BOARD OF GOVERNORS

Executive Committee Meeting

January 24, 2024 • 2:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017

AGENDA
Executive Committee Meeting
Board of Governors

DRAFT

Wednesday, January 24, 2024, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m7c50bed10ae2f1b706d5d23c08491444

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2496 205 1473 Password: lacare

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420.

If we receive your comments by 2:00 P.M. on January 24, 2024, it will be provided to the Committee members in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome — Alvaro Ballesteros, MBA, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve Meeting Minutes — *Chair*
   - November 15, 2023 Meeting p.5
   - January 17, 2024 Special Meeting p.11
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report — John Baackes, *Chief Executive Officer*
   - Government Affairs Update — Cherie Compartore, *Senior Directors, Government Affairs*

1/19/2024 9:31 AM

Committee Issues

6. Update: Consumer Advisory Committee Structure and Operations — Francisco Oaxaca, *Chief of Communications & Community Outreach*

7. Approve Amendment No. 54 to the Plan Partner Services Agreement with Anthem Blue Cross and to delegate to the Chief Executive Officer to execute amendment. **(EXE 100)** p.13 — Augustavia J. Haydel, Esq., *General Counsel*

8. Revisions to Human Resources Policies HR 101 (Auto Allowance Mileage Reimbursement, and Vehicle Damage Reimbursement) and HR 122 (Transportation Allowance) **(EXE A)** p.97 — Terry Brown, *Chief Human Resources Officer*

9. Approve the list of items that will be considered on a Consent Agenda for February 1, 2024 Board of Governors Meeting. — *Chair*
   - December 7, 2023 meeting minutes
   - Amendment No. 54 to the Plan Partner Services Agreement with Anthem Blue Cross and to delegate to the Chief Executive Officer to execute amendment.
   - Invent Health Contract Amendment to continue providing risk adjustment analytic services for all product lines, Duals Special Needs Plan (DSNP), L.A. Care Covered, and Medi-Cal lines of business
   - ImageNet Contract Amendment to support L.A. Care Claims and Provider Dispute Resolutions (PDR) Processing Services

10. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

ADJOURN TO CLOSED SESSION (Est. time: 60 mins.) — *Chair*

11. REPORT INVOLVING TRADE SECRET
    Pursuant to Welfare and Institutions Code Section 14087.38(n)
    Discussion Concerning New Service, Program, Technology, Business Plan
    Estimated date of public disclosure: *January 2026*

12. CONTRACT RATES
    Pursuant to Welfare and Institutions Code Section 14087.38(m)
    - Plan Partner Rates
    - Provider Rates
    - DHCS Rates
    - Plan Partner Services Agreement

13. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
    Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
    Three Potential Cases

14. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
    Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
    - Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
    - Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

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15. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: Chief Executive Officer
Agency Designated Representative: Alvaro Ballesteros, MBA
Unrepresented Employee: John Baackes

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

The next Executive Committee meeting is scheduled on Wednesday, February 28, 2024 at 200 p.m. and may be conducted as a teleconference meeting.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE EXECUTIVE COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH TUESDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings and by email request to BoardServices@lacare.org

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings and can be requested by email to BoardServices@lacare.org.

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – November 15, 2023
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Members
Alvaro Ballesteros, MBA, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson**
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary*

**Absent   ** Via Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Products Officer*
Alex Li, MD, *Chief Health Equity Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, MBA, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:12 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received in writing from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment. He provided information on how to submit a comment in-person, or using the “chat” feature.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Emergency Situation for Remote Participation	Board Member Raffoul declared that due to the unexpected closure of the 10 Freeway, which has caused gridlock in traffic and he was not able to participate in this meeting in person. He requested approval for his remote participation due to the emergency.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth, Raffoul)**
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 3 AYES**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the October 25, 2023 meeting were approved as submitted.	**Approved unanimously by roll call. 3 AYES**
CHAIRPERSON'S REPORT	Chairperson Ballesteros announced that nominations have been received for the election of 2024 Officers of the Board of Governors at the December meeting. Nominations can also be made at the December meeting. Staff will send information asking Board members to suggest charities for the random selection of two organizations to receive contributions from Board Members who wish to donate their stipends. A motion will be on the December board meeting agenda.	
CHIEF EXECUTIVE OFFICER REPORT	The Chief Executive Officer will report at the December Board meeting.	
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported that the Attorney General's office has finalized and published the title and the wording of the Managed Care Organization Tax Initiative for the November 2024 ballot. The signature gathering process can begin for the ballot initiative. About 550,000 signatures are needed by the end of June 2024, and more than that will be gathered to account for errors. At the federal level, the House of Representatives has passed a continuing resolution to continue to fund the government. It is expected the continuing resolution will be approved in the Senate and that the President will sign it. There is no additional funding in the bill, it just extends current funding. This bill contains a new type of extension – some programs are extended to January 2024, while other programs to February 2024. Congress will restart negotiations on an omnibus measure in the new year. There has been inaccurate reporting about an end to funding for the Women's	

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<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>Infant and Children (WIC) program, which has caused alarm in the community. USDA has publicly announced that the WIC program will continue to be funded.

