours (3 calendar days) after receipt of the request deposited with the United States Postal Service in time for pick- up by 72 hours (or 3 calendar days) from the receipt of the original request.</p> <p>NOA TEMPLATE: Denial or Modify</p>
<p><u>Delay of Expedited Request</u></p>	<p><u>DECISION TIMEFRAME</u> The time limit for a decision of an expedited request may be extended past the original 72 hours by an additional 48 hours up to 5 calendar days if the member requests an extension. If more</p>	<p><u>Practitioner</u> Verbal notification to requesting practitioner and member as soon as the decision is made not to exceed by 5 calendar days if the member requests an</p>	<p><u>Practitioner and Member: Written Notification for denials/ modifications,</u> written notification to requesting practitioner and member deposited with the United States Postal Service in time for pick-up by 5 calendar days or within 48 hours of receiving additional requested</p>

	<p>information is needed, notify the requesting practitioner or member by phone within 24 hours of receipt of the initial request. Allow at least 48 hours for the practitioner or member to provide the additional information. Make the decision within 48 hours of a) receiving a response from the member or practitioner or b) the expiration of the 48 hours allowed for the additional information to be supplied, whichever is sooner</p>	<p>extension, or within 48 hours of receiving additional requested information or expiration of the extension without receipt of additional requested information</p>	<p>information or expiration of the extension without receipt of additional requested information not to exceed 5 calendar days.</p> <p>NOA TEMPLATE: Delay</p>
<p><u>PRE-SERVICE ROUTINE</u> <u>Non-urgent Request</u></p>	<p><u>DECISION TIMEFRAME</u> Within 5 working days of receipt of request</p>	<p><u>Practitioner: Initial Notification:</u> <u>All decisions:</u> Within 24 hours of the decision with confirmation (Notification May Be Oral and/or Electronic)</p>	<p><u>Practitioner and Member:</u> Within 2 working days of approval/denial/modification decision Deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made not to exceed 14 calendar days from receipt of the original request.</p> <p>NOA TEMPLATE: Approval, Denial or Modify</p>
<p><u>DELAY OF PRE-SERVICE ROUTINE</u> <u>Non-urgent Request Extension Needed</u></p>	<p><u>Decision Timeframe</u> Within 5 working days of receipt of information not to exceed 14 calendar days from date of receipt of request</p>	<p><u>All decisions: Practitioner:</u> Within 24 hours of the decision with confirmation (Notification May Be Oral</p>	<p>NOA TEMPLATE: Delay Decisions resulting in delay, of all or part of the requested health care service shall be communicated to the practitioner and enrollee in writing within two business days of the</p>

		and/or Electronic)	decision
<p><u>URGENT CONCURRENT REVIEW (ACUTE HOSPITAL INPATIENT)</u></p> <p>Urgent Concurrent reviews are those reviews associated with inpatient care.</p> <p>A new request for inpatient care is considered urgent concurrent review and ongoing hospitalization requests are considered urgent concurrent review unless determined otherwise.</p> <p>Upon receipt of a new request for urgent concurrent review from a hospital, a review must be requested.</p> <p>If the request for authorization is made while a member is in process of receiving care, the request is an urgent concurrent request if medical care requested meets the definition of urgent, even if LA Care did not approve the earlier care.</p> <p>For example, if LA Care finds out on day 2 that a member is in an inpatient facility, and the member's practitioner requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request.</p>	<p><u>Decision Timeframe</u></p> <p>Within 24 hours of receipt of the request for authorization. If the request for authorization is made while a member is in process of receiving care, the request is an urgent concurrent request if medical care requested meets the definition of urgent, even if LA Care did not approve the earlier care.</p> <p>For example, if LA Care finds out on day 2 that a member is in an inpatient facility, and the member's practitioner requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request.</p> <p>Upon receipt of a request for urgent concurrent review, LA Care UM immediately requests necessary information. For operational purposes 24 hours is considered equivalent to 1 calendar day.</p>	<p><u>All Decisions: Practitioner:</u></p> <p>Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision.</p> <p>Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours.</p> <p>In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.</p>	<p><u>Practitioner and Member:</u></p> <p><u>Written Notification: For denials/modifications:</u> <small>ritten notifi</small></p> <p>Decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision.</p> <p>NOA Template: Terminate</p>

<p>If L.A Care receives a request for coverage of an acute inpatient stay after the member's discharge, L.A. Care handles the request as a post service issue.</p>	<p><u>Hospital Inpatient Stay Requests:</u></p> <p>Hospital Inpatient Stay Requests are considered Concurrent Urgent and the Urgent Concurrent decision timeframe applies unless: Necessary information is not received within 24 hours of receipt of the request for authorization and at least one call has been made to conduct the review or request the necessary information. The timeframe for decision making changes from Concurrent Urgent to Pre-Service Urgent (see Pre-Service Urgent above).</p> <p>When the hospital inpatient care has already been received, LA Care can decide to review the request for the already- rendered care as part of the Urgent Concurrent request, or change the timeframe to Post-Service request (see Post-Service below).</p> <p>If the request for authorization for an acute hospital stay is received after the member's discharge, the request is considered a Post-</p>		
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	<p>Service request (see Post-Service below).</p> <p>Course of Treatments Requests</p> <p>If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved by LA Care does not meet the definition of Urgent Care, the</p>		
<p><u>URGENT CONCURRENT REVIEW (ACUTE HOSPITAL INPATIENT)</u></p> <p>Urgent Concurrent reviews are those reviews associated with inpatient care.</p> <p>A new request for inpatient care is considered urgent concurrent review and ongoing hospitalization requests are considered urgent concurrent review unless determined otherwise.</p> <p>Upon receipt of a new request for urgent concurrent review from a hospital, a review must be requested.</p> <p>If the request for authorization is made while a member is in process of receiving care, the request is an urgent concurrent request if medical care requested meets the definition of urgent, even if LA Care did not approve the earlier care.</p> <p>For example, if LA Care</p>	<p><u>Decision Timeframe</u></p> <p>Within 24 hours of receipt of the request for authorization. If the request for authorization is made while a member is in process of receiving care, the request is an urgent concurrent request if medical care requested meets the definition of urgent, even if LA Care did not approve the earlier care.</p> <p>For example, if LA Care finds out on day 2 that a member is in an inpatient facility, and the member's practitioner requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request.</p>	<p><u>Practitioner: Initial Notification of Decision:</u></p> <p><u>All Decisions:</u></p> <p>Verbal, fax (with confirmation), or electronic notification to the requesting practitioner within 24 hours of the receipt of the request</p> <p><u>Member: Approvals:</u></p> <p>Within 24 hours of receipt of the request</p>	<p><u>Practitioner and Member: Written Notification:</u></p> <p><u>For denials/modifications:</u></p> <p>written notification to member and requesting practitioner within 24 hours of the receipt of the request.</p> <p>NOA Template: Terminate</p>

<p>finds out on day 2 that a member is in an inpatient facility, and the member's practitioner requests authorization for additional inpatient days, LA Care handles the request as an urgent concurrent request.</p> <p>If L.A Care receives a request for coverage of an acute inpatient stay after the member's discharge, L.A. Care handles the request as a post service issue.</p>	<p>Upon receipt of a request for urgent concurrent review, LA Care UM immediately requests necessary information. For operational purposes 24 hours is considered equivalent to 1 calendar day.</p> <p><u>Hospital Inpatient Stay Requests</u></p> <p>Hospital Inpatient Stay Requests are considered Concurrent Urgent and the Urgent Concurrent decision timeframe applies unless: Necessary information is not received within 24 hours of receipt of the request for authorization and at least one call has been made to conduct the review or request the necessary information. The timeframe for decision making changes from Concurrent Urgent to Pre-Service Urgent (see Pre-Service Urgent above).</p> <p>When the hospital inpatient care has already been received, LA Care can decide to review</p>		
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	<p>the request for the already-rendered care as part of the Urgent Concurrent request, or change the timeframe to Post-Service request (see Post-Service below).</p> <p>If the request for authorization for an acute hospital stay is received after the member's discharge, the request is considered a Post-Service request (see Post-Service below).</p> <p><u>Course of Treatments Requests</u></p> <p>If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved by LA Care does not meet the definition of Urgent Care, the request is handled as a new request and decided within the timeframe appropriate for the type of decision</p>		
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	(i.e., Pre-Service or Post-Service).		
<p><u>REQUEST TO CONTINUE CONCURRENT REVIEW (ACUTE HOSPITAL INPATIENT)</u></p> <p>A concurrent review decision is any review for an extension of a previously approved ongoing course already in place</p>	<p><u>Decision Timeframe</u></p> <p>If the request for authorization is to extend a course of treatment beyond the period of time or number of treatments previously approved does not meet the definition of Urgent Care, the request is handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., Pre-Service or Post-Service).</p>	<p><u>Practitioner: All Decisions:</u> Within 24 hours of receipt of the request</p> <p><u>Member: Approvals:</u> Within 24 hours of receipt of the request</p>	<p><u>Practitioner and Member: Written Notification:</u> Within 24 hours of receipt of the request</p> <p>If oral notification is given within 24 hours of request, then written/ electronic notification must be given no later than 3 calendar days after the oral notification.</p> <p>NOA Template: Terminate</p>
<p><u>POST-SERVICE / RETROSPECTIVE REVIEW</u></p>	<p><u>Decision Timeframe:</u></p> <p>Within 30 calendar days from receipt or request</p>	<p><u>Practitioner and Member:</u></p> <p>None specified</p>	<p><u>Practitioner and Member:</u> Within 30 calendar days of receipt of the request.</p> <p>NOA Template: Denial or Modify</p>
<p><u>HOSPICE - INPATIENT CARE</u></p>	<p><u>Decision Timeframe:</u></p> <p>Within 24 hours of</p>	<p><u>Practitioner: Initial Notification:</u> Within 24 hours of making the decision</p>	<p><u>Practitioner and Member: Written Notification</u> Within 2 working days of making the decision</p>

	receipt of request	Member: None Specified	NOA Template: Terminate
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Working day(s); means Business day(s)

Rev 2013-11-21

ATTACHMENT B
L.A. CARE HEALTH PLAN
L.A. Care Covered™

VISION, DENTAL, AND BEHAVIORAL HEALTH BENEFIT GRID BY PRODUCT LINE	
Vision Benefits	Children’s eye exams and eyeglasses are covered.
Dental Benefits	<p>Pediatric Dental - Covered California is working to embed pediatric dental in medical products in 2015. In 2014, coverage is provided through standalone plans offered by the following carriers:</p> <ul style="list-style-type: none"> • Anthem Blue Cross • Blue Shield of California • Delta Dental • Liberty Dental • Premier Access
Behavioral Health Benefits	Mental health, behavioral health, and substance abuse inpatient and outpatient services are covered.

PCP contacted?
IPA or MG CM contacted?

Care Management Referral Criteria

SPD and SNP Referrals

High Risk Profile Criteria

The presence of three or more of the following criteria in the same member qualifies the member for program enrollment: (select all that apply)

- Four or more ACTIVE chronic diagnoses
- Four or more medications prescribed on a chronic basis
- Medication profiles with greater than nine (9) medications
- Two or more hospitalizations in the past twelve months
- Age of 75 or older
- Significant impairment or one or more major activities of daily living, such as bathing, toileting, dressing, ambulating, feeding
- Evidence of malnutrition or failure to thrive
- Hospice

Complex Needs

The presence of one complex need qualifies the patient for case management.

- Spinal Injuries – Describe:
- Transplants – Describe:
- Cancer– Describe:
- Serious Trauma– Describe:
- HIV/AIDS
- Other– Describe:

Pharmacy Review

Patients who meet any of the pharmacy criteria qualify for case management.

- Medication profiles with greater than nine (9) medications
- Member on a biological drug (Embrel, ProCrit)

Care Coordination

Members that need short term, focused interventions to manage their healthcare needs and do not meet criteria for complex case management

- Member needs short-term, focused interventions to manage their health care needs and do not meet criteria for complex case management

Administrative Referral

Referral by discretion of Care Management team

- Includes any single or combination of social issues, traumatic injury, and multiple disease types as determined by the C.M. assessment

TB Elimination

Interferon-Gamma Release Assays (IGRAs)- Blood Tests for TB Infection

What are they?

Interferon-Gamma Release Assays (IGRAs) are whole-blood tests that can aid in diagnosing *Mycobacterium tuberculosis* infection. They do not help differentiate latent tuberculosis infection (LTBI) from tuberculosis disease. Two IGRAs that have been approved by the U.S. Food and Drug Administration (FDA) are commercially available in the U.S. They are:

- QuantiFERON®-Tb Gold In-Tube test (QFT-GIT);
- SPOT® TB test (T-Spot)

How do they work?

IGRAs measure a person's immune reactivity to *M. tuberculosis*. White blood cells from most persons that have been infected with *M. tuberculosis* will release interferon-gamma (IFN-g) when mixed with antigens (substances that can produce an immune response) derived from *M. tuberculosis*.

To conduct the tests, fresh blood samples are mixed with antigens and controls. The antigen, testing methods, and interpretation criteria for IGRAs differ (see Table 1).

What are the advantages of IGRAs?

- Requires a single patient visit to conduct the test.
- Results can be available within 24 hours.
- Does not boost responses measured by subsequent tests.
- Prior BCG (bacille Calmette-Guérin) vaccination does not cause a false-positive IGRA test result.

What are the disadvantages and limitations of IGRAs?

- Blood samples must be processed within 8-30 hours after collection while white blood cells are still viable.
- Errors in collecting or transporting blood specimens or in running and interpreting the assay can decrease the accuracy of IGRAs.
- Limited data on the use of IGRAs to predict who will progress to TB disease in the future.

Table 1: Differences in Current and Available IGRAs

	QFT-GIT	T-Spot
Initial Process	Process whole blood within 16 hours	Process peripheral blood mononuclear cells (PBMCs) within 8 hours, or iT-Cell Xpert® is used, within 30 hours.
<i>M. tuberculosis</i> Antigen	Single mixture of synthetic peptides representing ESAT-6, CFP-10 and TB7.7	Separate mixtures of synthetic peptides representing ESAT-6 and CFP-10
Measurement	IFN-g concentration	Number of IFN-g producing cells (spots)
Possible Results	Positive, negative, indeterminate	Positive, negative, indeterminate, borderline

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Limited data on the use of IGRAs for:

- Children younger than 5 years of age;
- Persons recently exposed to *M. tuberculosis*;
- Immunocompromised persons and
- Serial testing.
- Tests may be expensive.

What are the steps in administering an IGRA test?

Confirm arrangements for testing in a qualified laboratory, and arrange for delivery of the blood sample to the laboratory in the time the laboratory specifies to ensure testing of samples with viable blood cells.

- Draw a blood sample from the patient according to the test manufacturer's instructions.
- Schedule a follow-up appointment for the patient to receive test results.
- Based on test results, provide follow-up evaluation and treatment as needed.

How do you interpret IGRA test results?

IGRA interpretations are based on the amount of IFN- γ that is released or on the number of cells that release IFN- γ . Both the standard qualitative test interpretation (positive, negative, or indeterminate) and the quantitative (d) (4) (Y) (1)(F) (4) (U) (1)(F) (3) (Nil, TB, and Mit) (y) (u) concentrations or spot counts) should be reported.

As with the tuberculin skin tests (TSTs), IGRAs should be used as an aid in diagnosing infection with *M. tuberculosis*. A positive test result suggests that *M. tuberculosis* infection is likely, a negative result suggests that infection is unlikely. An indeterminate result indicates an uncertain likelihood of *M. tuberculosis* infection. A borderline test result (T-Spot only) also indicates an uncertain likelihood of *M. tuberculosis* infection.

A diagnosis of LTBI requires that TB disease be excluded by medical evaluation. This should include checking for signs and symptoms suggestive of TB disease, a chest radiograph, and, when indicated, examination of sputum or other clinical samples for the presence of *M. tuberculosis*. Decisions about a diagnosis of *M. tuberculosis* infection should also include epidemiological and historical information.

Recommendations on when to use IGRA tests

- IGRAs can be used in place of (but not in addition to) TST in all situations in which CDC recommends TST as an aid in diagnosing *M. tuberculosis* infection, with preferences and special considerations noted below. This includes contact investigations, testing during pregnancy, and screening of health care workers and others undergoing serial evaluation for *M. tuberculosis* infection. Despite the indication of a preference, use of the alternative test (FDA-approved IGRA or TST J) is acceptable medical and public health practice. Caution in interpretation should be used when testing certain populations because of limited data on the use of IGRAs (see Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection – United States).
- Populations in which IGRAs are preferred for testing:
 - **Persons who have received GCG (either as a vaccine or for cancer therapy) and**
 - Persons from groups that historically have poor rates of return for TST reading.
 - TST is preferred over IGRAs for testing children less than 5 years of age.
 - As with TST, IGRAs generally should not be used for testing persons who have a low risk of infection and a low risk of disease due to *M. tuberculosis*.
 - Each institution and TB control program should evaluate the availability and benefits of IGRAs in prioritizing their use.

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- Routine testing with both TST and IGRA is not recommended. However, results from both tests might be useful in the following situations:
 - » When the initial test is **negative** and:
 - The risk for infection, the risk for progression to disease, and the risk for a poor outcome are high (e.g., HIV infected persons or children under 5 years of age who are exposed to a person with infectious TB).
 - There is clinical suspicion for TB disease (e.g., signs, symptoms, and/or radiographic evidence suggestive of TB disease) and confirmation of *M. tuberculosis* infection is desired.
 - Taking a positive result from a second test as evidence of infection increases detection sensitivity.
 - » When the initial test is **positive** and:
 - Additional evidence of infection is required to encourage acceptance and adherence (e.g., foreign-born healthcare workers who believe their positive TST is due to BCG). A positive IGRA might prompt greater acceptance of treatment for LTBI as compared with a positive TST alone.
 - The person has a low risk of both infection and progression from infection to TB disease. Requiring a positive result from the second test as evidence of infection increases the likelihood that the test reflects infection. An alternative is to assume, without additional testing, that the initial result is a false positive or that the risk for disease does not warrant additional evaluation or treatment, regardless of test results.
 - » In addition, repeating an IGRA or performing a TST might be useful when the initial IGRA result is indeterminate, borderline, or invalid and a reason for testing persists.

Multiple negative results from any combination of these tests cannot exclude *M. tuberculosis* infection. Steps should be taken to minimize unnecessary and misleading testing of persons at low risk.

Selection of the most suitable test or combination of tests for detection of *M. tuberculosis* infection should be based on the reasons and the context for testing, test availability, and overall cost of testing.

Can IGRAs Be Given To Persons Receiving Vaccinations?

As with TST, live virus vaccines might affect IGRA test results. However, the effect of live virus vaccination on IGRAs has not been studied. Until additional information is available, IGRA testing in the context of live virus vaccine administration should be done as follows:

- Either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine
- At least one month after smallpox vaccination

Additional Information

Centers for Disease Control and Prevention. Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium tuberculosis* Infection, United States. (PDF) *MMWR* 2010; 59 (No. RR-5). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e

<http://www.cdc.gov/tb>

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November 2011

6.0 QUALITY IMPROVEMENT (QI) DEPARTMENT

The Mission of Covered California, the state’s health insurance Marketplace, is “Increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.” To this end, Covered California adopted the “**triple aim**” framework

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care

As the leading Medi-Cal health plan in Los Angeles County, L.A. Care believes that participation in Covered California is a perfect complement to the services we already provide to our existing one million members. Our focus will continue to be ensuring that low-income individuals and families have easy access to a high quality of health care. To achieve this purpose, L.A. Care annually prepares a comprehensive Quality Improvement Program that clearly defines L.A. Care’s QI structures and processes designed to improve the quality and safety of clinical care and services it provides to its members. A complete written copy of L.A. Care Quality Improvement Program is available by request by calling **(213) 694-1250, Ext. 4027**.

The L.A. Care Quality Improvement Program, consistent with the L.A. Care mission, strives to:

- Define, oversee, continuously evaluate and improve the quality and efficiency of health care delivered through organizational commitment to the goals and principles of our organization.
- Ensure medically necessary covered services are available and accessible to members taking into consideration the member’s cultural and linguistic needs.
- Ensure our contracted network of providers cooperate with L.A. Care quality initiatives.
- Ensure that timely, safe, medically necessary, and appropriate care is available.
- Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards.
- Promote health education and disease prevention designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.
- Maintain a well-credentialed network of providers based on recognized and mandated credentialing standards.
- Protect members’ Protected Health Information (PHI).