Each year the Government Affairs team brings a policy agenda to the Executive Committee and to the Board which helps shape L.A. Care's positions on legislation in California and at the federal level. The 2024 policy agenda will be presented to the Executive Committee in January 2024 and to the Board at the February 2024 meeting for consideration.</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>COMMITTEE ISSUES</td><td></td><td></td></tr>
<tr><td>Employee Annual Incentive Program FY 2022-23 (EXE 100)</td><td>Terry Brown, Chief Human Resource Officer, presented a motion to approve disbursement of funds under the Individual Annual Incentive Program for fiscal year 2022-23.

Board Member Booth asked if an employee does not reimburse L.A. Care for prepaid expenses within 30 days, could those funds be deducted from their bonus? Mr. Brown noted that failure to repay prepaid expenses would be addressed in a stepped discipline process, and he will explore taking the funds from the incentive payment.

<u>Motion EXE 100.1223</u>
To authorize the disbursement of funds not to exceed $10.12 million for the Individual Annual Incentive Program, based on the completion of pre-determined individual goals and targets in support of L.A. Care's FY 2022-23 Organizational Goals. Distribution of the annual incentive payout shall be guided by Human Resource Policy No. 602, Annual Organizational Incentive Program.</td><td>Approved unanimously by roll call. 3 AYES</td></tr>
<tr><td>Human Resources Policies HR-108 (Holidays), HR-114 (Paid Time Off) and HR-125 (Sick Leave For Per Diem, Part-Time, And Non-Regular Employees) (EXE A)</td><td>Mr. Brown summarized revisions to below policies. The revised policies are written to comply with changes to regulatory, legislative and judicial changes, and reflect changes in L.A. Care's practices.

<table>
<tr><th>Policy Number</th><th>Policy</th><th>Section</th><th>Description of Modification</th></tr>
<tr><td>HR-108</td><td>Holidays</td><td>Benefits</td><td>Revision: Added verbiage for employees on Alternative Work Schedule, Section 4.7</td></tr>
<tr><td>HR-114</td><td>Paid Time Off</td><td>Benefits</td><td>Revision: Updated definition of Eligible employees. Removed</td></tr>
</table></td><td></td></tr>
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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(continued nested table below)	

			section 3.3 (Pandemic) and 4.4 (Emergency PTO for COVID-19). Updated Unforeseeable Emergency 4.2.2.4, Up to 2 requests per calendar year.
HR-125	Sick Leave For Per Diem, Part-Time, And Non-Regular Employees	Benefits	Revision: Changed Monitoring and Reporting sections to standard verbiage. Clarified definition of Eligible employees. Updated 3.4 to allow employees to accrue 80 hours or 10 days from one calendar year based on SB 616, effective January 1, 2024; added 4.3 - Accrued, unused time is paid out to employee upon separation or when employee transfers to a position eligible for PTO, effective January 1, 2024.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Motion EXE A.1123 **To approve the Human Resources Policies HR-108 (Holidays), HR-114 (Paid Time Off) and HR-125 (Sick Leave For Per Diem, Part-Time, And Non-Regular Employees), as presented.**	**Approved unanimously by roll call. 3 AYES**
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for December 7, 2023 Board of Governors Meeting. • November 2, 2023 Board of Governors Meeting Minutes • Quarterly Investment Reports • Annual Review of Accounting and Finance Policies AFS-002 (Capital Assets), AFS-027 (Travel Expenses), and AFS-029 (Annual Budgets and Board of Governors Oversight) • InfoCrossing Contract Amendment to support regulatory enrollment requirements • Infosys, Ltd. Contract Amendment to provide Quality Assurance services • Kiriworks (i3/Hyland) Contract to provide Appeals & Grievances solution platform	

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<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>• North Star Alliances, LLC Contract to provide event planning, logistics, staffing and execution services and community relations support
• Ratify the selection by RCAC members of new and continuing members of the Temporary Transitional Executive Community Advisory Committee (TTECAC)
• Ratify the elected Chairperson and Vice Chairperson of the Temporary Transitional Executive Community Advisory Committee
• Ratify the elected Chairperson and Vice Chairperson of the Technical Advisory Committee</td><td>Approved unanimously by roll call. 3 AYES (Ballesteros, Booth, Raffoul)</td></tr>
<tr><td>PUBLIC COMMENTS</td><td>There were no public comments.</td><td></td></tr>
<tr><td>ADJOURN TO CLOSED SESSION</td><td colspan="2">The Joint Powers Authority Executive Committee meeting adjourned at 2:34 pm.

Augustavia J. Haydel, Esq., General Counsel announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:34 pm.

REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Business Plan
Estimated date of public disclosure: November 2025

CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
• Plan Partner Rates
• Provider Rates
• DHCS Rates

CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
Three Potential Cases

CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
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</table>

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:33 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:33 pm.	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: ________________________________

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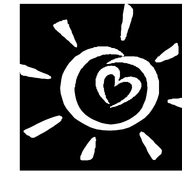
BOARD OF GOVERNORS
Executive Committee
Special Meeting Minutes – January 17, 2024
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017



L.A. Care
HEALTH PLAN

Members
Alvaro Ballesteros, MBA, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson*
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary*

**Absent ** Via Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia J. Haydel, Esq., *General Counsel*
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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, MBA, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 10:19 a.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received in writing from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment. He provided information on how to submit a comment in-person or using the “chat” feature.	