6.1 OBJECTIVES

L.A. Care’s quality improvement infrastructure is designed to:

- Identify, implement and monitor interventions, as appropriate, to continually achieve improvement in the quality and safety of clinical care and services.
- Educate practitioners regarding L.A. Care’s performance expectations and provide feedback about compliance with those expectations.
- Communicate the quality improvement process to practitioners/providers and members through appropriate persons and venues (e.g. meetings, print media, electronic media, and L.A. Care’s website).
- Identify, monitor, and address known or suspected quality of care issues and trends that affect the health care and safety of members.
- Document, monitor and strive to improve the performance of L.A. Care’s contracted network.
- Monitor compliance with corrective action plans and interventions.
- Coordinate relevant sources of information available to L.A. Care including quality of care

performance review (e.g. QI activities matrix reports, membership services, pharmacy and EPSDT data).

- Monitor the performance of network practitioners in providing access to quality care through the use of health-related indicators, member satisfaction surveys, provider satisfaction surveys, focused studies, facility inspections, medical record audits and analysis of administrative data.
- Monitor L.A. Care and network compliance with the contractual and regulatory requirements of appropriate state and federal agencies and other professional by recognized standards such as NCQA and JCAHO.
- Establish priorities for and conduct focused review studies with emphasis on preventive services, high-volume providers of services and high-risk services.
- Establish and maintain policies, procedures, criteria, and standards for the monitoring of credentialing, recredentialing, and reappointment of plan practitioners.
- Assure that members can achieve resolution to problems or perceived problems relating to service, access or other quality issues.
- Annually measure member and provider satisfaction with L.A. Care.
- Establish, maintain, and enforce a conflict of interest policy regarding peer review activities.
- Establish, maintain, and enforce confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
- Ensure that mechanisms are in place to support and facilitate continuity of care within the health care network and to review the effectiveness of such mechanisms.
- Establish standards of medical and behavioral health care (as required by product line) which reflect current medical literature and national benchmarks; design and implement strategies to improve compliance; and develop objective criteria and processes to evaluate and continually monitor performance and adherence to the guidelines.
- Sponsor the delivery of educational information to practitioners to enhance the diagnosis and management of medical/health conditions.
- Promote preventive health measures, health awareness programs, education programs, patient safety, health care disparities and cultural and linguistic programs that complement Quality Improvement interventions.
- Foster a supportive environment to assist practitioners and providers to improve safety within their practices.

6.2 ANNUAL QI PROGRAM EVALUATION

L.A. Care Annually reviews data reports and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a 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; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year.

6.3 ANNUAL QI WORK PLAN

The annual QI Work Plan is developed in collaboration with staff and is based, in part upon the results of the prior year's QI Program evaluation. Each of the elements identified on the Work Plan has activities defined, responsibility assigned and the date by which completion is expected. Quarterly updates to the Work Plan are

documented and reported to the Quality Oversight Committee and the Compliance and Quality Committee of the Board.

6.4 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 Quality Program. There is physician network participation on many of L.A. Care's QI Committees.

6.5 CLINICAL CARE MEASURES - *HEDIS*

L.A. Care measures clinical performance related to Healthcare Effectiveness Data (HEDIS). L.A. Care expects that the network assist the health plan in continuously improving its HEDIS rates. The network is also expected by contract to cooperate with the annual HEDIS data collection efforts and keep encounter data current and accurate. Common HEDIS measures are Well Child Visits, Well Adolescent Visits, Timely Prenatal and Postpartum Care, Diabetes measures, such as Diabetic Retinal Eye exams, LDLs, A1C and Nephropathy, Breast and Cervical Cancer Screenings, and others.

HEDIS and CAHPS Reporting

L.A. Care must submit to the Marketplace HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass and/or DHCS, per each Product Type for which it collects data in California. These measures may change as some may be added or removed by NCQA. The Marketplace reserves the right to use L.A. Care's reported measures scores to construct L.A. Care Covered™ summary quality ratings that the Marketplace may use for such purposes as supporting consumer choice and the Marketplace's plan oversight management.

- L.A. Care must report scores for Measurement Year ("MY") 2011, MY2012, MY2013 and MY2014 based on data reported to NCQA Quality Compass and/or DHCS County-level Product reporting for those periods. L.A. Care is not required to report DHCS County-level reporting HEDIS or CAHPS information if not already doing so for Medi-Cal.
- L.A. Care must collect its HEDIS and CAHPS data consistent with the standard measures set that is reported to NCQA Quality Compass and any applicable DHCS County-level reporting for those periods. L.A. Care will report scores separately for each Quality Compass Product Type and/or DHCS County-level product type (e.g.: commercial HMO/POS, commercial PPO, Medicaid HMO), for California. Beginning in MY2014, L.A. Care must include Marketplace Enrollees as part of its commercial population for the respective product types.
- For the purposes of determining Performance Measurement Standards, the Marketplace shall use the most appropriate Product Type based on the plan design and network operated for the Marketplace.
- L.A. Care may be required to conduct QHP product type CAHPS measurement and reporting effective MY 2014 and annually thereafter.
- Subject to changes in federal requirements, L.A. Care will not be required to collect and report QHP-specific HEDIS measures.
- The timeline for the L.A. Care Covered™ HEDIS and CAHPS quality data submission will be consistent with the timeline for submitting data to the NCQA Quality Compass and/or DHCS.
- The Marketplace reserves the right, as measures are added or removed from the national standard measures, to add or rename measures to the standard HEDIS measures and will provide L.A. Care or sufficient prior notice of intent to add or rename measures to the existing measure set.

- Health plan electing to pursue URAC plan accreditation instead of NCQA accreditation per Article 2, are not exempt from these requirements.

6.6 HEDIS/CAHPS CLINICAL EFFECTIVENESS MEASURE SET SUMMARY

Getting the Right Care

Appropriate Testing for Children With Pharyngitis
Appropriate Treatment for Children With Upper Respiratory Infection Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis Use of Imaging Studies for Low Back Pain
All-Cause Readmissions
Annual Monitoring for Patients with Persistent Medications
Plan All-Cause Readmission (average adjusted probability of readmission)
Diabetes Care
CDC: Medical Attention for Nephropathy CDC: Hemoglobin-A1c Testing
CDC: LDL-C Screening
CDC: Eye Exam (Retinal) Performed CDC: LCL-C Control (<100 mg/dl) CDC: HbA1c Control (<8.0%)
CDC: Blood Pressure Control (140/90 mm Hg) CDC: HbA1c Poorly Control (>9.0%)
Cardiovascular Care
Controlling High Blood Pressure
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)
Persistence of beta blocker treatment after a heart attack
Behavioral Health Care
Antidepressant Medication Management (Both Rates)
Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only) Follow-Up for Children Prescribed ADHD Medication (Both Rates) Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs and 18+ Yrs)
Other Chronic Care
Medication Management for People With Asthma (50%/75% remained on controller medications)
Use of Spirometry Testing in the Assessment and Diagnosis of COPD Drug Therapy for Rheumatoid Arthritis
Pharmacotherapy management of COPD Exacerbation (bronchodilator and systemic corticosteroid)
Doctor and Care Ratings
Global Rating of Care (CAHPS)
Global Rating of Personal Doctor (CAHPS) Global Rating of Specialist (CAHPS)
Appropriate Testing for Children With Pharyngitis
Appropriate Treatment for Children With Upper Respiratory Infection Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis Use of Imaging Studies for Low Back Pain
All-Cause Readmissions
Annual Monitoring for Patients with Persistent Medications

Plan All-Cause Readmission (average adjusted probability of readmission)
Diabetes Care
CDC: Medical Attention for Nephropathy CDC: Hemoglobin-A1c Testing
CDC: LDL-C Screening
CDC: Eye Exam (Retinal) Performed CDC: LCL-C Control (<100 mg/dl) CDC: HbA1c Control (<8.0%)
CDC: Blood Pressure Control (140/90 mm Hg) CDC: HbA1c Poorly Control (>9.0%)
Cardiovascular Care
Controlling High Blood Pressure
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)
Persistence of beta blocker treatment after a heart attack
Behavioral Health Care
Antidepressant Medication Management (Both Rates)
Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only) Follow-Up for Children Prescribed ADHD Medication (Both Rates) Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs and 18+ Yrs)
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Medication Management for People With Asthma (50%/75% remained on controller medications)
Use of Spirometry Testing in the Assessment and Diagnosis of COPD Drug Therapy for Rheumatoid Arthritis
Pharmacotherapy management of COPD Exacerbation (bronchodilator and systemic corticosteroid)
Doctor and Care Ratings
Global Rating of Care (CAHPS)

*certain CAHPS measures may not be available for all Product Types

Access to Care

Getting Care Quickly Composite (CAHPS)
Getting Needed Care Composite (CAHPS)
Child and Adolescent Access to Primary Care Practitioners (12-14, 25mo-6yr, 7-11, 12-19) HEDIS
Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years and 45 to 64 years) HEDIS

*certain CAHPS measures may not be available for all Product Types

Staying Healthy/Prevention

Checking for Cancer
Breast Cancer Screening Cervical Cancer Screening Colorectal Cancer Screening
Getting Help to Stay Healthy
Chlamydia Screening in Women (Age 21-24) Adult BMI Assessment
Prenatal and Postpartum Care (Both Rates)
Flu Shots for Adults (Ages 50–64) (CAHPS)
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)
Aspirin Use and Discussion(CAHPS)
Children and Adolescent Staying Healthy/Prevention
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life Well-Child Visits in the First 15 Months of Life Adolescent Well-Care Visits
Immunizations for Adolescents
Childhood Immunization Status - Combo 3 Chlamydia Screening in Women (Age 16-20)
Checking for Cancer
Breast Cancer Screening Cervical Cancer Screening Colorectal Cancer Screening
Getting Help to Stay Healthy
Chlamydia Screening in Women (Age 21-24) Adult BMI Assessment
Prenatal and Postpartum Care (Both Rates)
Flu Shots for Adults (Ages 50–64) (CAHPS)
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)
Aspirin Use and Discussion(CAHPS)
Children and Adolescent Staying Healthy/Prevention
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life Well-Child Visits in the First 15 Months of Life Adolescent Well-Care Visits
Immunizations for Adolescents
Childhood Immunization Status - Combo 3 Chlamydia Screening in Women (Age 16-20)
Checking for Cancer
Breast Cancer Screening Cervical Cancer Screening Colorectal Cancer Screening
Getting Help to Stay Healthy
Chlamydia Screening in Women (Age 21-24) Adult BMI Assessment
Prenatal and Postpartum Care (Both Rates)
Flu Shots for Adults (Ages 50–64) (CAHPS)

Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)
Aspirin Use and Discussion(CAHPS)
Children and Adolescent Staying Healthy/Prevention
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life Well-Child Visits in the First 15 Months of Life Adolescent Well-Care Visits
Immunizations for Adolescents
Childhood Immunization Status - Combo 3 Chlamydia Screening in Women (Age 16-20)
Checking for Cancer
Breast Cancer Screening Cervical Cancer Screening Colorectal Cancer Screening
Getting Help to Stay Healthy
Chlamydia Screening in Women (Age 21-24) Adult BMI Assessment
Prenatal and Postpartum Care (Both Rates)
Flu Shots for Adults (Ages 50–64) (CAHPS)
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)

*certain CAHPS measures may not be available for all Product Types

Plan Service

Plan Service
Claims Processing Composite (CAHPS)
Customer Service Composite (CAHPS)
Plan Information on Costs Composite(CAHPS)
Global Rating of Plan(CAHPS)

*certain CAHPS measures may not be available for all Product Types

6.7 HOSPITAL QUALITY

L.A. Care will develop and implement oversight programs (if not already in place by January 1, 2015) targeting the following areas related to hospital-based services, as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program, including:

- Deaths and readmissions
- Serious complications related to specific conditions
- Hospital acquired conditions
- Healthcare associated infections

These oversight programs will be consistent with Medicare performance areas whenever possible and should reflect the overall performance of the hospital. L.A. Care will regularly report program results according to the reporting requirements, including format, frequency and other technical specifications, that have been mutually agreed upon between the Marketplace and L.A. Care.

Service Measures

L.A. Care monitors services and member satisfaction by collecting, analyzing and acting on numerous sources of data such as Member Satisfaction (CAHPS), Complaints and Appeals, Access to and Availability of Practitioners and Provider Satisfaction.

6.8 CONTINUITY AND COORDINATION OF MEDICAL CARE

How well does your office coordinate care? If referring to a specialist, contact the specialist before the patient's appointment. Have staff set up a quick phone appointment and fax over the patient's medical history. Request that the specialist also contact you once the consultation and/or treatment is finished. Keep track of specialty referrals that require prior authorization. Talk to the PPG or IPA about getting timely hospital discharge reports that will help you follow up and coordinate care after a hospitalization.

6.9 CONTINUITY and COORDINATION OF MEDICAL and BEHAVIORAL HEALTH CARE

L.A. Care will coordinate and cover laboratory, radiological and radioisotope services needed for the diagnosis, treatment and monitoring of a mental health condition. L.A. Care covers mental health drugs listed on the formulary and prescribed by the PCP doctor or by a licensed mental health provider authorized to prescribe drugs. If medically necessary, L.A. Care may cover a mental health drug not on the formulary.

6.10 PREVENTIVE HEALTH AND WELLNESS

Health and Wellness Services

L.A. Care is required to encourage and monitor the extent to which L.A. Care Covered™ members obtain preventive health and wellness services within the first year of enrollment. And L.A. Care must report annually regarding on how it is maximizing L.A. Care Covered™ member access to preventive health and wellness services. Report information should be coordinated with existing national measures, whenever possible, including HEDIS. As part of that report, L.A. Care will assess and discuss the participation of L.A. Care Covered™ members in:

- necessary preventive services appropriate for each Enrollee
- tobacco cessation intervention, inclusive of evidenced based counseling and appropriate pharmacotherapy, if applicable
- obesity management, if applicable

Community Health and Wellness Promotion

Promoting better health requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. L.A. Care will report annually the initiatives; programs and/or projects that it supports that promote wellness and better community health that specifically reach beyond its members. Such programs may include, but are not limited to, partnerships with local or state public health departments and voluntary health organizations which operate preventive and other health programs.

L.A. Care will develop and provide reports on how it is participating in community health and wellness promotion. Report information should be coordinated with existing national measures, whenever possible.

Health and Wellness Enrollee Support Process

L.A. Care will provide the following information to the Marketplace:

- Health and wellness communication process to members and participating providers, or other caregivers
- Process to ensure network adequacy required by State or Federal laws, rules and regulation given the focus on prevention and wellness and the impact it may have on network capacity
- Documentation of a process to incorporate member health and wellness information into the L.A. Care Covered™ data, and information specific to each individual member. This member data is L.A. Care's most complete information on each member and is distinct from the member's medical record maintained by the providers.

Preventive Health Care Guidelines – See L.A. Care website for current and updated guidelines

Clinical Practice Guidelines for Acute and Chronic Medical Care – See L.A. Care website for current and updated guidelines including asthma and diabetes

Clinical Practice Guidelines for Behavioral Health Care – See L.A. Care website for current and updated guidelines including depression and ADHD

6.11 DISEASE MANAGEMENT PROGRAMS

The objective of each of L.A. Care's Disease Management Programs is to improve the health status of its eligible members with chronic or other conditions. The programs achieve their objective by educating the member and by enhancing the member's ability to self-manage the condition or illness. Disease management programs are developed from evidenced-based clinical practice guidelines and support the practitioner-patient relationship, plan of care and foster patient empowerment. Disease management programs are selected based on an analysis of internal data relating to disease prevalence in the L.A. Care population and are currently addressing Asthma (**L.A. Cares About Asthma**) and Diabetes (**L.A. Cares About Diabetes**). To enroll a member contact L.A. Care at **1-866-LA-CARE6 (1-866-522-2736)**.

6.12 POPULATION OF FOCUS: SERVING SENIORS AND PERSONS WITH DISABILITIES AND HEALTH DISPARITIES

L.A. Care seeks to improve the health and overall well-being of all its members, including seniors and people with disabilities as well as focusing on health disparities. L.A. Care specifically develops programs that target and accommodate members who are at higher risk for health disparities, including those related to race and ethnicity, language, disabilities and chronic conditions.

6.13 PATIENT SAFETY

L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety in their practices. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components. When performance is analyzed, patient safety is considered, opportunities are identified, prioritized and actions are taken to improve safety.

6.14 NURSE ADVICE LINE - 1-800-249-3619

L. A. Care provides a 24 hour, 7 days per week nurse advice line for L.A. Care Covered™ members. This service

may help members save time and money, avoid long ER lines, learn self-care management of common ailments, and reduce after hours calls to physicians. Members can also listen to the audio library of more than 1,000 easy to follow health topics.

6.15 MEMBER CONFIDENTIALITY

L.A. Care keeps confidential information secure and makes it available only to L.A. Care employees, contractors, and affiliates who have a need to know and who have signed a confidentiality statement.

L.A. Care ensures that all individuals or agencies who participate in the use, creation, maintenance, or disclosure of protected health information limit the use and disclosure only to the amount necessary to complete the task. Without a signed authorization, disclosure of protected health information is limited to the purposes of treatment, payment, or health care options. These purposes include the use of protected health information for quality of care activities, disease management service referrals, statistical evaluation, claims payment processes, medical payment determinations, practitioner credentialing, peer review activities, and the grievance and appeals process. Network practitioners and providers are obligated to maintain the confidentiality of member information and information contained in a member's medical record and may only release such information as permitted by applicable laws and regulation, including HIPAA.

L.A. Care maintains confidentiality in written, verbal, and electronic communications. L.A. Care has specific policies that outline appropriate storage and disposal of electronic and hard copy materials so that confidentiality is maintained within the plan and network.

6.16 DISEASE REPORTING STATEMENT

L.A. Care complies with disease reporting standards as cited by the California Code of Regulations, Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission and intervene rapidly when appropriate. Forms to report diseases can be found at www.lapublichealth.org/acd/cdrs.htm and via a link on the L.A. Care website: www.lacare.org.

7.0 CREDENTIALING

The network for L.A. Care Covered™ is organized around IPAs and medical groups with infrastructure to effectively build and manage physician networks. Only IPAs and Medical Groups known for quality and efficiency are selected for the network. Our guiding principles in contracting include the following:

- Strong track record of quality and efficiency
- Significant physician overlap between Medi-Cal network and Covered California network for continuity of care
- Cultural and geographic diversity

Most hospitals and ancillary providers contracted for L.A. Care's direct lines of business are included in the L.A. Care Covered™ network.

All providers are added to the L.A. Care Covered™ Provider Directory on the L.A. Care website at www.lacarecovered.org.

7.1 OVERVIEW

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

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 and abide by State and Federal laws and regulations. All providers/practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. This ensures continuity of providers for populations that may move between L.A. Care Covered™ and Medi-Cal. 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.

L.A. Care is responsible for monitoring all contracted PPGs' credentialing, and re-credentialing activities. A PPG must pass the L.A. Care Credentialing Department's due diligence (pre-delegation) credentialing audit in order to be delegated the credentialing responsibility. Otherwise, L.A. Care's Credentialing Department is responsible for a PPG's credentialing activities. Regardless of a PPG's credentialing delegation status, L.A. Care retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners, based on credentialing issues at all times.

The PPG is accountable for credentialing and re-credentialing its practitioners, even if it delegates all or part of these activities. If the PPG delegates any credentialing and re-credentialing activities, there is evidence of oversight of the delegated activity. There must be annual evidence of a mutually agreed upon delegation agreement by both the PPG and the delegate, i.e., NCQA certified CVOs, non-certified CVOs, etc. The

delegation agreement must meet all elements of NCQA's standards. As a note, CMS does not recognize NCQA certified CVOs. As such, all files are subject to full file review.