DRAFT

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously. 4 AYES (Ballesteros, Booth, Raffoul and Shapiro)**
PUBLIC COMMENT	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 10:33 am. Augustavia J. Haydel, Esq., *General Counsel* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 10:33 am. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: CEO Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 12: No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

____

Alvaro Ballesteros, MBA, *Board Chairperson*
Date: _________________________________

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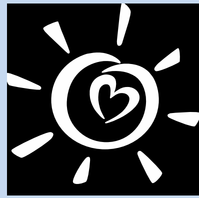

Board of Governors
MOTION SUMMARY

Date: January 24, 2024 **Motion No. EXE 100.0224**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Requesting Department: Legal Services

Issue: Request to approve and to delegate authority to negotiate and execute the following Plan Partner Services Agreement (PPSA) amendment which consists of the 2022 National Committee for Quality Assurance NCQA) delegation standards for Anthem Blue Cross (Amendment No. 54) (the amendments for Blue Shield Promise and Kaiser have already been approved).

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: The delegation standards exhibit of the PPSA has been revised to incorporate 2022 National Committee for Quality Assurance (NCQA) criteria.

Member Impact: This action will not affect L.A. Care members directly.

Budget Impact: None (already factored into the relevant budget).

Motion: **To approve Amendment No. 54 to the Plan Partner Services Agreements which updates the 2022 National Committee for Quality Assurance (NCQA) delegation standards for Anthem Blue Cross, and to authorize the Chief Executive Officer, or his designate, to execute such amendment and to authorize staff to make non-substantive revisions to the amendment.**

Amendment No. 4254
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Anthem Blue Cross

This Amendment No. 42 54 is effective as of July 1, 20212020[AV1], as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Cross of California dba Anthem Blue Cross***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq*.) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 42 54 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: ______________________________
John Baackes
Chief Executive Officer

Date: ___________________, 20232

By: ______________________________
Hector De La TorreAlvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: ___________________, 20232

Blue Cross of California dba Anthem Blue Cross
A California health care services plan

By: ______________________________
Les Ybarra
President
Medicaid Health Plan for California

Date: ______________________, 20232

I. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Anthem Blue Cross (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management, (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, and (vii) claims recovery. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and implementation timelines set and required by NCQA and State and Federal regulatory requirements, as modified from time to time. Anthem Blue Cross agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Anthem is responsible for sub-delegation oversight of any sub-delegated activities. Anthem Blue Cross will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Anthem Blue Cross as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Anthem Blue Cross will provide a specific corrective action plan acceptable to L.A. Care. If Anthem Blue Cross does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Anthem Blue Cross, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS starting January 1, 2022in 2021, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request.L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	QUALITY IMPROVEMENT	
Program Structure and Operations ~~Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026~~ (NCQA 2021~~2020~~ QI 1)	**Element A:** ~~**Element A:**~~ **QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated physician in the QI program 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership **Element B:** ~~**Element B:**~~ **Annual Work Plan**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Element C:Element C: Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and eEvaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **Element D: Element D: QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions 2. Analyzes and evaluates the results of QI activities 3. Ensures practitioner participation in the QI program through planning, design, implementation or review 4. Identifies needed actions 5. Ensures follow-up, as appropriate **Promoting**[AV4][DN5][ND6] **Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	
Health Services Contracting Applicable L.A. Care Policy: QI-007 (NCQA 20212020 QI 2)	**Element A:Element A: Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities.; 2. Practitioners allow the organization to use their performance data. **Element B: Element B: Provider Contracts**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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	Contracts with organization providers organization providerspractitioners specifically require that: 1. Providers cooperate with QI activities. 2. Providers allow the plan to use their performance data. NCQA related information: Use of provider manual or organization policies. The organization may use its provider manual or policies as evidence of performance against this element in the following circumstances. • Provider contracts specify that the manual or policy is an extension of the contract and that providers must abide by the conditions set forth in the contract, and in the manual or policy. • The manual or policy includes the required language. The organization includes an addendum addressing any factors not included in the contract. As reference by NCQA, *"Use of practitioner manual or organization's policies. The organization may use its practitioner manual or policies as evidence of performance against this element in the following circumstances.* *• Practitioner contracts specify that the manual or policy is an extension of the contract and that practitioners must abide by the conditions set forth in the contract and in the manual or policy.* *• The manual or policy includes the requirements specified in factors 1 and 2. The organization includes an addendum addressing any factors not included in the contract."* 3.	
Continuity and Coordination of Medical Care Applicable Policy QI-0026 (NCQA 20212020 QI 3)	**Element A:Element A: Identifying Opportunities** The organization annually identifies opportunites to improve coordination of medical care by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings.	

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	3. Conducting quantitative and causal analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement 5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement. **Element B:Element B: Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on a Taking action on the first opportunity for improvement identified in Element A, factor-4. 2. Acting on a Taking action on the second opportunity for improvement identified in Element A, factor 5. 3. Acting on aTaking action on the third opportunity for improvement identified in Element A, factor 6. **Element C: Element C: Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B. 3. The third opportunity in Element B. **Element D: Element D: Transition to Other Care** Refer to Utilization Management Delegated Activities Section	

Continuity and Coordination between Medical and Behavioral Healthcare Applicable L.A. Care Policy: QI-0026 (NCQA 20212020 QI 4)	**Element A:Element A: Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care 3. Appropriate use of psychotropic medications 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders 5. Primary or secondary preventive behavioral healthcare program implementation 6. Special needs of members with severe and persistent mental illness. **Element B:Element B: Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A 4. Identifying and selecting a second opportunity for improvement from Element A 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **Element C: Element C: Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B.	

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Standards [AV7]for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; d. Standards for the availability of medical records d.	
Sub-Delegation of QI Applicable L.A. Care Policy: QI-007 (NCQA 2021 2020 QI 5)[DN8][ND9]	**Sub**[SP10][DN11][ND12] **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	**Element A - Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Element A: Delegation Agreement** **The written delegation agreement:** 1. **Is mutually agreed upon** 2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity** 3. **Requires at least semiannual reporting by the delegated entity to the organization** 4. **Describes the process by which the organization evaluates the delegated entity's performance** 5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.*** 6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement**

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		Element B - Predelegation Evaluation For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. ~~**Element B: Predelegation Evaluation**~~ ~~**For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation begins.**~~ **Element C - Review of QI Program** 1. Annually reviews its delegate's QI program. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. 3. Semiannually evaluates regular reports, as specified in Element A. ~~**Element C: Review of QI Program**~~ ~~For arrangements in effect for 12 months or longer, the organization:~~ ~~1. Annually reviews its delegate's QI program~~ ~~2. Annually evaluates delegate performance against NCQA standards for delegated activities~~ ~~3. Semiannually evaluates regular reports, as specified in Element A~~ Element D - Opportunities for Improvement For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable. ~~Element D: Opportunities for Improvement~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.~~ * L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's

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		Policies and Procedures securing PHI through applicable protections, e.g, encryptionn ~~* L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption~~
POPULATION HEALTH MANAGEMENT		
PHM [AV13]Strategy[ND14] (NCQA 20212020 PHM 1)	**Element A: ~~Element A:~~ Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. 3. Activities that are not direct member interventions., 4. How member programs are coordinated. 5. How members are informed about available PHM programs. **Element B: ~~Element B:~~ Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate. 2. How to use program services. 3. How to opt in or opt out of the program.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Population [AV15]Identification (NCQA 20212020 PHM 2)	**Element A: ~~Element A:~~ Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters. 2. Pharmacy claims. 3. Laboratory results. 4. Health appraisal results. 5. Electronic health records. 6. Health Services programs within the organization. 7. Advanced data sources.	

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	Element B: ~~Element B:~~ Population Assessment The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Asseses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI). ~~Assesses the needs of of members racial or ethnic groups.~~ ~~5. Assesses the needs of members with limited English proficiency~~[DN16][ND17] **Element C: ~~Element C:~~ Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs. 2. Review and update its PHM resources to address member needs. ~~2. Review and update activities or resources to address health care disparities for at least one identified population.~~ [DN18][ND19] 3. Review community ~~Review community rer~~esources for integration into program offerings to address member needs. **Element D: ~~Element D:~~ Segmentation** 1. ~~At least annually, the organization~~ At least annually, the organization ~~s~~Segments or stratifies its entire population into subsets for targeted intervention. 2. ~~Assesses for racial bias in its segmentation or stratification methodology.~~[DN20][ND21]	
Delivery [AV22]System Supports (NCQA 2021~~2020~~ PHM 3)	**Element A: ~~Element A:~~ Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data.	**Element B: ~~Element B:~~ Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

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	2. Offering evidence-based or evidence-based or certified shared decision-making aids. 3. Providing practice transformation support to primary care practitioners. 4. Providing comparative quality information on selected specialties. 5. Providing comparative pricing information for selected services. 6. One additional activity to support practitioners or providers in achieving PHM goals.	
Wellness and Prevention[ND23] (NCQA 2021 2020 PHM 4)	**Element A: Element A: Frequency of Health Appraisal Completion** The organization has the capability to administer an HA annually. **Element B: Element B: Topics of Self-Management Tools** The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating 5. Managing stress. 6. Avoiding at-risk drinking. 7. Identifying depressive symptoms. 7.	
Complex Case Management [ND24] (NCQA 2021 2020 PHM 5)	**Element A:Element A: Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **Element B:Element B: Case Management Systems** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred;	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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	3. Automated prompts for follow-up as required by the case management plan. **Element C:** ~~**Element C:**~~ **Case Management Process** The organization's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of activities of daily living. 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Initial assessment of life-planning activities. 7. Evaluation of cultural and linguistic needs, preferences or limitations. 8. Evaluation of visual and hearing needs, preferences or limitations. 9. Evaluation of caregiver resources and involvement. 10. Evaluation of available benefits. 11. Evaluation of community resources. 12. Development of an individualized case management plan, including prioritized goals that considers the member and caregiver goals, preferences and desired level of involvement in the case management plan. 13. Identification of barriers to the member meeting goals or complying. With the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals. 15. Development of a schedule for follow-up and communication with members. 16. Development and communication of a member self-management plan. 17. A process to assess member progress against the case management plan. **Element D:** ~~**Element D:**~~ **Initial Assessment** An NCQA review of a sample of the organization's complex case mangagement	