When delegates have access to the PPG's protected health information (PHI) on members or practitioners, or create such information in the course of their work, the mutually agreed-upon document must ensure that the information will remain protected. This is not applicable if there is no delegation arrangement, or if the delegation arrangement does not involve the use, creation or disclosure of protected health information.

- If the delegation arrangement does not include the use of PHI in any form, an affirmative statement to that fact in the delegation agreement is sufficient, but is not required; the PPG may document the lack of PHI in a delegation arrangement in other manners.
- Prior to delegation, L.A. Care's Credentialing Department audits the PPG (the potential delegated entity) to determine if the PPG meets L.A. Care's criteria for delegation. The Credentialing Department evaluates the potential delegated entity's ability to perform the delegated activities, which will include all activities related to credentialing and re-credentialing in accordance with the standards of 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 each delegated entity's performance.

Types of Delegation Status

- After completion of the pre-delegation audit, the audit tool is scored and recommendations regarding delegation are presented to the Credentialing Committee as follows:
 - **Delegation** – PPG group scores between 80% to 100% on the pre-delegation audit. A corrective action plan must be successfully completed if score is below 100%.
 - **Full delegation** – PPG scores 100%. No CAP required.
 - **Full delegation with a CAP** – PPG scores between 80-99%. CAP required. A corrective action must be successfully completed.
 - **Denial of Delegation** – PPG chooses not to pursue delegation of credentialing, or it receives less than a 70% on the pre-delegation credentialing audit. PPG has a Non-Delegated credentialing status for a minimum of one year. The credentialing of PPG's practitioners is performed by L.A. Care's Credentialing department. Denial of delegation letters will be sent to the PPG.
- Following recommendations by the Credentialing Committee, delegation letters will be sent to the PPG's scoring 80% or above, and Delegation Agreements for credentialing will be executed.
- L.A. Care retains the right to determine in its sole discretion whether to delegate credentialing functions regardless of results of an audit.

Levels of Delegation

- Full – All 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.

Delegation Oversight

- The PPG agrees, upon delegation, to make available to L.A. Care the credentialing and re-credentialing status on the PPG’s participating practitioners, including credentialing data elements as well as documents and quarterly reports, as appropriate, using the standardized ICE form or another approved L.A. Care format.
 - On an annual basis, L.A. Care will audit the credentialing and recredentialing activities of the PPG. The PPG’s credentialing and recredentialing files will be reviewed according to the following file pull methodology: A roster of practitioners, which includes Autism providers, credentialed and recredentialed within the audit period and a list of the PPG’s UM Medical Director(s) will be requested. In addition, a full roster of the delegate’s network will also be requested. L.A. Care will also review the delegate’s quarterly reports for comparison and file selection. NCQA’s 8/30 methodology will be used in evaluating files. The minimum files reviewed will be eight (8) initial files and eight (8) recredential 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.
 - L.A. Care’s oversight audit will include a review of the PPG’s credentialing policies and procedures, Committee meeting minutes, practitioner credentialing and recredentialing files, which includes Autism providers, UM Medical Director(s), a list of contracted health delivery organizations (HDOs), ongoing monitoring reports, oversight audits and any sub-delegations agreements, if applicable.
 - Results of L.A. Care’s oversight audit will be reported to the PPG, including the corrective action plan if deficiencies are noted. L.A. Care’s Credentialing Department works collaboratively with the PPG when deficiencies have been identified through the oversight process. The delegate is given a Corrective Action Plan (CAP) and asked to respond within 30 days. If no response is received within 30 days, or the CAP is not acceptable or complete, the Regulatory Affairs and Compliance (RA&C) Department sends a second letter requesting a response within 14 days and advising that failure to respond may be cause for revocation of the delegation agreement. The PPG will implement such corrective action plan within the time period stated and will permit a re-audit by L.A. Care or its agent, if requested.
 - If a PPG fails to adequately correct the deficiencies within the required time period, L.A. Care retains the right to perform a focused audit as deemed necessary. If reoccurring deficiencies are identified during the third consecutive audit review, the PPG is subject to additional deductions and referred to Regulatory Affairs and Compliance for de-delegation. L.A. Care may de-delegate credentialing and assume responsibility for all or part of credentialing functions. At L.A. Care’s discretion, or in the event that L.A. Care determines that significant deficiencies are occurring related to performance by the delegate and are without remedy and the delegate fails to complete the corrective action plan process and has gone through the exigent process which results in de-delegation, the PPG cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the

sole discretion of the Credentialing Committee, regardless of the score.

- A PPG that receives a rating of “excellent”, “commendable”, “accredited”, or “certified”, from NCQA, will be deemed to meet L.A. Care’s requirements for credentialing. These PPGs may be exempt from the L.A. Care audit of credentialing in elements for which they are accredited or certified. As a note, CMS does not recognize NCQA certified CVOs. In such cases, all files may be subject to full file review. If a PPG sub-delegates to an NCQA CVO for primary source activities, the PPG must still perform annual oversight of these activities for the Medicare line of business, if applicable.
 - If the PPG is NCQA accredited, and L.A. Care chooses to use the NCQA accreditation in lieu of a pre-delegation or annual audit, the PPG will be required to demonstrate compliance with the credentialing and recredentialing of UM Medical Director(s) annually. This will be accomplished through a signed Attestation submitted by the Medical Director(s) attesting to compliance with this requirement. If the PPG is not compliant with this process, the PPG will be subject to sanctions according to the PPGSA, Sections 1.36 and 1.37.
- L.A. Care retains overall responsibility for ensuring that credentialing requirements are met and will require documentation from PPG to establish proof of NCQA accreditation status. Elements not listed in the NCQA accreditation documentation will require further validation through due diligence or annual audits. L.A. Care retains the right to perform oversight audits as necessary.
 - 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.

7.3 PPG RESPONSIBILITIES

- PPG must have policies and procedures to address credentialing of practitioners, non-practitioner health care professionals, licensed independent practitioners, Autism providers, UM Medical Director(s) and health delivery organizations that fall within in its scope of credentialing. PPG must state in policy that they do not make credentialing and re-credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the practitioner specializes. A statement that the PPG does not discriminate does not meet the intent of the requirement. The policy must explicitly describe how it both monitors and prevents discriminatory practices to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner which may include but are not limited to periodic audits of credentialing files and practitioner complaints, and maintaining a heterogeneous credentialing committee decisions to sign a statement affirming that they do not discriminate.
 - PPG will establish standards, requirements and processes for the health delivery organizations that are performing services for L.A. Care members to ensure that these practitioners and health delivery organizations are qualified to perform the services, and are

licensed and/or certified consistent with L.A. Care, California Covered, NCQA, DHCS, and CMS requirements. These standards, requirements and processes are applicable whether or not credentialing and re-credentialing activities are delegated.

- PPG's policies must explicitly define the process used to ensure that the information submitted to L.A. Care is consistent with the information obtained during the credentialing process which is included in member materials and practitioner directories. Specifically, any practitioner information regarding qualifications given to members should match the information regarding practitioner's education, training, certification, and designated specialty gathered during the credentialing process. "Specialty" refers to an area of practice, including primary care disciplines.
- PPG will 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.
 - PPG must notify the practitioner, in writing, of any adverse actions to the practitioner and notify L.A. Care of PPG's action taken as soon as the PPG has knowledge. The PPG must require the provider/practitioner to notify the PPG of any adverse action taken against them within 14 days of knowledge.
 - PPG must document the review of adverse events, actions taken, the monitoring and follow through of the process including timeframes and closure of each adverse events.
 - PPG must notify L.A. Care in writing, if any contracted practitioner has any adverse action or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network.
 - PPGs that are delegated for credentialing and recredentialing are required to review, investigate and take appropriate action for any adverse events or criminal actions taken against a contracted provider including, but not limited to fair hearing and reporting to appropriate authorities as delegated. L.A. Care retains the right to approve, close panel to new membership and/or terminate contracted practitioners at all times.
 - Practitioners must not have limitations or restrictions on hospital privileges. The Plan'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.
- L.A. Care reserves the right, pursuant to the Participating Practitioner Group Services Agreement, to coordinate, consolidate, and participate in any PPG participating practitioner disciplinary hearing, conducted in accordance with L.A. Care Policy and Procedures, and California Business and Professions Code Section 805.
- PPG will advise L.A. Care of any changes to its credentialing and re-credentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the

change. If L.A. Care deems the changed items not in compliance with L.A. Care, Covered California, NCQA, DHCS, and CMS requirements, L.A. Care shall notify PPG immediately. PPG will have 30 days to be in compliance, and, if not in compliance, L.A. Care may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

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

- Using the standardized ICE format and Excel grid will include the following:
 - Number of adds/deletes of PCPS (i.e. MDs, DOs, etc.)
 - Number of adds/deletes of SCPS (i.e. MDs, and DOs, etc.)
 - Numbers of adds/deletes of independent practitioners (i.e. DCs, DPMs, etc.)
 - Any new or revised policies and procedures, additions of a computer system, CVO
 - Practitioners termed for quality issues
- PPG will submit a profile of the PCP or SCP, Mid-Levels and Autism practitioners credentialing information to L.A. Care. Along with the profile, first and last page of the contract, W-9, all addenda to the California Participating Physician Application (CPPA), and appropriate hospital coverage letter, if applicable, must be attached.
 - PPG profiles must meet L.A. Care's requirements as follows: Practitioners who do not have hospital privileges with a L.A. Care contracted hospital, may use the PPGs admitting panel or have a direct agreement with a practitioner who has admitting privileges within the same specialty at a L.A. Care contracted hospital. This agreement must capture responsibility for the provisions and coordination of care, when patients are discharged from the hospital, referral of patients back to PCP with a hospital discharge summary, and coordinate a seven day week, 24-hour call coverage utilizing the practitioners that are contracted with the PPG.
- The PPG is responsible to ensure that members have access to their assigned PCP twenty-four (24) hours per day, seven (7) days per week. PPG will notify L.A. Care thirty (30) days prior to any changes in the status of any of the PPG's participating practitioners, including, but not limited to, termination, resignation or extended leave (more than 4 weeks). PPGs must ensure that physicians on leave of any duration are covered by a practitioner with a like specialty (e.g. Pediatrician covered by a Pediatrician) or a provider who is otherwise experienced and qualified to provide appropriate coverage.
 - Failure to ensure that physicians on extended leave are covered by a credentialed practitioner with a like specialty or a provider who is otherwise experienced and qualified to provide appropriate coverage shall be considered a material breach and may result in sanctions as outlined in section 1.36 of the Participating Provider Group Service Agreement (PPGSA).
- PPGs will ensure that practitioners and all of their contracted sites are reviewed in accordance with the requirements of L.A. Care, California Covered, NCQA, DHCS and CMS requirements. All Practitioners must have a current (i.e., within 3 years of the date of initial credentialing/re-credentialing) full scope site review at the time of initial credentialing/re-credentialing. Practitioners who are only contracted for the Medicare program are required to undergo a medical record review. Covered California does not require a facility site review.

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

Provisional Credentialing

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

7.4 CONFIDENTIALITY AND PRACTITIONER RIGHTS

- PPG's credentialing policies and procedures must clearly state the confidential nature of information obtained in the credentialing process. The PPG must also describe the mechanisms in effect to ensure confidentiality of information collected in this process. The PPG must ensure that information obtained in the credentialing process is kept confidential and, ensure that practitioners can access their own credentialing information, as outlined in *Right to review information*, below.
- During the credentialing process, all information that is obtained is considered confidential. All Committee meeting minutes and practitioner files are to be securely stored and can only be seen by an appropriate Medical Director or his/her equally qualified designee, and the Credentialing Committee members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1157 of the State of California Evidence Code and Section 1370 of the Health and Safety Code of the State of California.
- 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.).
- 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.
- 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.
- Policies and procedures must also state the practitioner's right to correct erroneous information submitted by another source. The policy must clearly state:
 - Timeframe for changes
 - Format for submitting corrections
 - The person to whom corrections must be submitted
 - Receipt of documented corrections
 - How practitioners are notified of their right to correct erroneous information as outlined in this manual.

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

Requirements

- All practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. Physicians must not be excluded, suspended or ineligible or opted out for participation in the Medi-Cal or Medicare programs. This ensures continuity of providers for populations that may move between L.A. Care Covered™ and Medi-Cal. Failure to meet Medi-Cal and CMS requirements may be cause for removal from L.A. Care’s network.
- The PPG/Vendor is required to notify the Plan immediately when providers/practitioners are identified on any sanctions or reports for removal from network.
- These requirements include verification of the following circumstances:
 - **Excluded Providers**
 - Confirmation that practitioners 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 health practitioners/ providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. All contracted PPGs and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.
 - Lists of the excluded providers are available at:
http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp.
 - **Medi-Cal Suspended and Ineligible Providers**
 - Medi-Cal law (*Welfare and Institutions Code*, Section 14123) mandates that the Department of Health Care Services (DHCS) suspends a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (b) suspended from the federal Medicare program for any reason.
 - Suspension is automatic when either of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the California Administrative Procedures Act.
 - All contracted PPGs and vendors, i.e., carved out contacts, are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.
 - **Opt-Out Providers**
 - If a practitioner opts out of Medicare, that practitioner/providers may not accept

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

- All contracted Participating Practitioner Groups (PPGs) and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration and take action as required by contract.

- **National Provider Identifier (NPI) Number**

- All practitioners of Covered Services, including physicians and specialists, must have a valid National Provider Identifier (NPI) Number.
- All contracted PPGs and vendors are required to verify that their contracted practitioners have a valid NPI number.

- **CLIA Certification**

- The Centers for Medicare & Medicaid Services (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 that perform even one test, including waived tests, on materials derived from human body for the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of health of, human beings to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of the tests performed.
- All contracted PPGs and vendors shall ensure that all contracted laboratory testing sites have either a current and valid CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. This must be monitored on an ongoing basis. If a vendor is used to perform laboratory testing, the vendor is required to have a CLIA certificate and there must be a contract between both parties.

- **DEA or CDS Certificate, as applicable**

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

- **Medicare Number**

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

Ongoing Monitoring of Sanctions, Complaints, and Quality Issues

- PPG must implement a process for monitoring practitioner sanctions, complaints and the occurrence of adverse events between re-credentialing cycles. The PPG must conduct ongoing monitoring of all practitioners who fall within the scope of credentialing. The PPG must be fully compliant with L.A. Care, Covered California, NCQA, DHCS, and CMS and use the approved current sources of sanction information.
- PPG develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles, and takes appropriate action against practitioners when it identifies occurrences of poor quality. PPG identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.
- PPG must show how they monitor all adverse events and demonstrate this process has been reviewed by the Credentialing Committee at least every six months. The PPG's Credentials committee may vote to flag a practitioner for ongoing monitoring. The PPG must make clear, the types of monitoring they impose, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the PPG's Credentialing Committee.
- PPG must provide proof of any practitioner identified on the OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc. The PPG must demonstrate that they have taken action to terminate the contracted practitioner. If a practitioner has been identified on any of the lists above, they are to be terminated for all lines of business for L.A. Care.
- PPG must notify L.A. Care promptly and no later than fourteen (14) calendar days of any adverse event or criminal action, changes in privileges, accusation, probation, other disciplinary action against a practitioner, or non-compliance with L.A. Care's policies and procedures. Failure to do so may result in the removal of the practitioner from L.A. Care's network.
- 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 the L.A. Care's Credentialing Committee determines otherwise.
- PPG who fails to comply with the requested information within the specific timeframe is subject to sanctions as described in L.A. Care's policies and procedures and PPGSA, section 1.36 and 1.37. In the event that the PPG fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and will be subject to L.A. Care's policies and procedures and Credentials committee's outcome of the adverse events.

7.5 RECREDENTIALING

- Participating practitioners must satisfy re-credentialing standards required for continued participation in the network. Re-credentialing is completed three years from the month of initial credentialing and every three (3) years thereafter.
- A facility site review does not need to be repeated as part of the re-credentialing 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 re-credentialing date, and does not need to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the Plan.

- If a practitioner/provider is contracted for the Medi-Cal and Medicare programs, they are subject to both a site review and medical record review. However, if the practitioner/provider is only contracted for the Medicare program, a medical record review is all that is required. However, Facility Site Review or other L. A. Care staff may visit a provider’s office at any time without prior notification.

7.6 CREDENTIALING COMMITTEE

- The Credentialing Committee will consist of not less than three (3) participating practitioners in good standings with state and federal agencies in order to ensure accurate representation of medical specialties.
- Administrative support staff may attend at the request of the Chair but are not entitled to vote.
- A quorum should consist of three (3) practitioner committee members. Any action taken upon the vote of a majority of members present at a duly held meeting at which a quorum is present shall be an act of the committee.

Meetings and Reporting

- The Credentialing Committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required action; and 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.
- Additional meetings of the Credentialing Committee may be called by the Committee Chairperson on an as-needed basis.

Committee Decisions

- L.A. Care considers the decision made by the Credentialing Committee to be final.
- The PPG's credentialing policies and procedures must include a time frame for notifying applicants of credentialing decisions, not to exceed sixty (60) calendar days from the Committee's decision.

Participation of Medical Director or other Designated Practitioner

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

Committee Functions

- Review and evaluate the qualifications of each practitioner applying for initial credentialing, and recredentialing.
- Investigate, review and report on matters referred by the Medical Director or his/her designee or the Board regarding the qualifications, conduct, professional character or competence of any applicant or practitioner, and;
- Review of periodic reports to the appropriate Committee and/or Board on its activities, i.e., ongoing monitoring reports, credentialing activity reports, etc.
- Review annually policies and procedures relevant to the credentialing process, and make revision as necessary to comply with L.A. Care, Covered California, NCQA, DHCS, and CMS requirements, regulations and practices.
- 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.
- PPG's Credentialing Committee must clearly document detailed discussion that reflects thoughtful consideration of credentials reviewed during its meeting in the minutes. Discussion that demonstrates approval/denial does not meet the intent of detailed discussion.
- 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.
- L.A. Care's Credentialing Committee may terminate, suspend or modify participation of those practitioners who fail to meet eligibility criteria. The decisions to terminate, suspend, or modify participation of a contracted practitioner as a result of a reportable quality of care issue shall be subject to an appeals process by the practitioner.

Credentials Committee File Review

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

7.7 APPEAL AND FAIR HEARING

- Delegated PPG, or if not delegated, L.A. Care must have a mechanism for the fair hearing and appeal process for addressing adverse decisions that could result in limitation of a practitioner's participation based on issues of quality of care and/or service, in accordance with all applicable

statutes. The process should include notification to practitioner within an established time frame and established time frame for practitioner to request a hearing, scheduling of hearing requests, followed by the procedures hearings, the composition of the hearing committee and the agenda for the hearing.

- 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 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:
- The following actions entitle the practitioner the opportunity to appear before a Peer Review Committee to present rebuttal evidence before a final determination is made. The practitioner shall have the right to be represented by an attorney during this process. The following actions also entitle the practitioner the opportunity for a hearing before a hearing panel in the event that the final determination of a Peer Review Committee is adverse to the practitioner, unless the right to a hearing has been forfeited as described below. The actions to which this section applies are:
 - Denial of initial panel appointment
 - Denial of reappointment to panel
 - Suspension of panel appointment (except as described below)
 - Revocation of panel appointment
 - Other adverse restrictions on panel appointment (except as described below)
- Peer Review Committee has the right to recommend suspension of a practitioner's panel appointment for up to fourteen (14) calendar days while an investigation is being conducted to determine the need for peer review action, without the practitioner having a right to the rebuttal and/or fair hearing process set forth below.
- A Peer Review Committee has the right to recommend immediate suspension or restriction of a practitioner's membership if the committee reasonably believes that the health of any individual would be jeopardized by the continued participation of the practitioner. In the case of such an immediate suspension or limitation on privileges (summary action), the practitioner has the right to receive notice, opportunity to present rebuttal information and fair hearing, in accordance with the procedure described in L.A. Care's Policy LS-005, but those rights apply subsequent to the summary action, rather than prior to it.

Required Reporting

- PPG must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank/Healthcare Integrity Protection Data Bank within thirty (30) calendar days after the effective date of the action, if any of the following events occur:
- The practitioner's application for participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.
- The practitioner's participation status is terminated or revoked for a medical disciplinary cause or reason.