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	files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of activities of daily living (ADL). 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Evaluation of cultural and linguistic needs, preferences or limitations. 7. Evaluation of visual and hearing needs, preferences or limitations. 8. Evaluation of caregiver resources and involvement. 9. Evaluation of available benefits 10. Evaluation of available community resources. 11. Assessment of life planning activities. **Element C: ~~Element E:~~ Case Management: Ongoing Management** NCQA's review of a sample of the organization's complex case management files demonstrates that the organization follows its documented process for: 1. Development of case management plans that includeg prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program. 2. Identification of barriers to meeting goals and complying with the case management plan. 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. ~~5.~~ Assessment of progress against case management plans and goals, and modification as needed. 5.	

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Population Health Management Impact (NCQA 20212020 PHM 6)	**Element A:Element A: Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **Element B:Element B: Improvement and Action** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Sub-Delegation of PHM (NCQA 2021 2020 PHM 7)[DN25][ND26]	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: Is mutually agreed upon Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity Requires at least semiannual reporting by the sub-delegated entity to the delegate Describes the process by which the delegate evaluates the sub-delegated entity's performance Describes the process for providing member experience and clinical performance data to its delegates when requested. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins.**Review of PHM Program** For arrangements in effect for 12 months or longer, the delegate: Annually reviews its sub-delegate's PHM program	**Element A - Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity 3. Requires at least semiannual reporting by the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested*

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	Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities Semiannually evaluates regular reports, as specified in the sub-delegation agreement Opportunities for Improvement For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement **Element B - Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation begins. **Element C - Review of PHM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's PHM program. 2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. **Element C: Review of PHM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable 3. Annually evaluates delegate performance against NCQA standards for delegated activities 4. Semiannually evaluates regular reports, as specified in Element A **Element D - Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the

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		past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable. * L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption * L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption
NETWORK MANAGEMENT		
Availability of Practitioners (NCQA 20212020 NET 1)	**Element A:Element A: Cultural Needs and Preferences** The organization: 1. Assesses the cultural, ethnic, racial and linguistic needs of its members. 2. Adjusts the availability of practitioners within its network, if necessary. **Element B:Element B: Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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	general medicine or family practice, internal medicine, and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care. 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Element C: ~~Element C:~~ Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of high volume and high-impact specialists. 2. Establishes measurable standards for the number of each type of high volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establish measureable standards for the geographic distribution of each type of high-impact specialist. ~~5.~~ Analyzes its performance against the established standards at least annually. **Element D: ~~Element D:~~ Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high volume behavioral healthcare practitioners. 2. Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner.	

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	3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner. 4. Analyzes performance against the standards annually.	
Accessibility of Services (NCQA 20212020 NET 2)	**Element A: ~~Element A:~~ Access to Primary Care** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments.; 2. Urgent care appointments.; 3. After-hours care. **Element B: ~~Element B:~~ Access to Behavioral Healthcare** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours. 2. Urgent care within 48 hours. 3. Initial visit for routine care within 10 business days. 4. Follow-up routine care. **Element C:~~Element C:~~ Access to Specialty Care** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care. 2. High-impact specialty care.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Assessment of Network Adequacy (NCQA 2021 2020 NET 3)	**Element A: ~~Element A:~~ Assessment of Member Experience Accessing the Network** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from Behavioral Healthcare and Services.ME 7, Element E.	

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	3. Compiling and analyzing requests for and utilization of out-of-network services. 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **Element B:~~Element B:~~ Opportunities to Improve Access to Nonbehavioral Healthcare Services** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements B and C), accessibility,(NET 2, Elements A and C), and member experience accessing the network (NET 3, Element A, factors 1 and 3) 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions if applicable. **Element C:~~Element C:~~ Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: ~~1.~~ Prioritizes opportunities for improvement ~~opportunities~~ identified from analyses of availability(NET 1, Element D), accessibility (NET 2, Element B), and member experience accessing the network (NET 3, Elements A and D, factor 2 and 4) 1. Implements interventions on at least one opportunity, if applicable. 2. Measures the effectiveness of the interventions, if applicable.	
Continued Access to Care (NCQA 2021 ~~2020~~ NET 4)[DN27][ND28]	**Element A: ~~Element A:~~ Notification of Termination** Refer to Utilization Management Delegated Activities Section. *The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective terminaton date, and helps them select a new practitioner.* **Element B:~~Element B:~~ Continued Access to Practitioners**	

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	Refer to Utilization Management Delegated Activities Section *If a practitioner's contract is discontinued, the organization allows affected member continued access to the practitioner, as follows:* *1. Continuation of treatment through the current period of active treatment, or up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.* *2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.* *L. A. Care combined NCQA Standard NET 4, Continued Access to Care, Element A and B under NCQA Standard, QI 3 Element D, Coordination of Medical Care.* ~~L. A. Care combined NCQA Standard NET 4, Continued Access to Care, Element A and B under NCQA Standard, QI 3 Element D, Coordination of Medical Care.~~	
Physician and Hospital Directories (NCQA 2021 ~~2020~~ NET 5)	**Element A: ~~Element A:~~ Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Board certification. 7. Accepting new patients. 8. Language spoken by the physician or clinical staff. 9. Office locations and phone numbers. **Element B: ~~Element B:~~ Physician Directory Updates** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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	Element C: ~~Element C:~~ Assessment of Physician Directory Accuracy Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers. 2. Accuracy of hospital affiliations. 3. Accuracy of accepting new patients. 4. Awareness of physician office staff of physician's participation in the organization's networks. **Element D: ~~Element D:~~ Identifying and Acting on Opportunities** ~~1.~~ Based on results of the analysis performed in Element C, at least annually, the organization: ~~2.~~1. ~~3.~~ Identifies opportunities to improve the accuracy of the information in its physician directories. 2. ~~4.~~3. Takes action to improve the accuracy of the information in its physician directories. **Element E: ~~Element E:~~ Searchable Physician Web-Based Directory** The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Accepting new patients. 7. Languages spoken by the physician or clinical staff. 8. Office locations. **Element F: ~~Element F:~~ Hospital Directory Data** The organization has a web-based hospital directory that includes the following information: 1. Hospital name. 2. Hospital location and phone number.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	3. Hospital accreditation status. 4. Hospital quality data from recognized sources. **Element G: ~~Element G:~~ Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the hospital. **Element H: ~~Element H:~~ Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name. 2. Hospital location. **Element I: ~~Element I:~~ Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level. 2. Intuitive content organization, 3. Ease of navigation. 4. Directories in additional languages, if applicable to the membership. **Element J: ~~Element J:~~ Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print. 2. Telephone.	
~~Sub-~~Delegation of NET (NCQA 2021 ~~2020~~ NET 6)[DN29][ND30]	~~**Sub-Delegation Agreement**~~ ~~The written sub-delegation agreement:~~ ~~Is mutually agreed upon~~ ~~Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity~~ ~~Requires at least semiannual reporting by the sub-delegated entity to the delegate~~ ~~Describes the process by which the delegate evaluates the sub-delegated entity's performance~~	**Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity 3. Requires at least semiannual reporting by the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	Describes the process for providing member experience and clinical performance data to its delegates when requestedDescribes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the delegate: Annually reviews its sub-delegate's network management procedures Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	5. Describes the process for providing member experience and clinical performance data to its delegates when requested * 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement **Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity 3. Requires at least semiannual reporting by the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested * 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Element C: Review of Delegated Activities** 1. For arrangements in effect for 12 months or longer, the organization: 2. Annually evaluates delegate performance against NCQA standards for delegated activities 3. Semiannually evaluates regular reports, as specified in Element A **Element C: Review of Delegated Activities**