- Restrictions are imposed or voluntarily accepted for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason. 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:
 - Resigns, retires, or takes a leave of absence
 - Withdraws or abandons the application
 - Withdraws or abandons his or her request for renewal

7.8 EXPIRED LICENSE

- L.A. Care requires that all practitioners who are performing services for L.A. Care members have a current license at all times to provide patient care to members and abide by State and Federal laws and regulations.
- **Failure to Renew**
 - Practitioners contracted with L.A. Care shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. The license to practice medicine in California must be renewed upon expiration (every two (2) years).
 - If any practitioner fails to renew their license by the expiration date, the following steps will be initiated by L.A. Care.
 - If the identified practitioner(s) has member enrollment:
 - Close provider’s panel to new members upon license expiration.
 - Notify PPG of expiration and possible reassignment of members
 - Remove assigned members from unlicensed practitioner/practitioner 5 business days following license expiration, if not renewed
 - Reassign members to a qualified licensed credentialed practitioner
 - Remove unlicensed practitioner from network
 - If the identified practitioner(s) has no member enrollment:
 - Close practitioner’s panel to new members
 - 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 to the requirements outlined above, PPGs must adhere to the requirements further described in their delegation agreement.

8.0 PROVIDER NETWORK OPERATIONS (PNO)

8.1 SPECIFIC AREAS

Provider Contracting

The Provider Network Contracting team is responsible for developing and negotiating financially sound contracts with physicians, Participating Physician Groups (PPGs), hospitals, ancillary providers and other health professionals in order to maintain a comprehensive provider network for the provision of health care services to covered members.

- **PPG Responsibilities:** PPG shall at all times comply with L.A. Care's Quality Improvement Program, including, but not limited to, allowing L.A. Care to use practitioner performance data

Provider Relations

Provider Relations Manager and Provider Network Representatives are responsible for the following:

- Serving as key contacts for PPGs, hospitals, and other providers to resolve all operational and ongoing service issues.
- Coordinating closely with Provider Contracting, Member Services, Claims, Utilization Management and PPGs when necessary to resolve issues.
- Training PPG personnel to ensure L.A. Care procedures and requirements are understood and followed.
- Conducting Joint Operations Meetings to ensure that administrators and staff are kept informed of policy and procedure changes.
- Provider grievance resolution.

Provider Network Research & Analysis

The Provider Network Research & Analysis (PNRA) has program responsibility over the multifaceted, highly technical functions that combine the services of information technology, provider network information, and statistical studies and reporting.

In this capacity, PNRA has oversight responsibility for the management, accessibility, and usability of provider information. PNRA is also responsible for conducting comprehensive provider related studies as mandated by the state Department of Health Care Services (DHCS), Medical Risk Management Insurance Board (MRMIB), and other governing agencies/bodies. Other key functions of PNRA are the production of L.A. Care's provider directories; the production of the Quarterly Impact Report, and the entry/updating of contractual terms/rates into MHC for our directly contracted PPGs, hospitals, ancillary providers, and individual providers for claim payment purposes.

8.2 PROVIDER TRAINING AND EDUCATION

Provider education is implemented by L.A. Care Health Plan and its PPGs. Goals, objectives, curricula, and implementation guidelines are established by L.A. Care. The PPGs are responsible for conducting provider training and orientation. L.A. Care provides additional resources and opportunities for provider education. L.A. Care provides special training and workshops for traditional and safety net providers. Ultimately, the goal

of provider training and education is to improve the delivery of services to members by providing appropriate forums for providers to:

- Become well informed about products offered by L.A. Care and its systems and processes.
- Understand the needs of L.A. Care members.
- Improve clinical, patient interaction, and administrative/management skills.

A training and education curriculum will be developed and implemented by the PPGs with collaborative oversight, guidance, and approval of L.A. Care, or it will be provided directly by L.A. Care. L.A. Care's Health Education & Cultural and Linguistics department and PNO share responsibility for L.A. Care's involvement in the training process.

Training and Education Materials and Methods

All provider training and education materials produced and distributed by PPGs must be approved by L.A. Care prior to distribution. The following provider training and education materials must be used by the PPGs.

- Provider Manuals
 - Each PPG must distribute a provider manual to its contracted network within Los Angeles County that includes information about L.A. Care's contracted programs. This can also be downloaded through L.A. Care Connect.
- Orientation Sessions and On-site Visits
 - Provider orientation sessions and on-site visits will be conducted by PPGs to provide an in-service training on their provider manual and to conduct additional training, as needed, for newly contracted providers and programs within ten (10) business days of the contract effective date. The training may include, but is not limited to:
 - Cultural sensitivity
 - Customer service
 - Community Based Adult Services (CBAS)
 - Mental health services
 - Medical management delegation & payment responsibility
 - Authorization, claims and member eligibility verification processes for hospitals, skilled nursing facilities and ancillary providers
 - Authorization processes for DHS
 - Disenrollment process
 - Online eligibility verification
 - Child Health & Disability Prevention (CHDP) claims submission
 - Seniors and People with Disabilities
 - Model of care
 - Provider group orientation
- Provider Bulletins and Newsletters
 - 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 and its providers, will meet the requirement of publishing semi-annual newsletters/bulletins.

- **Focused Seminars, Workshops and Symposia**
 - L.A. Care and PPGs will work together to conduct focused seminars, workshops, and symposia on special topics.

8.3 PROVIDER DATA MAINTANCE PROCEDURES

Adding a New Provider

- Prior to adding a new provider record or an additional site for an existing provider into MPD, the PNRA staff will verify with the Credentialing department that the provider is eligible for inclusion in L. A. Care's provider network.
- The physician must meet all credentialing requirements and have no sanctions, debarred status, or expired license.
- Upon approval, PNRA staff, based on information contained on the provider profile, enters all eligible providers' data into MPD.

Changing Provider Data

- Upon approval of the written request via electronic/U.S. mail or fax from a PPG to change a provider's capacity, specialty, member age parameter, or other data element of a provider's record, PNRA staff will make the appropriate update in MPD.

Changing a Provider's Address

- PNRA staff will receive written notification, via U.S./electronic mail or fax, from L. A. Care Health Plan's contracted PPGs advising that a provider's address should be changed.

Closing a Provider's Panel

- PNRA staff will receive written notification, via U.S./electronic mail or fax, from L. A. Care Health Plan's contracted PPGs advising that a provider's membership panel should be closed to any new member assignments.
- The PNRA analyst will close the provider's panel in MPD within one (1) business day of receipt.

Terminating a Provider

- PNRA staff will receive notification, via U.S./electronic mail or fax, from L. A. Care Health Plan's contracted PPGs advising that a provider has been terminated from the entity's network.
- Prior to terminating a provider's record in MPD, PNRA staff will notify Member Services, via a "Change Form", that members assigned to the physician must be moved to a new PCP as designated by the PPG.
- Once the members have received a sixty (60) calendar day prior notification and have been re-assigned to the new PCP, Member Services will notify PNRA of the transfer via the "Change Form".
- The primary care physician's record will then be terminated in MPD. The member transfer process

is not applicable for specialty care providers.

Completion of the provider termination process should occur within a five (5) business day timeframe.

8.4 PROVIDER DIRECTORIES

L.A. Care produces a provider directory for all product lines on an annual basis. The directory is a listing of all the PPGs, contracted PCPs, community clinics, hospitals, and other primary care providers. Upon request, L.A. Care will send a directory to the requesting party. Provider's contact information is updated on L.A. Care's website in real time for potential members and members to access. Online directories for potential L.A. Care Covered™ enrollees are available on L.A. Care's website at <http://www.lacarecovered.org>.

8.5 MID-LEVEL MEDICAL PRACTITIONERS

The use of non-physician practitioners is designed to increase members' access to appropriate primary care and specialty medical services, maximize the patient's health and well-being, and promote cost-effective care. The delegation of specified medical procedures to non-physician practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the non-physician practitioner. Physicians may supervise up to four mid-level medical practitioners according to the following ratios (full-time equivalent physician supervisor to mid-level medical practitioners):

- One physician to four nurse practitioners (NPs).
- One physician to three certified nurse midwives.
- One physician to four physician assistants (PAs).
- Four non-physician practitioners in any combination as long as they do not exceed more than three certified nurse midwives or four physician assistants and maintain the full-time equivalence limits.

Mid-level Support and Patient Care

- A single non-physician practitioner can potentially increase the supervising physician's total member capacity by 1,000 members. However, the physician cannot be responsible for more than 5,000 patients in total.
- The non-physician practitioner may only provide those medical services that he/she is competent to perform and that are consistent with the practitioner's education, training and experience, the terms of which must be delineated in writing by the supervising physician.
- The stipulated scope of practice must be in full compliance with standards set forth by the Physician Assistant Examining Committee of the Medical Board of California, California Board of Nursing, the Nursing Practice Act, DOC, the California Code of Regulations, the California Administrative Code, the California Business and Professions Code, and the requirements of any other applicable professional licensing body, law and regulations.
- A scope of practice agreement which 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
- The supervision or back-up physician must be available in person or through electronic means at all times when the non-physician practitioner is caring for patients.
- The supervising physician must review, on a continual basis, tasks delegated to the non-physician practitioners for competency.
- Medical record documentation by the non-physician practitioner must be reviewed and countersigned by the supervising physician within thirty (30) calendar days of the date care was provided.

The following requirements must be included within the standardized procedures for mid-level medical practitioners, and reflected in written agreements as indicated above:

- Each PPG must set and implement credentialing elements for mid-level medical practitioners and ensure that they are consistent with the criteria and scope of practice requirements set forth in this manual and any other policies, procedures, and directives issued by L.A. Care.
- As part of the credentialing process, the appropriate credentialing committee, prior to the provision of care by mid-level medical practitioners, must verify that a signed scope of practice agreement, a signed set of procedures by the supervising provider, and appropriate license(s) are present. L.A. Care will audit the PPG's credentialing verification process.

8.6 ELIGIBILITY LISTS

Covered CA will notify L.A. Care daily, via an electronic 834 file, of each applicant who has:

- Completed an application
- Been verified as eligible
- Designated L.A. Care as their health plan

The Marketplace provides written notice to applicants of their eligibility determination within five business days from the date of the eligibility determination. L.A. Care Member Services contacts the Enrollee, upon receipt of the enrollment file, to select a primary Care Physician. L.A. Care will assign a PCP to members who do not select one based on:

- Language needs of the member
- Distance (within 10 miles is goal)
- PCP's specialty most appropriate for the member's age

8.7 PROCEDURE FOR HANDLING PROVIDER QUESTIONS & CONCERNS

Communication

- Providers can communicate their questions and concerns to their PPG or to L.A. Care directly. Providers may communicate with L.A. Care by telephone, in person, in writing, or by e-mail.

Resolution

- Provider Network Representatives from the PPG or L.A. Care will be able to answer most provider questions and resolve provider concerns immediately. Any question or concern, which suggests a quality of care issue, will be handled as a clinical grievance. The provider network representative will

answer the provider's question(s) and inform the provider of his/her right to file an informal complaint or formal grievance if desired.

- If the provider asks a question over the telephone or in person, the answer will be provided orally. If the provider writes a letter, the answer will be provided in writing within seven (7) business days.

8.8 PROVIDER GRIEVANCES

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

Communication of Formal Grievances

- Providers must communicate their formal grievances directly to their PPG for all services that are the responsibility of the PPG, otherwise the formal grievance must be submitted directly to L.A. Care. This communication may be in person or in writing.
- If the provider wishes to file a formal grievance, the Provider Network Representative will give the provider detailed instructions for filing a grievance. The Provider Network Representative will assist providers in filing grievances, including assistance with completing a grievance form, if applicable.
- The Provider Dispute Intake Clerk will record the grievance on the provider grievance log. Grievances submitted electronically will be acknowledged within 2 business days while Grievances submitted via paper will be acknowledged within fifteen (15) business days.
- The entity who received the grievance (PPG or L.A. Care) will be responsible for: resolving the grievance within thirty (45) working days; and for informing the provider of the resolution/disposition of the case.
- The PPG will be responsible for resolving the grievance within thirty (30) calendar days and informing L.A. Care of the resolution/disposition. L.A. Care will be responsible for informing the provider of the resolution/disposition in this case.

Resolution

- All grievances will be resolved within forty five (45) business days.
- The PPG and/or L.A. Care will provide written notice of grievance resolution/disposition and deliver each letter by way of certified mail.

Dispute Resolution

- A provider has the right to file an appeal. The provider must submit a detailed written grievance, including the desired resolution and all supporting documentation and correspondence to the Provider Grievance Department which will send an acknowledgment letter within fifteen (15) business days for grievances that are not submitted electronically. Grievances submitted electronically will be acknowledged within 2 business days.
- A Provider Relations Subcommittee will convene within thirty (30) calendar days of receipt of the dispute to decide whether the committee has authority to address the issue. The grieving party will have the opportunity to address the issue in front of the committee, if L.A. Care's committee has deemed it applicable. A resolution will be made by the committee with notification to the provider

within seven (7) business days of the decision.

All providers have the right to file a grievance with the Department of Managed Health Care (DMHC). The toll-free telephone number is **(800) 400-0815**. If you have a grievance against L.A. Care Health Plan, contact L.A. Care and use our grievance process.

8.9 PRACTITIONER & PROVIDER COMMUNICATION REQUIREMENTS NCQA HEALTH PLAN 2013 STANDARDS AND GUIDELINES

Practitioner & Provider Communication Requirement	NCQA Standard
Annual communication requirement	
Information about the quality program goals and processes and outcomes as related to member care and service.	QI 2B.2
<p>Annually <u>and after updates</u>, the organization communicates to prescribing practitioners:</p> <ul style="list-style-type: none"> • A list of pharmaceuticals, including restrictions and preferences • How to use the pharmaceutical management procedures • An explanation of limits or quotas • How prescribing practitioners must provide information to support an exception process <p>The organizations process for generic substitution, therapeutic interchange and step-therapy protocols</p>	UM 13B
Communicate upon contracting and annually thereafter	
The member rights and responsibilities statement (new and existing practitioners)	RR 1B.3 RR 1B.4
NCQA does not specify frequency of communication; communicate at least once during the look-back period	
The process for the practitioner to refer members to case management	QI 7C.6
<p>Provides practitioners with written information about the DM program that includes:</p> <ul style="list-style-type: none"> • Instructions on how to use the DM services; and • How the organization works with a practitioner's patients in the program. 	QI 8G.1 QI 8G.2
The organization distributes clinical practice guidelines and preventive health guidelines to the appropriate practitioners	QI 9A.3 QI 9B.3
How practitioners can obtain UM criteria	UM 2B.1
The availability of staff to answer questions about the UM process	UM 3A.1
The availability of TDD/TTY services for deaf, hard of hearing or speech impaired members with questions about the UM process	UM 3A.4
The availability of language assistance for members to discuss UM issues	UM 3A.5
The organizations' policy prohibiting financial incentives for utilization management decision-makers	UM 4F.1 UM 4F.2 UM 4F.3

Communicate one time as needed (upon denial, upon recall, when there is an update, etc.)	
The organization distributes clinical practice guidelines and preventive health guidelines to the appropriate practitioners. (also see “at least once” requirement)	QI 9A.3 QI 9B.3
<p>The organization provides written notification to the treating practitioner as it relates to denials (BH and non-BH):</p> <ul style="list-style-type: none"> The specific reason for the denial, in easily understandable language; <p>A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial was based; and</p> <ul style="list-style-type: none"> Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based upon request 	UM 7B.1 UM 7B.2 UM 7B.3 UM 7E.1 UM 7E.2 UM 7E.3
<p>The organization’s written denial notification to the members contains the following information (BH and non-BH):</p> <ul style="list-style-type: none"> A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal; An explanation of the appeal process, including the right to member representation and time frames for deciding appeals; <ul style="list-style-type: none"> Timeframe member has to submit the appeal Timeframe for deciding the appeal Right to member representation, including an attorney Availability of applicable office of health insurance consumer assistance or ombudsman, with contact information A description of the expedited appeal process for urgent pre-service or urgent concurrent denials. <p>Notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment</p>	UM 7C.1 UM 7C.2 UM 7C.3 UM 7C.4 UM 7F.1 UM 7F.2 UM 7F.3 UM 7F.4
<p>The organization identifies and notifies prescribing practitioners affected by:</p> <ul style="list-style-type: none"> Class II recalls or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification; Class II recalls using an expedited process for prompt notification 	UM 13C.1 UM 13C.2
<p>Annually <u>and after updates</u>, the organization communicates to prescribing practitioners:</p> <ul style="list-style-type: none"> A list of pharmaceuticals, including restrictions and preferences How to use the pharmaceutical management procedures An explanation of limits or quotas How prescribing practitioners must provide information to support an exception process The organizations process for generic substitution, therapeutic interchange and step-therapy protocols. <p>(also see annual requirement)</p>	UM 13B

<p>The organization notifies affected practitioners (practitioners for which it has altered their conditions of participation) of its appeal process, and includes the following information in the notification:</p> <ul style="list-style-type: none"> • Notice that a professional review action has been brought against the practitioners, reasons for the action and a summary of the appeal rights and process; • The practitioners right to request a hearing and the specific time period for submitting the request; • That the practitioner has at least 30 days from the date of the notification to request a hearing; • That the practitioner may be represented by an attorney or another person of the practitioner’s choice; • That the organization will appoint a hearing officer or panel of individuals to review the appeal; and <p>Written notification of the appeal decision that contains specific reasons for the decision</p>	<p>CR 7C.1 CR 7C.2 CR 7C.3 CR 7C.4 CR 7C.5 CR 7C.6</p>
<p><i>Special Medicaid Requirements – required in practitioner materials</i> The organization requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members</p>	<p>MED 1E</p>

9.0 HEALTH EDUCATION

9.1 OVERVIEW

Health education is the process of providing health information, skill training, and support to individuals to enable and empower them to modify their behaviors and improve their health status. L.A. Care Health Plan is responsible for the planning, implementation, and evaluation of member health education, health promotion, and patient education for our L.A. Care Covered™ members. Primary Care Providers (PCPs) are responsible for delivering individual education during member doctor visits, continually reinforcing positive health behavior change in patients, and documenting the delivery of health education services in the patient's medical record. PPG's are responsible for assisting L.A. Care in educating providers about health education requirements, services and available programs and resources.

The mission of L.A. Care Health Plan's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve direct line of business member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care. This is achieved through assisting direct line of business members to:

- Effectively use the managed health care system, including primary and preventive health care services, obstetrical care, health education services and appropriate use of complementary and alternative care
- Modify personal health behaviors, achieve and maintain healthier lifestyles, and promote positive health outcomes
- Learn and follow self-care regimes and treatment therapies for existing medical conditions, chronic diseases or health conditions.

9.2 HEALTH EDUCATION SERVICES

Health In Motion™ L.A Care Members Only

L.A. Care Health Plan's mobile health education program brings health education directly to L.A. Care members in their communities. *Health In Motion™ L.A. Care Members Only* is for L.A. Care Health Plan's direct line of business only and will be therefore expanded to L.A. Care Covered™ members. All classes are available at no cost to members and are conducted in English and Spanish. Interpretation services (including ASL) are also available. Programs include:

Chronic Disease

- **Asthma Basics:** (1 session) Educates children and parents on risk factors, asthma attack prevention, medication adherence, and the use of peak flow meters and spacers.
- **Little Sugar in the Blood (Pre-Diabetes):** (1session) Teaches pre-diabetes in easy-to-understand terms, risk factors for diabetes, the importance of knowing blood sugar numbers, and ways to prevent or control diabetes through nutrition and physical activity.
- **Healthier Living:** (6 session series) Teaches skills to help manage patient's chronic disease. Instruction includes nutrition, goal setting, and how to better communicate with providers and family members.
- **Love Your Heart:** (1 session) Teaches skills to prevent and manage high blood pressure and high cholesterol. Instruction includes nutrition and exercise information.
- **Diabetes Self-Management Education and Support:** (4 session series) Teaches skills to help manage diabetes. Instruction includes awareness of disease complications, nutrition, and exercise

education.

Wellness

- **Burn Rubber:** (1 session) An exercise program where participants will “burn” calories with the use of a “rubber” resistance band. Popular resistance band exercises have been modified to perform in a chair to meet the needs of the senior population. Eight different exercises are covered for a total body workout.
- **Cold or Flu? Antibiotics Won’t Work for You!:** (1 session) Teaches participants the difference between a virus and bacteria, what antibiotics are used for and how to take them, awareness of the risk of antibiotic resistance, and ways to help relieve cold and flu symptoms without the use of antibiotics. **Know Your Medicine:** (1 session) Teaches adults the different types of drugs and what makes them different, the difference between generic and brand-name drugs, ways to take medications safely and how to get the most of your personal pharmacist.
- **Living Well With A Disability:** (8 session series) A peer support workshop for anyone with a health challenge or disability to build skills, and maintain a life of healthy independent living.
- **Stress and Anxiety Management:** (1 session) Teaches what stress is, its effect on health, signs/symptoms of stress, and ways to manage stress.
- **What To Do When Your Child Gets Sick:** (1 session) Using the Institute for HealthCare Advancement’s low-literacy book and curricula, this class offers parents helpful “how-to” tips for when their newborns and young children get sick. Instruction includes how to use the book at home to care for a sick child and how to protect a child from accidents and injury. The class also discusses how to get the right medical care for a child.

Nutrition

- **My Healthy Plate:** Introduces “My Healthy Plate” to the entire family. Teaches how to build a healthy plate by balancing portion size and including all basic food groups. (One session)
- **e.n.e.r.g.y.** (Eating Nutritiously, Exercising Regularly & Growing "Y"-isely): An 8-week weight management program for children 6 to 17 years old and their families. Teaches healthy nutrition, importance of physical activity, and components of behavior modification. (Eight session series)
- **Eat and Play in a Healthy Way:** (2 sessions) Teaches parents and caregivers of children ages 2-5 how developmental stages are linked to common mealtime behaviors, the “parent provides, child decides” principle for healthy nutrition and the importance of physical activity at a young age.

Primary care physicians may refer L.A. Care direct line of business members to health education by utilizing the online Health Education Referral Form located on the L.A. Care website at:

<http://www.lacare.org/providers/resources/healtheducation>

Health education staff will contact the patient and schedule the requested health education service(s). The outcome of the health education referral will be sent back to the member’s PCP. The PCP must document health education referrals and outcome data in the patient’s medical record.

L.A. Care Health Plan Family Resource Centers

L.A. Care Health Plan operates two community health education resource centers in the South Los Angeles communities of Lynwood and Inglewood. L.A. Care Health Plan partners with community organizations to offer no or low cost health education classes on asthma, diabetes, HIV, exercise, nutrition, parenting, smoking cessation, weight management, senior wellness, and activities and services for people with disabilities. New member orientations, health screenings, and application and enrollment assistance are also provided. For more

information go to: <http://www.lacare.org/providers/familyresourcecenters>

9.3 HEALTH EDUCATION PROGRAMS

L.A. Care Health Plan conducts several health education programs targeting specific vulnerable populations.

Adult Weight Management Program

This program consists of two main interventions: 1) identification of members who are overweight or obese; and 2) provision of weight management counseling/educational services appropriate for the members' condition and readiness to change. Members are identified as overweight or obese via the Health Risk Assessment, provider or L.A. Care staff referral, encounter data, or self-referral through Member Services. Once enrolled in the program, members are assessed by an L.A. Care health educator for their BMI and any co-morbid conditions, their readiness to change, and their preference for delivery of services (in-person, telephonic, on-line, or group). Based on this information, members are offered services including educational materials, online weight management services, telephonic counseling, or group workshops.

Medical Nutrition Therapy (MNT)

MNT is the treatment of medical conditions through nutrition counseling. Members must be referred by a provider. Services are delivered by a registered dietitian who performs an assessment with the member, determines a nutrition diagnosis and treatment plan, implements an intervention, and evaluates and monitors the member's progress. MNT is provided telephonically. Referred members receive an initial one-hour consultation and typically three follow-up consultations. MNT services are made available for DLOB members with one or more of the following:

- Uncontrolled type I or II diabetes (HBA1c>8)
- Pre-end-stage renal disease (GFR 13-50ml/min/1.73m)
- Obesity (pediatric, age 2-18 years, BMI>95th percentile and adults, age 18 years and over, BMI >35)
- Underweight (pediatric, age 2-18 years, BMI< 5th, adults, age 18-64 years, BMI<18, and older adults, age 65 years and older, BMI <23)

Tobacco Cessation Program

L.A. Care Covered™ Members are eligible for L.A. Care's tobacco cessation program. Members are identified as smokers via the Health Risk Assessment, pharmacy and encounter data, provider referral, or self-referral through Member Services. They are then contacted by a trained L.A. Care health educator, assessed for readiness to change and co-morbid conditions, and offered appropriate stop smoking services. Services range in nature from being given a phone number if they want assistance in the future for those with low risk and low readiness to change; educational material, telephonic consult and follow-up with a trained smoking cessation counselor for those who are ready to change; additional coordinated pharmaceutical support from L.A. Care's Pharmacy Department for those with higher risk and high readiness to change; and further monitoring by an L.A. Care health educator for those who have already quit smoking.

9.4 HEALTH EDUCATION MATERIALS AND RESOURCES

Health Education Materials

L.A. Care makes available health education materials in multiple topics and languages to meet the needs of direct line of business members. Health education topics includes: asthma, breastfeeding, dental, diabetes, exercise,

family planning, HIV/STD prevention, hypertension, immunizations, injury prevention, nutrition, parenting, perinatal/pregnancy, substance abuse, tobacco prevention/cessation, and weight management and more. Providers may order L.A. Care health education materials through the health education material order form online application located at: <http://www.lacare.org/providers/resources/healtheducation>. Written Health Education Materials provided by L.A. Care comply with the guidelines set forth by Covered California. Alternative Formats – L.A. Care Health Plan makes health education materials available in alternative formats (video, audio, accessible materials online or on CD, large size print, and/or other appropriate technologies and methods) upon request.

Health Education and Social Services Directory

L.A. Care Health Plan provides an online community resource directory focusing on health education/social services within Los Angeles County. The resource directory includes program topics, languages, location, fee, and contact information. The resource directory is available online at: <http://www.lacare.org/providers/resources/crd>.

9.5 PROVIDER EDUCATION

The provider network must be regularly educated on health education requirements, services and available resources. L.A. Care health plan shares this responsibility with PPGs. Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and special trainings.

Content of provider education includes, but is not limited to:

- 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

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

9.6 HEALTH EQUITIES INITIATIVE

Overview

L.A. Care's Health Equities Initiative is a multifaceted program which builds upon existing strategies to improve or increase disparity-related guidance, support, and resources for healthcare providers and members. The overall goal of L.A. Care's Health Equities Initiative is to provide disparities-related information, guidance, support and resources to health care providers and members, ultimately reducing health inequities within L.A. Care's membership. This overall goal is supported by secondary goals and activities targeting four pillars: Compliance, Care, Community, and Competence.

Compliance

L.A. Care ensures compliance with state and federal regulations including OMH CLAS standards, SB 853, MMCD, and NCQA through the provision of continuous in-person and telephonic interpreting services, including American Sign Language (ASL), and through the provision of culturally sensitive translated member materials. These strategies also support the care and compliance pillars.

Care

L.A. Care strives to ensure all members receive the same quality care. To this end, L.A. Care offers performance-based incentives to physicians for providing more culturally competent care as well as ensures the availability of culturally sensitive and linguistically appropriate health education materials and group appointments, workshops and individual consults. These strategies also support the competence pillar.

L.A. Care systematically implements reminder phone calls and distributes reminder post-cards to populations identified as needing preventive care services, such as breast and cervical cancer screenings.

The distribution of “I Speak” cards in multiple languages and the availability of an ASL interpreting services video help to ensure all members, regardless of language preference or ability, are provided quality care without language barriers. These strategies also support the community pillar.

Community

Community capacity building has been shown to be an effective way of identifying the root causes of disparities, responding to community needs, preventing rejection of programs, and empowering the community. To ensure members are informed about and have a voice in L.A. Care activities, L.A. Care operates Regional Community Advisory Committees (RCACs) throughout Los Angeles County. The RCACs strive to be reflective of overall member demographics. Member leadership positions are available in the RCACs; members holding these positions participate in L.A. Care’s Executive Community Advisory Committee (ECAC).

Additionally, use of community health workers has been recognized as an effective strategy in programs across the US to reduce health disparities. L.A. Care has trained and currently deploys promotors into the community as a grass-roots effort to target hard-to-reach populations. Other strategies include focus groups on select health topics and field testing of health education materials.

Competence

Cultural competency training has the greatest amount of evidence in the literature supporting its potential to reduce health disparities. L.A. Care currently offers a robust education and training program to providers and staff. Examples of available trainings include Health Care Interpreter Training, How to Effectively Communicate with Limited English Proficient Members Using Interpreters, and Introduction to Cultural Competency. The provider toolkit “Better Communication, Better Care: A Provider Toolkit for Serving Diverse Populations” is available for download on L.A. Care’s website.

10.0 CULTURAL & LINGUISTIC SERVICES

10.1 OVERVIEW

The relationship between culture, language, and health is complex and inextricably linked to the health status of individuals and subsequently communities. L.A. Care Health Plan maintains a comprehensive Cultural and Linguistic Services program, which supports and works collaboratively with other L.A. Care Health Plan departments.

The mission of L.A. Care Health Plan's Health Education, Cultural and Linguistic Services Department (HECLS) is to improve member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care.

Within the HECLS department there are two units: Health Education and Cultural and Linguistic Services. The goals of the Cultural and Linguistic Services unit are to:

- Ensure that limited English proficient (LEP) members 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 and written materials in members' preferred language 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.

Interpreting Services

L.A. Care Health Plan provides timely, 24-hour, 7 day a week health care interpreting services, including American Sign Language (ASL), at medical and non-medical points of contact, at no cost to members.

Telephonic Interpreting Services

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

- **PPGs: 1-888-718-4366**
- **Network Practitioners: 1-888-930-3031**
- **Network Pharmacies: 1-888-942-**

7670 Face-to-Face Interpreting Services

To request face-to-face interpreting services (including American Sign Language), call L.A. Care's Member Services Department at 1-888-839-9909 at least 5-10 business days prior to the patient's appointment.

The following information will be required in order to access an interpreter:

- Provider Name
- Language being requested
- Member's name and ID number
- Member's date of birth
- Member's preferred gender of interpreter (if requested)
- Requestor name and contact number
- Date, time, and duration of appointment
- Location of appointment (Name of Facility, Address, Suite/Room Number)

- Type/Purpose of appointment
- Provider Specialty
- Name and phone number of contact person at appointment site
- Other special instructions

10.2 CALIFORNIA RELAY SERVICE (CRS) FOR MEMBERS WITH HEARING OR SPEECH LOSS

California Relay Service (CRS) is a Marketplace service that can be used to contact a member. A member can also use the services to contact his/her provider. CRS enables a person using a TTY to communicate with a person who does not use a TTY by phone. The service also works in reverse by allowing a non-TTY user to call a TTY user. Trained relay operators are on-line to relay the conversation as it takes place. PPGs and network providers can call the CRS directly for members with hearing or speech loss. The statewide access for voice or Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) is 1-888-877-5379 voice (SPRINT) or 1-800-735-2922 voice (MCI).

10.3 TRANSLATION SERVICES

L.A. Care provides limited English proficient (LEP) members with written member informing materials in the member's identified primary threshold language. Threshold languages for L.A. Care members are English and Spanish. L.A. Care provides templates of translated notice of action (NOA) letters to PPGs; however PPGs are responsible for the translation of member specific information in PPG letters.

10.4 CULTURAL AND LINGUISTIC SERVICES TRAININGS

L.A. Care offers ongoing language access, cultural competency and disability literacy trainings on a variety of topics to network providers and their staff. Trainings are conducted on an as needed basis and cover topics such as:

- Knowledge of L.A. Care's policies and procedures for language assistance
- How to access interpreting services and written materials in threshold languages and alternative formats
- Working effectively with LEP members
- Working effectively with interpreters
- Understanding cultural diversity and sensitivity to cultural differences relevant to the delivery of health care interpreting services
- Working with special needs populations, including seniors and people with disabilities
- Understanding health disparities and cultural awareness
- Providing linguistically and culturally competent services

10.5 CULTURAL AND LINGUISTIC RESOURCES

Provider Toolkit for Serving Diverse Populations

In collaboration with the ICE collaborative, L.A. Care has developed a C&L Toolkit to assist providers in providing high quality, effective, and compassionate care while meeting the changing service requirements of state and federal regulatory agencies. This toolkit is available through L.A. Care's website:

<http://www.lacare.org/providers/resources/healtheducation>.

Language Skills Assessment Tool

L.A. Care and the ICE collaborative have developed an Employee Language Skills Assessment Tool for provider offices to use in documenting language proficiency of providers and staff. The tool can be downloaded through L.A. Care's website at <http://www.lacare.org/providers/resources/downloadableforms>.

Interpreting Services Poster

L.A. Care makes available and routinely distributes translated signage promoting interpreting services to provider offices. Provider offices are required to post the signage prominently in the medical office. Copies of the translated poster can be ordered through the online Health Education, Cultural and Linguistic Services Materials Order Form at: <http://www.lacare.org/providers/resources/healtheducation/order-form>

Complaint/Grievance Forms

Grievance forms in threshold languages are available on the L.A. Care website at <http://www.lacare.org/grievancelocalization>. Members have the right to file a complaint or grievance if they've been denied interpreting services or if the member information was not available in their primary language in written format or over the phone. All complaints are filed with L.A. Care's Member Services Department and are routed to the appropriate areas within the organization.

L.A. Care Health Education and Social Services Directory

L.A. Care ensures that members are referred to culturally and linguistically appropriate community services through use of the L.A. Care Community Resource Directory. L.A. Care staff, primary care physicians, and PPG staff may refer L.A. Care members to services by using the online directory accessible through the L.A. Care website: <http://www.lacare.org/providers/resources/crd>.

10.6 CULTURAL AND LINGUISTIC SERVICES

REQUIREMENTS Provider Education & Training

The provider network must receive ongoing education on cultural and linguistic requirements, services and available resources. L.A. Care Health Plan shares this responsibility with PPGs and subcontracting providers including behavioral health, LTSS, and pharmacy.

Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and special trainings.

PPGs are required to educate providers on the following topics:

- Upcoming C&L related trainings offered by L.A. Care
- C&L requirements, including, but not limited:
- Posting of the interpreter poster at provider office sites
- Maintaining language proficiency and qualifications of bilingual staff on file
- Ensuring 24-hour, 7 day a week access to interpreting services, including ASL, at all points of contact, including after-hours
- Discouraging the use of family and friends, particularly minors, as interpreters
- Documentation of the member's preferred language in the medical record
- Documenting request/refusal of interpreting services in the medical record

- Processes for filing a grievance if a patient’s language needs are not met
- C&L resources including:
- The online searchable Health Education and Social Services Directory
- The online Health Education, Cultural and Linguistic Services materials order form.

L.A. Care routinely makes promotional/educational materials available for PPGs to assist them in educating providers of C&L requirements, services, and resources. Additional provider tools can be found on L.A. Care’s website under the “Provider Resources” section.

PPGs are required to inform network providers about upcoming trainings and available resources. PPG staff members are also required to attend L.A. Care Health Plan’s cultural competency and disability literacy trainings.

10.7 INTERPRETING SERVICES

PPGs and network providers must utilize qualified interpreters when communicating with limited English proficient (LEP) L.A. Care members. Qualified interpreters can be accessed through L.A. Care Health Plan. PPGs may choose to contract with a professional interpreting services vendor to communicate with members. If a PPG chooses to contract with an interpreting services vendor, PPG must ensure that services are provided by qualified interpreters. In addition, PPG must submit an annual detailed tracking report of all interpreting services provided to L.A. Care members quarterly. L.A. Care Health Plan providers shall not require, or suggest to, LEP members that they provide their own interpreter.

A member may choose to use a relative or friend as an interpreter after they are informed of the right to free interpreting services. If a member refuses professional interpreting services, this refusal and the member’s request to use a family member or friend must be documented in the medical chart. Use of minors as interpreters is not allowed except in extraordinary circumstances such as medical emergencies.

10.8 TRANSLATION SERVICES

PPGs are responsible for ensuring NOA letters are sent to members, upon request, in their preferred threshold language and in a manner and format that is easily. If the PPG develops a member informing material, PPG is responsible for translating the material into threshold language(s) and sending it to the member in the appropriate language. Any material that is sent in English must include a notice that has been translated into the threshold language(s) informing the member of the availability of translation and interpreting services.

Quarterly, PPGs are required to submit a translation tracking report to L.A. Care

PPGs must provide written member informing materials in alternative formats upon request.

Assessing Proficiency of Bilingual Staff

PPG and provider office staff members who communicate with members in a language other than English must be qualified and formally assessed for their capabilities. PPGs and provider offices must keep evidence of the results of formal language assessments on file. This information must be updated annually for provider office staff and every three years for providers, at a minimum.

If bilingual staff members are providing interpreting services for members, the following documentation must be available for review:

- Written or oral assessment of bilingual skills

- Documentation of the number of years of employment the individual has as an interpreter
- Documentation of successful completion of a specific type of interpreter training program
- Other reasonable alternative documentation of interpreter capability.

10.9 PPG REPORTING

Annually, by January 31, PPGs must submit a report to L.A. Care containing the following information:

- A list of bilingual staff, including the following information:
 - Name
 - Title/Department
 - Language Spoken
 - Level of proficiency (using the ICE Employee Language Skills Assessment Tool)
 - Documentation of successful completion of an interpreter training program.

Quarterly, PPGs must submit reports to L.A. Care containing the following information:

- Log of interpreting services provided to L.A. Care members (if PPG chooses to utilize their own vendors)
- Tracking log of all documents translated, including document title, language(s) translated into, type of document, product line, and date sent to the member
- All reports should be submitted to CLReports@lacare.org.

10.10 PROVIDER EDUCATION/TRAINING

PPGs are responsible for educating network providers on cultural and linguistic requirements, programs, and services. PPGs are also required to attend and promote cultural competency trainings made available by L.A. Care.

Supporting documentation of provider education must be available for review and must include:

- Copies of program handouts or correspondence
- Sign-in sheets
- Agenda/ Training Outline
- Meeting minutes
- Evaluation

10.11 MONITORING/COMPLIANCE

PPGs are required to develop and distribute policies and procedures that outline all cultural and linguistic requirements listed in this provider manual. PPGs are also responsible for provider education and oversight to ensure full compliance with state and federal laws.

11.0 FINANCE

Under contractual agreement, each month L.A. Care and Participating Physician Groups (PPGs) accept capitated payments for the provision of health services to L.A. Care members, regardless of how frequently members access services. This section covers guidelines for financial reports requirements, capitation and other related issues.

11.1 CAPITATION PAYMENTS

One-hundred percent (100%) of capitation payments will be remitted to a PPG no later than the tenth (10th) business day after receipt of the funds by L.A. Care from the payer for that specific month of eligibility (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 Services Agreement.

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

A Capitation Statement Report will be placed on a protected PPG web site on or before the tenth (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). This number represents the number of retroactive disenrollment months processed.
- Capitation amount.
- Capitation total.

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

11.3 INSURANCE

Each PPG is responsible for total costs, except as provided herein, for care rendered to members enrolled with that PPG under the terms of its Services Agreement with L.A. Care. The PPG must maintain adequate insurance set forth in the following:

Professional Liability Insurance

The PPG has, and shall maintain at its expense throughout the term of this Agreement, Professional Liability Insurance for each employed physician with limits of not less than one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate for the year of coverage or such other amount acceptable and permitted by Health Plan in writing. PPG shall provide copies of insurance policies within five (5) business days of a written request by Health Plan.

FTCA Alternative

In lieu of providing Professional Liability Insurance as set forth in Section 11.3.1, a PPG may provide

Health Plan 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 (“FICA Coverage”). However, a PPG shall ensure that only those providers covered pursuant to section 11.3.1 or under FICA Coverage may provide provider services to members.