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
		For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's network management procedures 2. Annually evaluates delegate performance against NCQA standards for delegated activities 3. Semiannually evaluates regular reports, as specified in Element A **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable. ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption* * L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
		Procedures securing PHI through applicable protections, e.g, encryption
UTILIZATION MANAGEMENT		
UTILIZATION MANAGEMENT		
Continued Access to Care (NCQA 2021 Net 4)NCQA NET 4) and Continuity and Coordination of Medical Care (NCQA 2021 Net 4 and QI 3)	**Element A:NET 4 Element A: Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. **Element B:NET 4 Element B: Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **QI 3 Element D: QI 3 Element D: Transition to Other Care** The organization helps with members' transition to other care when their benefit ends, if necessary.]	
Program Structure (NCQA 2021 2020 UM 1)	**Element A: Element A: Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated senior-level physician in UM program implementation. 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes to determine benefit coverage and medical necessity.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	6. Information sources used to determine benefit coverage and medical necessity. **Element B: ~~Element B:~~ Annual Evaluation** The organization annually evaluates and updates the UM Program, as necessary.	
Clinical Criteria for UM Decisions (NCQA 2021 ~~2020~~ UM 2)	**Element A: ~~Element A:~~ UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs. 3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. **Element B: ~~Element B:~~ Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria. ~~2.~~ Makes the criteria available to its practitioners upon request. 2. **Element C: ~~Element C:~~ Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA 2021 ~~2020~~ UM 3)	**Element A: ~~Element A:~~ Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA 2021 2020 UM 4)	**Element A:Element A: Licensed Health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision -making. **Element B: Element B: Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training,or professional experience in medical or clinical practice 2. A current clinical license to practice or an administrative license to review UM cases. **Element C: Element C: Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional, as appropriate, to review any non-behavioral healthcare denial based on medical necessity. **Element D:Element D: Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. **Element E: Element E: Practitioner Review of Pharmacy Denials** The organization uses a physician or pharmacist to review pharmacy denials based on medical necessity. **Element F:Element F: Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board--certified consultants to assist in making medical necessity determinations. 2. Provides evidence that it uses board-certified consultants are used for medical necessity determinations.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	2.	
Timeliness of UM Decisions (NCQA 2021 2020 UM 5)	**Element A: Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1.N/A Marketplace[DN31] 2. 2.For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners and members and members within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners and members and members within 72 hours of the request. 4. For non-urgent Medicaid preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners and members and members within 14 calendar days of the request. 5. For post-service decsions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. 5. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Element B: Element B: Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace)[DN32] 2. 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. 3. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners and members	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	and members within 72 hours of the request. 4. 4. For Medicaid non-urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners and members and members within 14 calendar days of the request. 5. 5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners and members and members within 30 calendar days of the request. **Element C: Notification of Pharmacy DecisionsElement C: Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For urgent preservice decisions, electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For nonurgent preservice decisions, electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For postservice decisions, electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. :The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For urgent preservice decisions, electronic or written notification of the decision to members and practitioners within 72 hours of the request.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	3. For nonurgent preservice decisions, electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For postservice decisions, electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Element D: UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Nonbehavioral UM decision making. 2. Notification of nonbehavioral UM decisions. 3. Behavioral UM decision making. 4. Notification of behavioral UM decisions. 5. Pharmacy UM decision making. 6. Notification of pharmacy UM decisions. 4. 5. Pharmacy UM decision making. 6. Notification of pharmacy UM decisions. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards*** Note: This only applies to pharmaceuticals covered under the medical benefit.	
Clinical Information (NCQA 2021 2020 UM 6)	**Element A: Element A: Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Element B: Element B: Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **Element C: Element C: Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making.Note: This only applies to pharmaceuticals covered under the medical benef	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
Denial Notices (NCQA 2021 2020 UM 7)	**Element A: Element A: Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. **Element B: Element B: Written Notification of Nonbehavioral Healthcare Denials** The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Element C: Element C Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written nonbehavioral denial notifications to members and their treating practitioners contain the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant the appeal. 2. An explanation of the appeal process, including members' rights to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **Element D: Element D: Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	physician, appropriate behavioral healthcare reviewer or pharmacist reviewer **Element E:** ~~**Element E:**~~ **Written notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Element F:** ~~**Writen Notification of**~~~~**Element F:**~~ **Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Element C:** ~~**Element G:**~~ **Discussing a Pharmacy Denial With a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denials decisions with a physician or pharmacist. **Element H:** ~~**Element H:**~~ **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information:	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	1. The specific reasons for the denial in language that is easy to understand. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. **Element I:Element I: Pharmacy Notice of Appeals -Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care 4. Note: This only applies to pharmaceutical covered under the medical benefit.	
Policies for Appeals (NCQA 20212020 UM 8)	**Element A: Element A: Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least 60 calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken. 3. Fully investigationing of the substance of the appeal, including any aspects of clinical care involved. 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal. 5. Appointment of a new person to review the appeal , who was not involved in the initial determination	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	and who is not the subordinate of any person involved in the initial determination. 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar *(defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as 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) ** ~~6. (defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as 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)~~ specialty. 7. The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request. 8. The decision for a post-service appeal and notification to the member within 30 calendar days of receipt of the request. 9. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 10. Notification to the member about further appeal rights 11. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based. 12. Giving the member reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. 13. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	14. Allowing an authorized representative to act on behalf of the member 15. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 16. Continued coverage pending the outcome of an appeal. ~~16.~~ * Definition of "same and similar" as agreed by both parties as reflected in Amendment No. 24. [DN33][ND34]	
Appropriate Handling of Appeals (NCQA 2021 ~~2020~~ UM 9)	**Element A:** ~~**Element A:**~~ **Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documention of the substance of appeals. 2. Investigation of appeals. 3. Appropriate response to the substance of the appeal. **Element B:** ~~**Element B:**~~ **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice, and expedited appeal process is within the specified time frames: 1. The organization resolves preservice appeals within 30 calendar days of receipt of the request 2. The organization resolves postservice appeals within 30 calendar days of receipt of the request 3. The organization resolves expedited appeals within 72 hours of receipt of the request **Element C:** ~~**Element C:**~~ **Appeal Reviewers** The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-imilar specialist review, as appropriate. ~~**Element D:**~~ **Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request. 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal within the organization or to an independent external organization, as applicable, along with relevant written procedures. 6.	
Evaluation of New Technology (NCQA 20212020 UM 10)		**Element A: Element A: Written Process** The organization's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plan includes an evaluation of the following: 1. Medical procedures. 2. Behavioral healthcare procedures. 3. Pharmaceuticals. 4. Devices This element is NA: • For Medicaid product lines if the state mandates all benefits and new technology determinations. – The organization provides the state's language. • If the organization does not determine which technologies, pharmaceuticals, devices, procedures or other services are included in benefits plans it offers to members. – For example, when these determinations are made by all purchasers of the organization's services. **Element B: Description of the Evaluation Process** This element is NA for Medicaid product lines if the state mandates all benefits and new technology determinations. The organization must produce documentation that demonstrates this. This element is NA if the organization does not determine which technologies, pharmaceuticals, devices, procedures or other services are included in benefits plans it offers to members. For example, when these determinations are made by all purchasers of the organization's services.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
Procedures for Pharmaceutical Management (NCQA 2021 ~~2020~~ UM 11)	**Element A: Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures. 2. A process that uses clinical evidence from appropriate external organizations. 3. A process to include pharmacists and appropriate practitioners in the development of procedures. 4. A process to provide procedures to practitioners annually and when it makes changes. **Element B: Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicatesto members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions and preferences. 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The organization's process for generic substitution, therapeutic interchange and step-therapy protocols. **SB1052**: Anthem shall post formulary on its Internet website and update that posting with changes on a monthly basis. **Element C: Pharmaceutical Patient Safety Issues** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification. 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **Element D: Reviewing and Updating Procedures**	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	With the participation of physicians and pharmacists, the organization annually: 1. Reviews the procedures. 2. Reviews the list of pharmaceuticals. 3. Updates the procedures as appropriate. 4. Update the list of pharmaceuticals as appropriate. SB1052: Anthem shall post the formulary list with changes on its Internet website on a monthly basis. . **Element E: Considering Exceptions** Implementing policies and procedures for considering exceptions when a closed formulary is used, which include: 1. Making an exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of exception requests ~~5.~~ Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request. 5.	
UM System Controls (NCQA 2021~~2020~~ UM 12)	**Element A: UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **Element B: UM Appeal System Controls**	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. 7.	
Sub Delegation of UM (NCQA 20212020 UM 13)		**Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and responsibilities of organization and delegated entity 3. Requires at least semiannual reporting by the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested* 6. Describes the remedies available to organization . if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the delegate evaluates delegate capacity to meet NCQA requirements before delegation began. **Element C: Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program 2. Annually audits UM denials and appeals files against regulatory guidelines and NCQA standards for each year that delegation has been in effect