Reinsurance/Stop-Loss Insurance

The PPG must maintain adequate stop-loss insurance to cover PPG’s catastrophic cases in an amount reasonably acceptable to L.A. Care, but in no event less than thirty thousand dollars (\$30,000) plus fifty percent (50%) of any medically necessary billed charges. The cost of the PPG’s reinsurance/stop-loss coverage is the PPG’s sole financial responsibility.

General Liability Insurance

The PPG shall 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 shall not be less than \$100,000 for each claim and \$300,000 in aggregate under each policy period.

Errors and Omissions

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

Directors and Officers

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

Independent Certified Public Accounting Firm Liability Insurance

PPG shall ensure that all Independent Certified Public Accounting Firm conducting audits on PPG’s financial statements maintain at its expense throughout the Term of this Agreement, Liability Insurance with limits of not less than two hundred and fifty thousand dollars (\$250,000.00) in aggregate for the year of coverage or such other amount acceptable and permitted by Health Plan in writing. PPG shall provide copies of such insurance policies within five (5) business days of a written request by Health Plan.

11.4 MINIMUM FINANCIAL SOLVENCY STANDARDS

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

- Prepare quarterly financial statements in accordance with Generally Accepted Accounting Principles (GAAP). These financial statements, including but not limited to, a Balance Sheet, a Statement of Income, and a Statement of Cash flow must be submitted to the Financial Compliance department of L.A. Care no later than forty-five (45) calendar days after the close of each quarter

of the fiscal year.

- Process claims in a timely manner.
- A payer shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim, unless the complete claim or portion thereof is contested or denied. A payer may contest or deny a claim, or portion thereof, by notifying the provider in writing that the claim is contested or denied within 45 working days after the date of receipt of the claim by the payer.
- Estimate and document, on a monthly basis, the organization'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.
- Maintain, at all times, a positive Working Capital (current assets net of related party receivables less current liabilities).
- Maintain, at all times, a positive Tangible Net Equity (TNE) as defined in Title 28, California Code of Regulations, Section 1300.76(e).
- Maintain a "Cash to Claims ratio" (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) unpaid claims are payable and incurred but not reported (IBNR) claims) as listed per SB 260 Title 28, California Code of Regulations, Section 1300.75.4.2. Maintain at all times a "cash to claims ratio" of .60 as of January 1, 2006, .65 as of July 1, 2006 and .75 as of January 1, 2007.
- On an annual basis, submit to the Financial Compliance department of L.A. Care, 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 one-hundred fifty (150) calendar days after the close of the fiscal year.

Each PPG must actively monitor its 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.

On a discretionary basis, the Financial Compliance department of L.A. Care will have the right to periodically schedule audits to ensure compliance with the above requirements including all regulations per SB 260 Title 28, California Code of Regulation requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the line(s) of business contracted with L.A. Care. Representatives of the PPGs shall facilitate access to records necessary to complete the audit.

Collaboration of Financial Auditing Activities

To reduce the duplication of the annual financial audit(s) and ER delegation audits of PPGs by the Plan(s), L.A. Care Health Plan have agreed to conduct only one financial audit and one ER delegation audit annually per PPG. The audits will be conducted by the designated Plan, as detailed in L.A. Care Policies and Procedures, and the audit results and work papers shall be made available for review by the Plans.

11.5 REIMBURSEMENT SERVICES AND REPORTS

In accordance with the provisions of a 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 in cases where utilization management is delegated.

Upon request, the PPG will provide to L.A. Care a copy of payment records, summaries and reconciliations with respect to L.A. Care members, along with any other payment compensation reports which the PPG customarily provides to its providers.

11.6 RECORDS, REPORTS, AND

INSPECTION Records

Each PPG will maintain all books, records, and other pertinent information that may be necessary to ensure the PPG's compliance with its L.A. Care Services Agreement, and the requirements of regulatory agencies which included the DMHC, for a period of five (5) years from the end of the fiscal period in which its Services Agreement with L.A. Care terminates. These books, records, and other information must be maintained in accordance with generally accepted accounting principles, applicable state law and regulations, MRMIB, DHCS and DMHC requirements.

These books and records will include, without limitation, all physical records originated or prepared pursuant to the performance under this 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
- Any reports deemed necessary by L.A. Care, regulatory agencies and DMHC to ensure compliance by L.A. Care with the requirements of the regulatory agencies and DMHC

Each PPG will maintain all books and records necessary to disclose how the PPG is fulfilling and discharging its obligations under their L.A. Care Services Agreement, and their responsibilities as defined by the regulatory agencies and DMHC. These books and records will be maintained to disclose the following:

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

Inspection of Records

PPGs will allow L.A. Care, DMHC, and any other authorized state and federal agencies to inspect, evaluate, and audit any and all books, records, and facilities maintained by the PPG and its providers as they pertain to services rendered under the PPG's Physician Capitated Services Agreement, at any time during normal business hours, subject to the confidentiality restrictions discussed in the PPG's Physician Capitated Services Agreement.

Records Retention Term

The PPG's books and records must be maintained for a minimum of five (5) years from the end of the fiscal year in which the PPG's contract with L.A. Care expires or is terminated. However, in the event the PPG has been duly notified that DMHC or other applicable regulatory agency has initiated an audit or investigation of L.A. Care, the PPG, or the Physician Capitated Services Agreement, the PPG will retain these records the greater of the above timeframe or until the matter under audit or investigation has been resolved.

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 DMHC, will be made available to DMHC and any other regulatory agencies.

This section is subject to change pursuant to receipt of supplemental regulations under Title 10.

12.0 CLAIMS

This section covers guidelines for claims processing and other claims related issues for Direct Line of Business Contracted Providers.

12.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

Contracted Providers, PPG's and Hospitals that have an agreement with L.A. Care are responsible to perform certain tasks for claims under the terms of their agreement in L.A. Care's Covered™. PPG's and hospitals must be in compliance with Title 28 of the California Code of Regulations (CCR), Section 1300.71 Claims Settlement Practices, and other applicable Federal and State regulations.

After reviewing this section, please refer to "Exhibit B – Division of Responsibility" in the agreement between the Provider, PPGs or Hospital and L.A. Care, to determine what entity is responsible for specific claims.

Exhibit 14 specifies which health care services are the financial responsibility of L.A. Care, and which are the financial responsibility of the Provider, PPG's or Hospital. The Provider, PPG or Hospital is responsible for handling all claims for those services they have financial responsibility.

12.2 EXPLANATION OF BENEFITS (EOBs)

Explanation of Benefits, as required by Federal and State laws, rules and regulations, are issued in a form that is consistent with industry standards.

12.3 COLLECTION OF CHARGES FROM MEMBERS

Balance billing of L.A. Care members is generally prohibited for in-network L.A. Care Covered™

providers, but may be allowed for out-of-network providers.

12.4 THIRD PARTY LIABILITY/ESTATE RECOVERY

The contracted Provider/Hospital and its providers may attempt recovery in circumstances involving third party tort liability (TPL) or estate recovery for an L.A. Care Covered™ member. The PPG or Hospital will notify L.A. Care immediately upon discovery of a potential TPL case and coordinate its recovery activities with L.A. Care.

Accidents or illnesses, which may result in third party tort liability/estate recovery will be reported to L.A. Care within five (5) business days of discovery by the PPG. If L.A. Care requests details of the services provided, the PPG will deliver the following information within ten days of the date of the request and will include the following information:

- Member name
- Complete CIN # (Client Identification Number)
- Social Security number
- Date of birth
- PPG provider name
- Date(s) of service
- Diagnosis code and/or description of illness/injury
- Procedure code and/or description of services rendered
- Amount billed by a subcontractor or out-of-plan provider to PPG (if applicable)
 - Amount paid by other health insurance to PPG or subcontractor
 - Amount and date paid by PPG to subcontractor out-of-plan provider (if applicable)
- Date of denial and reasons (if applicable)

Finally, if the provider, PPG or hospital receives any request by subpoena from attorneys, insurers, or beneficiaries for copies of bills, they will provide L.A. Care with a copy of any document released, and will provide the name, address, and telephone number of the requesting party within five days of compliance with the request.

- L.A. Care retains lien/claim rights over third party tort liability and estate recovery for L.A. Care Covered™ members.

L.A. Care's Participating Physician Group Services Agreement, Section 3.11 Reimbursement/Subrogation, covers all other instances.

Implementation Guidelines

- When a claims is received and it is determined that the injuries are a result of a third party, the claim will be processed and paid normally. After L.A. Care is informed of a TPL case, it will notify the member or legal representative that reimbursement be made upon receipt of any payments from the third party, whether by action at law, settlement or otherwise.
- If the member or their legal representative is unresponsive or uncooperative, the decision will be made whether legal action must be pursued.

12.5 CLAIMS SUBMISSION

Submitted claims must be completed with all required information to ensure timely processing and payment as stipulated in the provider's contract.

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 forms for facility services.

Claim Filing Limit

The provider shall bill using appropriate forms and in a manner acceptable to L.A. Care within the filing limit specified in the provider's Participating Physician Group Services Agreement.

L.A. Care's Claims Submission Address

In order to determine who is responsible for paying a claim, please refer to Exhibit B, the Division of Financial Responsibility, in your company's contract with L.A. Care. The Division of Financial Responsibility specifies what entity is responsible for paying a claim.

If you have a question about where to send a claim, please call L.A. Care's Provider Information Line. You will access our Interactive Voice Recognition (IVR) system that will guide you to one of our Provider Network Representatives that can assist.

For all claims for which L.A. Care is financially responsible, please mail the claims to:

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

Claim Status Inquiries

Please be advised that you may inquire about the status of a claim, including the date of receipt, for which L.A. Care is financially responsible by calling **1-866-LA-CARE6**.

12.6 CLAIMS PROCESSING

Claims processing by PPG (delegated or otherwise) must meet L.A. Care's Claims requirements and procedures and including but not limited to the specifications described below:

Fee-For-Service Claims System

The PPG's claim processing system must be designed so that data for all claims received for reimbursement on

a fee-for-service basis are maintained and accounted for in a way that allows for the determination of the date of receipt, date and amount of paid, the status or resolution of any claim, the dollar amount of unpaid claims, and the rapid retrieval of any claim.

Claim status or resolution categories include, but are not limited to:

- To be processed
- Processed, waiting for payment
- Pending, waiting for approval for payment or denial
- Pending, waiting for additional information
- Denied
- Paid
- Other, if appropriate

The system used could involve either a claims log, claims numbering system, electronic data processing records, and/or any other method approved by L.A. Care.

Payment for Out-of-Plan and Emergency Services

If a PPG is delegated to pay such claims, PPGs must ensure the timely and appropriate payment for all authorized and non-authorized emergency services that meet the definition of “Emergency Services” as defined Article I of the Services Agreement and by the California Code of Regulations, Title 22, Division 3, Chapter 4, Article 7, Section 53622. Please be aware that balance billing of L.A. Care members for services provided by a network provider is prohibited by law in most circumstances.

Provider Claims

Each PPG must operate its claims processing system in a manner which ensures the timely payment of claims to providers of authorized health care services, including contracted providers and non-contracted providers, within regulatory requirements.

L.A. Care CoveredTM **claims must be paid within the State requirement of forty-five (45) working days.** A PPG’s claims processing payments systems must also reasonably determine the status of received claims and calculate provisions for Incurred But Not Reported (IBNR) claims.

All records regarding fee-for-service reimbursement must be maintained in accordance with the provisions of California Code of Regulations, Title 28, Chapter 2, Article 9, Section 1300.77.4.

If a claim is contested, the PPG must give notice to providers within thirty (30) calendar days of receipt. In addition, the PPG must retain a file copy of the notices sent and make them available for review upon request by L.A. Care.

Member Claims

PPGs will pay uncontested claims for emergency services or other health care services for which a member has been billed within forty-five (45) working days. If a claim is contested by the PPG, the PPG must notify the member that the claim is being contested within forty-five (45) working days of the date the claim was received by the PPG. The notice will identify the portion of the claim that is being contested and the specific reasons for contesting the claim. Upon request, PPGs will provide L.A. Care a copy of the notice.

L.A. Care, at its option, may monitor the claim resolution process and facilitate the resolution of any member claim disputes.

The PPG shall process and pay claims for emergency services, as appropriate, for all services medically necessary to diagnose and stabilize the patient without prior authorization pursuant to California Code of

Regulations, Title 28, Division 1, Chapter 2, Article 8, Section 1300.71.4.

Hospital Emergency Departments (ED) under Federal and State laws are mandated to perform a Medical Screening Examination (MSE) on all patients presenting to the ED and to treat all patients with emergency conditions. The PPG is required to reimburse the ED and the emergency physician for the MSE without prior authorization regardless of the outcome of the MSE.

Aging Schedule of Outstanding PPG Member Claims

Upon request, PPGs will provide an aging schedule of outstanding/unpaid claims from contracted and non-contracted providers submitted for payment, and from subscribers and Enrollees for reimbursement. This report will include a brief summary explanation of the reason(s) any claim remains unpaid for longer than thirty (30) calendar days.

12.7 PROVIDER AND MEMBER CLAIMS DISPUTE, GRIEVANCE, AND APPEALS PROCESS

If delegated for grievance and appeals processing, the PPG will implement a grievance and appeals process for review of provider and member claims disputes that comply with the time limits and other requirements of California Code of Regulations, Title 28, Division 1, Chapter 2, Article 8, Section 1300.68. This dispute procedure, and any amendments, must be approved by L.A. Care and meet State Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) regulatory requirements, as appropriate. If not delegated for grievance, and appeals processing, the PPG will promptly forward any grievances or appeals received at their office to L.A. Care's Grievance and Appeals Coordination Unit.

L.A. Care provides an additional level of grievance appeal above that which exists at the PPG level. Claim disputes which are unresolved or for which the disposition of the PPG is unsatisfactory to the provider or member may be submitted to L.A. Care for further consideration. (In cases of delegation, they should first be considered by the PPG, and in turn by L.A. Care if the provider or member chooses). Claims grievance appeals must be submitted to the Member Services department of L.A. Care. Claims will be triaged by an appropriate health care professional and subsequently considered by clinical, member services or provider network operations staff, as appropriate. Resolving claims grievance appeals may take up to forty-five (45) calendar days.

L.A. Care has the ability to pay and deduct for claims not paid or inadequately by a PPG when a service is the PPG's financial responsibility or when the PPG or its contracted providers improperly authorize a service that would otherwise be L.A. Care's financial responsibility.

Claim denial or Notice of Decision letters issued by PPGs must fully describe the grievance and grievance appeal process. This must include a description of timelines as well as higher levels of consideration, including

L.A. Care and DMHC. The address for such reconsideration is:

Grievance and Appeals Coordination Unit
P.O. Box 811610
Los Angeles, CA 90081

When L.A. Care is processing a provider dispute or a grievance or an appeal involving the actions or

inaction of the PPG, the PPG will respond to L.A. Care's requests for information within 10 working days or sooner if required for compliance with regulatory requirements. If the PPG does not respond within that time-frame or the response is inappropriate, L.A. Care retains the right to pay and deduct from the PPG's capitation whatever amount is necessary to satisfy any member or provider claims, which are the subject of the dispute, appeal or grievance. Further, unless the PPG provides to L.A. Care a copy of its provider contract showing a lower amount in advance of such claims payment, then L.A. Care will pay the provider the either L.A. Care's contracted rate for that provider or the amount required to satisfy state payment requirements for non- contracted providers.

12.8 CLAIMS TIMELINESS REPORTS

PPGs shall provide an aging schedule of provider and member claims disputes, no later than twenty-five (25) business days following the end of each fiscal quarter. This report will include a brief summary explanation of the reason(s) any claim remains unpaid for longer than thirty (30) business days. The information should be mailed to:

L.A. Care Health Plan
Attn: Financial
Compliance
1055 West 7th Street – 10th
Floor Los Angeles, CA 90017

In addition to submitting these Claims Timeliness Reports, PPG's must provide L.A. Care appropriate reports, findings, recommendations, corrective action plans, and other pertinent information.

13.0 MARKETING

13.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs) must receive prior approval from L.A. Care's Sales & Marketing department to utilize L.A. Care Covered™ branded marketing materials and activities.

PPG MARKETING MATERIALS AND ACTIVITIES

L.A. Care must approve all PPG-created marketing materials and outreach activity plans that:

- Mention L.A. Care Covered™
- Include the L.A. Care name or logo

Submission should be made to the Sales & Marketing department. Sales & Marketing will submit the marketing material(s) to the applicable regulatory agency. These regulatory agencies include but are not limited to the Department of Managed Health Care (DMHC), Covered California, and L.A. Care's Regulatory Affairs & Compliance Department, and Legal Department when applicable. Upon receipt of approvals, the Sales & Marketing department will notify the PPG regarding implementation and use of materials.

Violation of regulatory guidelines and L.A. Care approval policy will not be tolerated.

By distributing this manual, L.A. Care is providing all PPGs with written policies and procedures for obtaining approval on provider-created marketing materials. PPGs shall be held responsible for ensuring marketing materials and activities of their contracted providers are reviewed and approved prior to use.

13.2 GUIDELINES

PPGs must adhere to the guidelines set forth below prior to engaging in marketing activities:

- All marketing materials must identify L.A. Care as L.A. Care Health Plan. Notice that there is no space after the period in "L."
- PPG marketing directed at members or potential members must be at the 6th grade reading level or below and include the L.A. Care logo containing the ® mark and must adhere to the specific graphic standards provided by L.A. Care.
- PPGs will ensure that all materials are ethnically and culturally sensitive, and linguistically competent. (See Section 10 of this manual, Cultural & Linguistic Services)

Continuous monitoring of marketing activities by PPGs shall be the responsibility of L.A. Care, whereas continuous monitoring of marketing activities by the PPG's contracted providers shall be the responsibility of the PPGs and L.A. Care.

Any discovered acts of marketing abuse (fraud) will result in immediate penalties that may include, but are not limited to, sanctions.

13.3 MATERIAL MISSIONS

Provider Responsibilities:

Contracted providers must submit a set (copy) of the proposed materials for review and approval to their PPG(s) using these guidelines:

- Materials that do not reference a PPG's name or logo, but do mention L.A. Care's Covered™ program can be submitted to one PPG.
- Materials referencing PPG(s) or including their logo(s) must be submitted to those PPGs for approval.
- Contracted provider submissions sent directly to L.A. Care for approval will not be accepted.
- All material submissions must be in final composition, be legible and contain actual copy and photos. Rough drafts or incomplete ideas will not be accepted.
- All submissions must include a brief material description including the intended use(s), distribution and readability score.
- Materials should be submitted at least thirty (30) days in advance of intended use.
- Once materials have been approved, they can be reused as long as there are no material changes in the content. Dates and locations are not considered material.
- Providers should allow at least two (2) months for a response to submissions which takes into account regulatory reviews.

PPG Responsibilities:

PPGs are responsible for informing their providers that no L.A. Care Covered branded marketing materials are to be used and/or activities engaged in without prior consent from L.A. Care.

The procedures are as follows:

- Upon receiving provider material submissions, PPGs should review documents for clarity and accuracy of information. Upon completing review and before final authorization is given to the provider, PPGs shall forward materials to L.A. Care's Provider Network Operations department for review and approval. A signature of approval by the PPG should be included.
- PPGs shall review all responses from L.A. Care and communicate in writing; within seven (7) calendar days should they disagree with the findings.
- PPGs must maintain all responses received from contracted providers and L.A. Care for future reference.
- PPGs are responsible for monitoring provider outreach activities as well as marketing material development, usage and distribution.
- PPGs shall immediately provide written notification to L.A. Care's Sales and Marketing department regarding any marketing violations, and should supply documentation when possible.
- Materials that must be approved include but are not limited to: General advertising used to reach prospects and patients; Tactical advertising with PPG names and/or logos; Collateral items such as brochures, pamphlets, fliers and promotional items.

L.A. Care Responsibilities:

L.A. Care shall provide PPGs with these marketing guidelines. In addition, L.A. Care shall maintain oversight

accountability for marketing materials and activities implemented by PPGs and contracted providers. L.A. Care's Sales & Marketing department shall review and respond to all submitted materials within thirty (30) days of receipt. All applicable materials will then be forwarded to the appropriate regulatory agency for final approval. Material review responses shall be based on the following:

PPG Submissions

- Proposed materials have not been produced and/or used prior to receiving necessary approvals.
 - Submissions of proposed materials that mention the L.A. Care Covered™ brand and that include the L.A. Care Covered™ logo.
- Materials referencing other PPGs or organizations, by name or logo, must include authorized signatures from those providers confirming approval to use their name, etc.
- All material submissions must be in final composition, be legible and contain actual copy and photos. Rough drafts or incomplete ideas will not be accepted.
- All submissions must include a brief material description including the intended use(s), distribution and readability testing score.

Contracted Provider Submissions

- L.A. Care's Sales & Marketing department will review contracted provider submissions only after they have been reviewed by contracted PPGs.
- Contracted provider submissions sent directly to L.A. Care will not be accepted.
- Upon receipt of contracted provider submissions from PPGs, the Sales & Marketing department will review and determine whether further action is required to bring materials into compliance.
- Within thirty (30) days of receiving a PPG's materials for contracted providers, a written response of approval/non-approval (with explanation) shall be sent to the PPG.
- If a PPG disagrees with L.A. Care's findings, a written rebuttal should be submitted for reconsideration within seven (7) calendar days of receipt.
- L.A. Care's Sales & Marketing department will contact and provide written notification to PPGs found to be in violation of policies, requesting a cease of material or activity use, and warning of impending action for failing to adhere to policy.
- L.A. Care will investigate and forward violation information to the appropriate parties at L.A. Care or to the regulatory agencies (as needed) to determine liable party and if penalty is to be levied.

13.4 MEMBER EDUCATION

L.A. Care will develop and coordinate the distribution of educational materials focused on program benefits as well as improving members' overall health status and disease management. Materials will also be designed to increase awareness and choice for L.A. Care. Also see Section 9, Health Promotion and Education.

All materials will be culturally sensitive and linguistically competent and produced in the necessary threshold languages. See Section 10, Cultural & Linguistic Services for details.

13.5 MARKETING STAFF

Marketing managed care services to prospects and members is strictly regulated and monitored by regulatory agencies. Therefore, PPGs must adhere to the L.A. Care requirements, stated below, regarding their marketing staff:

L.A. Care and PPG staff who have regular contact with prospects and members should also be knowledgeable, principled and skilled in marketing, including material development, approval processes, marketing ethics and regulatory agencies' marketing guidelines. In addition, L.A. Care, PPG and contracted provider staff working as marketing representatives shall adhere to all regulatory agency guidelines related to appropriate marketing activities and solicitation of eligible applicants, as well as marketing violations.

13.6 MARKETING GUIDELINES FOR CONTRACTED PROVIDERS

Do's:	Don'ts:
Submit all potential marketing materials and planned activities to L.A. Care's Sales & Marketing department to secure necessary approval priors to implementation.	Engage in marketing activities or use materials without prior written approval from L.A. Care and the appropriate regulating agency*
Provide L.A. Care at least thirty (30) days for review of materials submissions. Ensure that materials accurately describe the program and your involvement.	Misrepresent your business, yourself, L.A. Care Covered™, or L.A. Care or any health care agency or health plan through false statements or claims, or misrepresent or disparage the program or other health plans.
Ensure the language and information used in marketing materials is clear, simple (6 th grade reading level) and communicates that Enrollees have choices.	Mislead Enrollees to entice them to select a specific doctor or medical facility. Make disparaging written/oral statements aimed at competitors – including the use of false performance data for comparison.
Ensure that staff who come in contact with L.A. Care Covered™ members have had appropriate marketing training and understand guidelines, set forth by L.A. Care and regulatory agencies.	Use information that has derogatory language, comments or implications or that makes misleading comparisons. Also, do not use any satisfaction or “Best Plan” data that is not substantiated by a credible third party and that is solely based on the contracting plan's assessment of itself and competitors.
Ensure that L.A. Care Health Plan marketing materials given to you are available for distribution to members or prospective members.	Make any claims that a health plan or medical facility has been endorsed or recommended by L.A. Care, a governing agency or organization that has not certified its endorsement in writing.
Forward L.A. Care an MOU (Memorandum of Understanding) or a letter of agreement regarding intended marketing activities taking place on your premises or any other facility which you may be participating in.	Offer monetary or like incentives to prospects as an enticement to enroll with a contracted health plan or to become a patient at your medical facility. Engage in marketing activity on any unauthorized premises.
Review and follow marketing policies and procedures located in the Provider Manual	Coerce, intimidate or threaten prospects into enrolling with a health plan or to choose your medical facility
Ensure marketing efforts are done appropriately within outlined guidelines and do not violate governing regulations.	Allow staff or pay independent agents to engage in door-to-door marketing, solicit via phone or mail to enroll with a health plan or to select your facility
Make sure staff involved in marketing material development and activities are trained and have	Engage in marketing practices that discriminate against prospective members based on race,

a copy of the marketing policies and procedures

creed, color, marital status, religion, age, sex, national origin, sexual orientation, ancestry, pre-existing physical or mental handicap or health status

14.0 ENCOUNTER DATA AND REPORTING

Each Participating Physician Group (PPGs) is responsible for gathering, processing, and submitting all encounter data for the services provided to all L.A. Care Covered™ members assigned to its PCPs for which the PPG is financially responsible. The encounter data elements required by Covered California can be found on the Covered California website: www.coveredca.com.

Encounter Data is the primary source of information about the delivery of services provided by practitioners and other providers of care to L.A. Care Covered™ members. Encounter data is utilized by the Covered California and Center for Medicare and Medicaid Services to validate the level of services provided to members and will be used to determine current risk adjustment for Marketplace enrollees. That validation process will affect current and future reimbursement levels for our mutual members.. Therefore, accurate and timely Encounter Data from our contracted PPGs is extremely important. Moreover, encounter data that is timely, accurate, and complete is critical in being able to help consumers track their annual deductible and out-of-pocket maximum limits, while helping providers determine whether co-payments need to be collected at the point of service. The same information provided in the Encounter Data is critical for monitoring and oversight functions including HEDIS quality measures that L.A. Care must meet in order to continue participating in Covered California.

L.A. Care has contracted with Trans Union, a data clearinghouse company, to assist PPGs with the proper formatting timely and accurate submission of encounter data. PPGs must submit encounter data directly to Trans Union.

14.1 REQUIREMENTS

- PPGs are required to submit encounter data on a daily basis, Monday through Friday, if they have 500 or more L.A. Care Covered members assigned.
- PPGs with fewer than 500 members shall submit encounters once per week according to a schedule agreed upon.
- All encounters for services provided to L.A. Care Covered™ members must be submitted to L.A. Care within ten (10) business days after the date of service and no later than thirty (30) calendar days after the date of service.

The encounter data must be submitted in an electronic format in accordance with the encounter data specifications established by Trans Union. When a PPG uses Trans Union to process its encounter data, Trans Union will convert the PPG's encounter data into the appropriate format to meet L.A. Care's specifications. If a PPG is contracted with L.A. Care for more than one product, the encounter data needs to be submitted separately by product line.

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

Trans Union
5875 Green Valley Circle
Culver City, CA 90230
(310) 973-2880
Contact: Noelle Clark Porter

Use of Trans Union

PPGs are required to:

- Submit data to Trans Union within the parameters required by Trans Union.
- Submit data to Trans Union within timeframes to ensure routine and timely submission of encounter data to L.A. Care.
- Provide a completed encounter data batch cover sheet, which is designed to facilitate an accurate accounting of encounter data submissions, to Provider Network Operations' Business Analyst concurrently with the submission to Trans Union.

14.2 REPORTING REQUIREMENTS

L.A. Care is required to submit numerous reports to Covered California, including but not limited to, those listed below. As a condition of participation in the L.A. Care Covered™ provider network, PPGs are required to work cooperatively with L.A. Care throughout the Benefit Year to ensure L.A. Care meets its reporting requirements to Covered California and as required by the Affordable Care Act.

Standard Reports

Standard reports shall include, but are not limited to:

- Enrollee customer service reports including phone demand and responsiveness, initial call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution;
- L.A. Care will provide utilization data regarding its nurse advice line based on its current standard reporting. L.A. Care and the Marketplace shall work together in good faith to identify mutually agreeable information for L.A. Care Contractor to provide to the Marketplace that will be useful in identifying patterns of utilization, including regarding health conditions or symptoms that are frequent topics of calls from L.A. Care Covered™ members

Additional required reports include the following:

- Collaborative marketing and enrollment efforts, including the L.A. Care Covered™ marketing plan and documentation relating to testing of interfaces with Marketplace's eligibility and enrolment system
- Evaluation of LA. Care Covered™ performance
- Compliance with requirements for status as a Certified Qualified Health Plan
- Licensure and good standing
- Benefit plan design
- Sales and marketing practices for products through the Marketplace and outside the Marketplace
- Network adequacy standards
- Service Area
- Participating Provider Directory
- Participating Provider recruitment and retention
- Changes in Participating Provider network
- Geographic distribution and changes in ECP network
- Applications and notices
- Rate information provided to Health Insurance Regulators and in such form as required by Marketplace

- Transparency in coverage
- Accreditation
- Segregation of funds
- Compliance with special rules governing American Indians or Alaskan Natives
- Participating Provider Agreements
- Out-of-network, other benefit costs and network requirements
- Credentialing)
- Utilization review and appeals
- Customer service standards
- Compliance programs
- Enrollment and eligibility reconciliations
- Minimum Participation Rates
- Premium information and reconciliation
- Collection practices
- Appeals and grievances
- Enrollee and marketing materials
- Agent compensation, appointment and conduct
- Notice of changes
- Other financial information, including, audited financial statements, annual profit and loss statement and other financial information
- Nondiscrimination
- Conflict of interest
- Compliance with other laws
- Transition plan
- Contractor's representations and warranties
- Quality, Network Management and Delivery System Standards
- Rate updates, premium collection and remittance
- Participation fee, including, allocation of fee across entire risk pool, payment information and information necessary to conduct evaluations
- Performance measures
- Recertification process
- Breach of agreement
- Insolvency
- Duties upon non-recertification
- Further assurance regarding transition and continuity of care
- Insurance
- Privacy and security standards
- Books records and data, including, clinical records, financial records (including electronic commerce standards), storage and back-ups, examination and audit, and tax reporting
- Intellectual Property
- Quality, Network Management and Delivery System Standards
- Accreditation
- HEDIS and CAPHS reporting
- Participation in quality initiatives
- Data sets
- Enrollee reports (e.g., claims, utilization)

- Hospital Compare program requirements (e.g., readmissions, hospital acquired conditions)
- eValue8 information
- Health and wellness services
- Prevention, Health and Wellness
- Access, Coordination, and At-Risk Enrollee Support
- Patient Centered Care and Shared decision making
- Reward based Consumer incentive progress
- Value-based reimbursement and performance
- Payment reform
- Customer Service Standards, including:
 - Customer call volumes
 - Telephone responsiveness
 - Responsiveness to written correspondence
 - Number, accuracy, and timeliness of ID card distribution
 - Nurse advice line volume, talk time, and topics discussed
 - Use of Contractor's website

Future Ongoing Reports

The Marketplace will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of quality programs which should include:

- the percentage of total Participating Providers, as well as the percentage of the Marketplace specific providers participating in the programs
- the number and percentage of potentially eligible Plan Enrollees who participate through L.A. Care Covered™ in the Quality Initiative
- the results of L.A. Care Covered™ participation in each program, including clinical, patient experience and cost impacts
- other information that the Marketplace and L.A. Care identify as important to identify programs worth expanding

The Marketplace and L.A. Care will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and the Marketplace and L.A. Care may consider participation by L.A. Care as a requirement for future certification.

15.0 COMPLIANCE

L.A. Care's Compliance Program is designed to ensure the provision of quality health care services to all L.A. Care members. This is achieved through a variety of compliance activities. L.A. Care's Compliance Program activities include:

- Auditing Oversight of Delegated Responsibilities
- Fraud & abuse prevention/detection (through L.A. Care's Program Integrity Plan and the Special Investigation Unit discussed below)
- HIPAA Compliance (Privacy, Information Security and Electronic Transactions)
- Ongoing monitoring of quality health care services
- Education for PPGs about new legislation and other health care compliance requirements

15.1 GOALS AND OBJECTIVES

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

L.A. Care's Compliance Program:

- Provides oversight of delegated responsibilities to provider network.
- Implements corrective action plans with PPGs to address deficiencies in provision of health care services.
- Identifies and investigates potential fraud & abuse activities. Takes appropriate actions to resolve all fraud & abuse activities.
- Provides education and other available resources to assist PPGs in becoming compliant with HIPAA and fraud and abuse requirements.
- Conducts ongoing monitoring of provider network to assess quality of health care services provided to health plan members.
- Implements corrective actions as necessary to address identified deficiencies.
- Provides new legislation updates to PPGs that specify required actions to ensure contract compliance. Makes available additional information about compliance activities and requirements to PPGs on an on-going basis.
- Provides L. A. Care's latest Code of Conduct online training program at:
http://www.lachp.org/compliance/coc_2010_ppg.nsf/coc_login

(When taking the online training, please log-in with your name, as well as the name of the organization before beginning.)

15.2 AUTHORITY AND RESPONSIBILITY

L.A. Care's Compliance Program strives to ensure compliance with California, California Covered, and federal rules and regulations, L.A. Care's payer contracts, and other standards as required by applicable regulatory agencies. This includes, but is not limited to, the following requirements as applicable to each PPG's contract with L.A. Care:

- Rules and regulations promulgated by and for the Department of Managed Health Care and the Department of Health Care Services.
- All applicable federal rules and regulations that apply to the provision of health care services.

- Federal and California governing law and legal rulings.
- Terms and conditions as set forth in L.A. Care’s contracts with California and federal agencies, private foundations, and other payer organizations for the provision of health care services.
- Requirements established by L.A. Care and implemented with the PPG as stated in the PPG’s contract with L.A. Care.

15.3 DELEGATION OF COMPLIANCE PROGRAM

L.A. Care does not delegate its Compliance Program responsibilities to a PPG. L.A. Care staff works with PPG staff to administer compliance activities and implement corrective actions to rectify deficiencies. PPG staff is encouraged to work with L.A. Care’s compliance staff to ensure compliance with all program requirements.

15.4 AUDIT & OVERSIGHT ACTIVITIES

To ensure that all L.A. Care health plan members receive quality and appropriate health care services, L.A. Care staff performs an annual audit of contract responsibilities and services delegated by L.A. Care to the PPG. L.A. Care’s audit program for delegated PPGs includes but is not limited to, the following activities:

- Annual on-site visit to delegated PPGs to ensure that all delegated responsibilities and services are in compliance with program requirements.
- Ad-hoc on-site visits to review PPG activities to ensure compliance with program requirements.
- Ongoing monitoring through review of periodic reports and data required as outlined in the delegation agreement.
- PPGs shall maintain and provide to L.A. Care all books, records and information as may be necessary to demonstrate compliance with California, federal, and L.A. Care contractual requirements. Records include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and nonmedical services rendered to members, and such other information as reasonably requested by L.A. Care.

15.5 L. A. CARE’S PROGRAM INTEGRITY PLAN

L.A. Care Health Plan (“L.A. Care”) recognizes the importance of preventing, detecting and investigating fraud and abuse. 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.

These responsibilities are delegated to the Special Investigation Unit (SIU) whose mission is to maintain adherence to the Program Integrity Plan to ensure the integrity of publicly funded programs.

What are Fraud and Abuse?

- **Fraud** is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Abuse** is defined as practices that are inconsistent with sound fiscal or business practices and sound medical practices and results in unnecessary cost to the federal Medicaid and Medicare programs.

Examples of Fraud and Abuse

Member/Beneficiaries:

- Changing, forging or altering a prescription
- Changing medical records
- Changing referral forms
- Letting someone else use their I.D. card to get medical services
- Misrepresentation of eligibility status
- Identity theft
- Prescription drug diversion and inappropriate use
- Resale of medications on the black market
- Prescription stockpiling
- Doctor shopping.

Prescriber/Provider:

- Lying about credentials
- Billing for services that were not done
- Billing a balance that is not allowed
- Double billing, upcoding, and unbundling
- Underutilization – not ordering services that are medically necessary
- Forging a signature on a contract
- Pre- or post-dating a contract
- Intentionally submitting false claims

Reporting Potentially Fraudulent Activities to L.A. Care

Under the terms of the contract between L.A. Care and the PPG, the PPG is required to report suspected cases of fraud and abuse. There are four (4) ways in which PPGs can do this:

1. Through the Compliance Helpline

- Call **1-800-400-4889** or **file a report online at – www.lacare.ethicspoint.com**. The Compliance Helpline is available 24 hours a day, 7 days a week and can be used by L.A. Care Board members, employees, contractors, providers, members and other interested persons to report all violations or suspected violations of law and/or the compliance program and/or questionable or unethical conduct or practices including, without limitation, the following:
 - Incidents of fraud and abuse
 - Criminal activity (fraud, kickback, embezzlement, theft, etc.)
 - Conflict of interest issues
 - Code of Conduct violations

2. Through the Special Investigation Unit (SIU)

- The Special Investigation Unit (SIU) is set up to handle all types of potentially fraudulent activities. You can access this by calling L.A. Care's Compliance Officer directly at **213-694-1250, ext. 4292**.

3. In Writing

- You can mail a written letter regarding potentially fraudulent activities to L.A. Care at:

**L.A. Care Health Plan Attn: Compliance Officer
Regulatory Affairs & Compliance**

c/o Special Investigation Unit (SIU) 1055
West 7th Street, 10th Floor
Los Angeles, CA 90017

4. Call the Provider Inquiry Line:

If, for whatever reason, you are not able to report a potential fraud case by calling these phone numbers, please call L.A. Care's Provider Inquiry Line at **1-866-522-2736**.

Fraud can also be reported to any of the following:

The Office of Patient Advocate provides an overview of the health care industry www.opa.ca.gov or 1.866.466.8900

California Department of Managed Health Care (DMHC) oversees HMOs and some PPOs www.dmhc.ca.gov. or 1.888.466.2219

California Department of Insurance (CDI) handles complaints against PPOs www.insurance.ca.gov. or 1.800.927.4357

Department of Health Care Services ("DHCS"): The California state agency responsible for financing and administering a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), and Covered California.

Referral Requirements

Regardless of what method you choose to use to report fraud or abuse to us, you should include the following:

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

If fraud or abuse is found or suspected, the fraudulent incident or activity is reported to the appropriate outside law enforcement and/or regulatory agency.

Communication of L.A. Care's Fraud and Abuse Detection Efforts

L.A. Care uses various means to educate its provider network and membership about its fraud and abuse detection and prevention efforts. Information about L.A. Care's fraud and abuse detection activities is communicated in some of the following ways: provider bulletins; provider mailings; provider trainings; member newsletters; New Member Handbook, and other sources which may include L.A. Care's Regional Community Advisory Committee (RCAC) meetings.

15.6 THE FEDERAL FALSE CLAIMS ACT

The federal False Claims Act is the Government's primary weapon in the fight against health care fraud. The majority of funds recovered come from False Claims Act suits or settlements. The federal False Claims Act permits a person who learns of fraud against the United States Government, to file a lawsuit on behalf of the government against the person or business that committed the fraud. If the action is successful, the person

filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery. These persons are often referred to as whistleblowers. Successful whistleblowers can receive anywhere from fifteen percent (15%) to fifty percent (50%) of the total amount recovered.

Who can be a plaintiff?

Any person may bring a lawsuit called a "*qui tam action*" regardless of whether he or she has "direct" or first-hand knowledge of the fraud. However, if substantially the same allegations or transactions alleged in the claim were publicly disclosed, the court may dismiss the claim.

What types of fraud qualify?

When a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he or she is not otherwise entitled, that person has committed fraud. This usually -- although not always -- involves money. However, under the False Claims Act, fraud has a much wider and more inclusive meaning.

Under the Act, the defendant need not have actually known that the information it provided to the government was false. It is sufficient that the defendant supplied the information to the Government either: (i) in "deliberate ignorance" of the truth or falsity of the information; or (ii) in "reckless disregard" of the truth or falsity of the information.

Thus, if a defendant should have known that its representations to the government were not true or accurate, but did not bother to check, such recklessness may constitute a violation of the Act. Likewise, if a defendant deliberately ignores information which may reveal the falsity of the information submitted to the government, such "deliberate ignorance" may constitute a violation of the Act.

What are the penalties for violations of the False Claims Act?

Persons who violate the False Claims Act can be liable for civil monetary penalties of not less than \$5,500 but no more than \$11,000, plus three times the government's damages with respect to each false claim, and the costs of the civil action (e.g., attorneys' fees, etc.). However, under new health care reform laws, certain types of violations can also carry a civil penalty of up to \$50,000 per claim. Additionally, the government may opt to include other civil and criminal laws in the suit which impose monetary penalties for submitting false claims.

What protection is there for a plaintiff who brings an action?

The False Claims Act provides protection to employees, agents or contractors who are retaliated against by an employer because of the employee's, agent's or contractor's participation in a *qui tam* action. The protection is available to any employee, agent or contractor who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee, agent or contractor investigates, files or participates in a *qui tam* action.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

California has a False Claims Act that is similar to the federal False Claims Act.

15.7 ANNUAL FRAUD WASTE AND ABUSE (FWA) AND GENERAL COMPLIANCE AWARENESS TRAINING REQUIREMENT

On an annual basis, all providers are required to take an acceptable FWA and General Compliance training or administer their own “In-house” FWA and General Compliance training program which shall include, but not be limited to, the topics listed below. All Providers are required to submit an executed FWA and General Compliance Awareness Attestation confirming their organization’s compliance with this requirement.

“In-house” FWA and General Compliance training shall include the following elements:

- Definitions of fraud and abuse
 - Federal False Claims Act and State False Claims Act
 - Anti-Kickback Statute/Stark Law
 - HIPAA Privacy & Information Security Requirements
 - Entities/individuals excluded from doing business with the Federal Government-Office of Inspector General (OIG) exclusion lists:
 - Obligations of the provider , and related entities to have appropriate policies and procedures to address fraud and abuse
 - Process for reporting to L.A. Care suspected fraud and abuse
 - Protections for providers, vendors and employees who report suspected fraud and abuse
- General Compliance Training
- Covering the role of the Compliance Officer and/or the compliance committee
 - Code of conduct
 - Ethical principles governing your organization
 - Examples of noncompliance that an employee might observe
 - An overview of how to ask compliance questions, request compliance clarification or report suspected or detected noncompliance

15.8 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA is the Health Insurance Portability & Accountability Act of 1996 (August 21, 1996), Public Law 104-191. Also known as the Kennedy-Kassebaum Act, the Act includes a section, Title II, entitled Administrative Simplification, requiring:

- Improved efficiency in health care delivery by standardizing electronic data interchange
- Protection of confidentiality and security of health data through setting and enforcing standards

More specifically, HIPAA called upon the Department of Health and Human Services (DHHS) to publish rules that ensure:

- Standardization of electronic patient health, administrative and financial data
- Unique health identifiers for individuals, employers, health plans and health care providers
- Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future

Security Rule

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

that technical security measures are in place to protect networks, computers and other electronic devices. The Security Rule is intended to be scalable; in other words, it does not require specific technologies to be used. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

Privacy Rule

The Privacy Rule is intended to protect the privacy of Protected Health Information (PHI) in the hands of covered entities, regardless of whether the information is or has been in electronic form. The Privacy Rule:

- Gives patients new rights to access their medical records, restrict access by others, request changes, and to learn how patient's health information has been accessed
- Restricts most disclosures of Protected Health Information to the minimum needed for healthcare treatment, payment and business operations
- Provides that all patients are formally notified of covered entities' privacy practices
- Enables patients to decide if they will authorize disclosure of their PHI for uses other than treatment or healthcare business operations
- Establishes criminal and civil sanctions for improper use or disclosure of PHI
- Establishes requirements for access to records by researchers and others
- Requires that business associate agreements with business partners and vendors contain language that safeguards their use and disclosure of PHI.
- Implements a comprehensive compliance program, including:
 - Conducting an assessment to determine gaps between existing information practices, policies and HIPAA requirements
 - Reviewing functions and activities of the organization's business partners to determine where Business Associate Agreements are required
 - Developing and implementing enterprise-wide privacy policies and procedures to implement the regulations
 - Assigning a Privacy Officer who will administer the organizational privacy program and enforce compliance
 - Training all members of the workforce on HIPAA and organizational privacy policies
 - Updating systems to ensure they provide adequate protection of patient data

The Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”)

The Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”) made a number of significant changes to HIPAA. Final regulations implementing much of HITECH were released in January 2013. The following are some of the changes impacting covered entities such as Providers; Providers are encouraged to review HITECH and its implementing regulations to understand all possible impacts:

Breach Notification Rules

Prior to HITECH, the HIPAA Privacy Rule required that a Provider only “mitigate” harmful effects known to the Provider from an improper release of Protected Health Information (“PHI”). HITECH has expanded what a Provider must do in the event of the “**breach**” of the security or privacy of an individual's PHI, requiring both

the patient involved, and media outlets in certain cases, to be notified of the breach. HITECH also created requirements that apply directly to a Provider's business associates ("BA") in the event of such a breach.

Covered entities, including Providers, must demonstrate that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification
- The unauthorized person who used the PHI or to whom the disclosure was made
- Whether the PHI was actually acquired or viewed
- The extent to which the risk to the PHI has been mitigated

How do the Breach Notification Regulations Apply?

The Breach Notification Regulations only apply to "unsecured" PHI. For PHI to be secured, it must be rendered unusable, unreadable, or indecipherable to unauthorized persons.

PHI that does not meet these standards is "unsecured." A use or disclosure of PHI that is not permitted under the Privacy Rule may trigger the notifications required under the Breach Notification Regulation.

What Must a Covered Entity or Business Associate do if a Breach Occurs?

The Provider must provide written notification to the affected individuals within a sixty (60) calendar day period following the discovery of the breach. If a BA learns of a breach, it is required to notify the Provider so that the Provider can notify the individuals involved. The 60-day timeframe begins when the Provider, in the exercise of reasonable diligence, should have known of the breach.

In addition to notifying affected individuals, the following items are important:

- If a breach affects more than 500 people, Providers must inform the media about the breach.
- Providers are also required to provide notice to Department of Health and Human Services ("DHHS"), which will publicize the breach on its web site.
- For breaches affecting less than 500 people, Providers are required to keep an annual log of any breaches and notify DHHS within 60 days of the start of the next calendar year.

Business Associates Directly Regulated Under HIPAA

Business associates (BAs) have historically had to comply with certain HIPAA requirements solely as a result of their agreements with Providers. If a BA breached its obligations, it would only be liable to the Provider under that contract and it would not be subject to direct oversight or penalties by DHHS. HITECH has increased the stakes for compliance for BAs.

As a result of this change, BAs are subject to a host of obligations:

- In addition to the breach notification obligations, they are directly subject to parts of the HIPAA Security Rule requiring the use of technical, physical and administrative safeguards to ensure the confidentiality of electronic PHI.
- Understanding the requirements of the Security Rule, what types of safeguards are acceptable and how the safeguards should be implemented will be required of the BAs.
- BAs must directly comply with a host of standards found in the Privacy Rule, including using and disclosing PHI only as permitted under the Privacy Rule.

- Providers can be penalized directly by DHHS and other enforcement agencies.

Enhanced Enforcement Options and Increased Penalties for Noncompliance

HITECH significantly expanded options for HIPAA enforcement. For example, State Attorney Generals have been empowered, since February 2009, to bring civil actions against persons who violate HIPAA if the Attorney General believes the violation threatens state residents. DHHS will also be conducting audits of Providers and BAs to ensure their compliance with the Privacy and Security Rules.

In addition, HITECH increased the penalties against Providers and BAs for violating HIPAA.

- HITECH expanded regulators' ability to impose criminal penalties for violating HIPAA.
- HITECH imposed increased penalties. For example, while the maximum fine that could be imposed for identical violations in a one year period was \$25,000 under the previous rule, HITECH permits fines of up to \$1.5 million for identical violations within the same year. The enhanced civil penalties are linked to the Provider's level of culpability.
- HITECH has eliminated certain defenses that could be raised in the past against HIPAA violations. No longer can parties avoid penalties by claiming that they did not have actual or constructive knowledge of the violation. Together with the new obligations discussed above, these enhanced penalties have increased the risks of noncompliance.

Other Notable Points about HITECH

- HITECH has expanded the disclosures for which Providers must maintain an accounting to include disclosures for treatment, payment and health care operations, if the disclosures for those purposes are made through an electronic health record.
- Providers will be required to agree to an individual's restriction on disclosures of their PHI to a health plan if the disclosure is for payment or health care operations purposes and it pertains solely to services for which the Provider involved was paid in full out-of-pocket.
- Significantly less leeway exists for Providers to engage in marketing or fundraising activities.

15.9 GOVERNMENTAL AND HIPAA-RELATED RESOURCES & WEB SITES

U.S. Department of Health and Human Services, Administrative Simplification

<http://aspe.hhs.gov/admsimp/index.shtml>

U.S. Department of Health and Human Services - Office of Civil Rights, HIPAA

<http://www.hhs.gov/ocr/hipaa/>

Workgroup for Electronic Data Interchange (WEDI)

<http://www.wedi.org>

National Committee on Vital and Health Statistics

<http://www.ncvhs.hhs.gov/>

National Council for Prescription Drug Programs

<http://www.ncpdp.org>

Electronic Healthcare Network Accreditation Commission

<http://www.ehnac.org>

Centers for Medicare & Medicaid Services

http://www.cms.hhs.gov/hipaageninfo/01_overview.asp

16.0 PHARMACY

16.1 OVERVIEW

The Outpatient Prescription Drug Formulary is used to administer the pharmacy benefits for our members. L.A. Care Health Plan uses a Formulary (Preferred Drug List) which is a list of preferred drugs for prescribing practitioners to prescribe. The goal of the Formulary is to enhance the prescribing practitioners and pharmacist's abilities to provide optimal cost effective drug therapy for our members. L.A. Care has a Pharmacy, Therapeutics and New Technology (PT&T) Committee to develop, maintain and improve the Formulary. The PT&T committee, comprised of practicing physicians and pharmacists in Los Angeles County, meets at least quarterly to review and revise the Formulary. L.A. Care highly encourages our network practicing prescribing practitioners and pharmacists to provide suggestions and comments for formulary additions and changes.

The L.A. Care PT&T Committee uses the following criteria in the evaluation of drug selection for its Formulary:

- Drug safety profile
- Drug efficacy
- Drug effectiveness
- Comparison of relevant drug benefits to current formulary agents of similar use, while minimizing duplications
- Equitable cost and outcomes of the total cost of drug and medical care

To view our latest Formulary, Formulary updates and Formulary Drug Review Request Form, please go to our website at www.lacare.org/providers/pharmacy

Follow these steps to view the Formulary, Formulary Updates, Formulary Drug Review Request Form, and the Prior Authorization Form:

- To access the Formulary, under Provider, select Formulary & Pharmacy, on the left hand side of the page
- Under Formulary select, “click on this sentence to print a copy of our L.A. Care Covered™ Formulary”
- To access the Formulary Updates, select Formulary Updates on the left hand side of the page.
- Select the links, Updates will be listed by effective date from most recent to oldest.
- To access the Formulary Drug Review Request Form, select Formulary Updates on the left hand side of the page.
- Select, “Click on this sentence to print our Formulary Drug Review Request Form.”
- To access the Formulary Prior Authorization Request Form, select Prior Authorization on the left hand side of the page.
- Select, “Click on this sentence to print a copy of our Prior Authorization Form”
- Certain formulary medications and all non-formulary medications require a written Prior Authorization (PA) request to be submitted by the prescribing practitioner for our L.A. Care members.
- Each PA request will be reviewed based on the individual member's need. All PA requests will be reviewed within one (1) business day. Determination will be based on documentation of existing medical need.

16.2 BENEFIT COVERAGE AND LIMITATIONS

Depending upon a member's specific benefit parameters, the following topics may apply:

1. **Generic Substitution**

L.A. Care promotes utilization of appropriate generic alternatives as first line therapies when medically appropriate

2. **Step Therapy**

L.A. Care uses Step Therapy to promote cost-effective pharmaceutical management when there are multiple effective drugs to treat a medical condition. Drugs that are listed in the Formulary as Step Therapy (ST) 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 first step drug by submitting a completed Medication Request 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 Prior Authorization process.

To view a copy of our Step Therapy medication list in the formulary, please go to our website at www.lacare.org/providers/pharmacy

3. **Quantity Limits**

L.A. Care has identified a select number of medications to be subjected 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 quantity of medication that exceeds our limit, a written request on a Medication Request Form will be required with documentation of medical need for consideration. Procedures and timeframes will follow our Prior Authorization process.

To view a copy of our Quantity Limits medication list in the formulary, please go to our website at www.lacare.org/providers/pharmacy

4. **Prior Authorization (PA)**

Depending upon plan benefit design, a medication request process for prior authorization review may apply as follows:

A. **Formulary Agents**

Drugs that are listed in the Formulary as Prior Authorization (PA) require evaluation prior to dispensing at a network pharmacy. Each written request on the Medication Request Form will be reviewed based upon the individual member needs for consideration. Procedures and timeframes will follow our Prior Authorization process.

B. **Non-Formulary Agents**

Any available drug not found in the Formulary listing shall be considered a Non-Formulary drug. Coverage for non-formulary agents may be applied for in advance by the prescribing practitioner. Each written request on the Medication Request Form will be reviewed based upon the individual member needs for consideration. Procedures and timeframes will follow our Prior Authorization process.

All PA requests will be reviewed within one (1) business day. Determination will be based on documentation of medical need. To print a copy of our Medication Request Form, please go to our website at www.lacare.org/provider/pharmacy/priorauthorizations:

Coverage questions or information regarding the medication request or formulary process may be obtained by:

- Faxing a completed Medication Request Form to MedImpact at 1-800-681-7651.
- Contacting MedImpact at (800) 788-2949 and providing all necessary information requested.
- MedImpact will provide an authorization number, specific for the medical need, for all approved requests.
- Request(s) not approved by MedImpact are forwarded to L.A. Care for plan review and consideration.
- Non-approved requests may be appealed. The prescribing provider must provide information to support the appeal on the basis of medical necessity.

5. ***Therapeutic Interchange***

L.A. Care may use Therapeutic Interchange to promote rational pharmaceutical therapy when evidence suggests that outcomes can be improved by substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. Therapeutic Interchange protocols are never automatic; a dispensing provider may not substitute a therapeutically equivalent alternative drug for the prescribed drug without the knowledge and authorization of the prescribing practitioner.

Drugs may be considered for Therapeutic Interchange if they are:

- High risk
- High volume
- High cost
- Overused in routine conditions

In designing Therapeutic Interchange protocols, drug characteristics are considered including:

- Efficacy
- Effectiveness
- Dosage formulation
- Safety
- Cost
- Pharmacoeconomic variables

16.3 **OVER-THE-COUNTER MEDICATION COVERAGE**

L.A. Care Health Plan may offer select over-the-counter (OTC) medications to be covered when approved by the Pharmacy, Therapeutics and New Technology (PT&T) Committee and prescribed by a licensed practitioner as a cost effective alternative to prescription drugs.

The following categories are covered for treatment and monitoring of diabetes by L.A. Care Covered™:

- Blood glucose monitors (preferred brand is Abbott Products)
- Blood glucose test strips (preferred brand is Abbott Products)
- Ketone urine test strips
- Lancets and lancet puncture devices
- Pen delivery systems for giving insulin
- Insulin products (except when used with insulin pumps)
- Insulin syringes (except when used with insulin pumps)

16.4 DEVICES

L.A. Care Health Plan provides coverage on the pharmacy benefit for the following devices for L.A. Care Covered™:

- Spacers
- Peak flow meters

16.5 EXCLUDED MEDICATIONS

L.A. Care Health Plan does not cover the following medications on its pharmacy benefit:

- Experimental or investigational drugs used in an experimental manner
- Weight-loss medications, except as medically necessary for morbid obesity
- Fertility medications
- Any drugs or medications for cosmetic purposes
- Over-the-counter medications, or their equivalents, unless otherwise specified in the Formulary listing
- Dietary or nutritional products, except when medically necessary or for the treatment of phenylketonuria
- Compound medications with formulary alternatives or those with no FDA-approved indications
- Non self-administered injectable drug products are not covered unless otherwise specified in the Formulary listing
- Drugs specifically listed as not covered
- Drugs for Erectile Dysfunction or lifestyle drugs

16.6 FORMULARY UPDATES AND FEEDBACK

Except in cases where patient safety is an issue, L.A. Care will give the L.A. Care Covered™ members and their prescribing physician(s), sixty (60) calendar days written notice prior to the removal of a drug from formulary status, unless it is determined that a drug must be removed for safety purposes more quickly. The Notice will apply only to single source brand drug and will include information related to the appropriate substitute. It will also include a statement of the requirements of the Health and Safety Code and Insurance Code prohibiting

L.A. Care from limiting or excluding coverage for a drug to an L.A. Care Covered™ member if the drug had been previously approved for coverage by L.A. Care for a medical condition of the member, except under specified conditions. An exception to the notice requirement is allowed when L.A. Care continues to cover a drug prescribed for an L.A. Care Covered™ member without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from formulary status.

The Formulary is a tool to promote cost-effective prescription drug use. The PT&T Committee has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. L.A. Care welcomes the participation of prescribing practitioners, pharmacists, and ancillary medical providers, in this dynamic process. Please refer to “Formulary Updates” and “Pharmacy and Therapeutics Committee Updates” at: <http://www.lacare.org/providers/pharmacy/formularyupdates>. Prescribing practitioners and pharmacists are highly encouraged to direct any suggestions, comments or formulary additions to L.A. Care via e-mail to PharmacyandFormulary@lacare.org or by mail at the following address:

Chairperson, Pharmacy & Therapeutics Committee
L.A. Care Health Plan
1055 W. 7th Street, 10th Floor
Los Angeles, CA 90017

16.7 PHARMACY CO-PAYMENTS

L.A. Care’s L.A. Care Covered™ members are responsible for pharmacy co-payments that vary according to the “metal” level of the plan:

Type of Drug	Co-Payments			
	Platinum	Gold	Silver	Bronze
Generic Drugs	\$ 5	\$19	\$19	\$19
Preferred Brand Drugs	\$15	\$50	\$50	\$50
Non-Preferred Drugs	\$25	\$70	\$70	\$75
Specialty Drugs	10%	20%	20%	30%

**copayments also vary according to percentage of FPL*

16.8 PHARMACY BENEFIT MANAGER (PBM) SERVICES

L.A. Care subcontracts select pharmacy services through MedImpact Healthcare Systems, Inc. (MedImpact) to administer the pharmacy benefits network, which includes over 1400 pharmacies in Los Angeles County.

MedImpact’s role for L.A. Care includes:

- Processing pharmacy claims
- Processing initial prior authorization requests
- Managing the pharmacy network
- Monitoring and reporting drug utilization patterns
- Conducting online DUE programs at the point of sale

16.9 PRESCRIPTIONS BY MAIL

L.A. Care offers members the option of getting up to a 90-day supply of maintenance medications mailed to their home or alternate address through our prescription mail order program. Please remember to write a 30-day supply, as well as a 90-day supply plus refills prescription, for their maintenance medications. They can locate the mail order form on L.A. Care’s website or call L.A. Care Health Plan Member Services (1-888-522-1298) for the mail order form. This mail order service is free for members.

16.10 E-PRESCRIBING/ELECTRONIC HEALTH RECORDS (EHR)

L.A. Care strongly encourages all prescribing practitioners to adopt e-prescribing and electronic health records. As of 2011, the Centers for Medicare & Medicaid Services (CMS) will begin paying bonuses to prescribing practitioners who use an e-prescribing system (and show “meaningful use”) to manage Medicare patients. These

prescriptions are managed through Surescripts (RxHub). E-prescribing allows providers to:

- Enhance formulary compliance and
- Verify alternatives and generic substitutions
- Check drug quantity limits
- Avoid drug-drug interactions/medication errors
- Improve patient safety (Reduce Adverse Drug Events)
- Enhance efficiency

Please refer to L.A. Care's website (<http://www.lacare.org/aboutlacare/hitec-la>) for information to assist you with adopting e-prescribing/EHRs.