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
		3. Annually evaluates delegate performance against NCQA standards for delegated activities 4. Semiannually evaluates regular reports as specified in Element A. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable. ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*
	~~CREDENTIALING~~	
	CREDENTIALING[DN35][AV36]	
Credentialing Policies (NCQA 2021 ~~2020~~ CR1) DHCS 6.5.4.2 DHCS APL 19-004	The organization has well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. [DN37] **Element A: Practitioner Credentialing Guidelines** The organization specifies: 1. The types of practitioners to credential and re-credential [*State Contract 6.5.4.2: include all administrative physician reviewers responsible for making medical decisions*] 2. The verification sources it uses. 3. The criteria for credentialing and re-credentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet organization's established criteria. • *Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files). The organization may present all practitioner files to the Credentialing*	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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	Committee or may designate approval authority of clean files to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. a. Credentialing policies and procedures: ▪ *State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.* ▪ *Specify the process for preventing discriminatory practices.-Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes.* ▪ *Specify how the organization monitors the credentialing and recredentialing processes. for discriminatory practices, at least annually. – Monitoring involves tracking and identifying discrimation in credentialing and recredentialing processes.* 7. The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization. 8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	other materials for members are consistent with credentialing data, including education, training, board certification and specialty. **Element B: Practitioner Rights** The organization notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. • The timeframe for making corrections. • The format for submitting corrections. • Where to submit corrections. 3. Receive the status of their credentialing or recredentialing application, upon request. **Element C: Credentialing System Controls** The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. • If the organization contracts with an external entity to outsource storage of credentialing information, the contract describes how the contracted entity ensures the security of the stored information . 5. How the organization audits the processes and procedures in factors 1–4. **Medi-Cal FFS Enrollment *** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 2. The process for ensuring and verifying Medi-Cal enrollment. 3. The process for practitioners whose enrollment application is in process.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	4. The process for monitoring between recredentialing cycles to validate continued enrollment. 5. Process for practitioners not currently enrolled in the Medi-Cal program. 6. Process for practitioners deactivated or suspended from the Medi-Cal program *Anthem supports this requirement under its Network Management operations.	
Credentialing Committee (NCQA 20212020 CR 2)	The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. [DN38] **Element A: Credentialing Committee** The organization's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. • *The Credentialing Committee is a peer-review body with members from the typesrange [DN39]of practitioners participating in the organization's network.* • *The organization may have separate review bodies for each practitioner type (e.g., physician, oral surgeon, psychologist), specialty or multidisciplinary committee, with representation from various specialties.* • *If the organization is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review* committee for the local organization. 2. Reviews credentials for practitioners who do not meet established thresholds. The Credentialing Committee: • *Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network.* • *Gives thoughtful consideration to credentialing information.* • *Documents discussions about credentialing in meeting minutes.* 3. Ensures that files meet established criteria are reviewed and approved by a medical director or designated physician.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	• *Has a process for medical director or qualified physician review and approve clean files.*	
Credentialing Verification (NCQA 20212020 CR 3) DHCS 6.5.4.2 APL 19-004	The organization verifies credentialing information through primary sources, unless otherwise indicated. [DN40] The organization conducts timely verification of information to ensure that practitioners have legal authority and relevant training and experience to provide quality care. **Element A: Verification of Credentials** The organization verifies that the following are within the prescribed time limits: 1. A current, valid license to practice. *(Develop a process to ensure providers licenses are kept current at all times).* 2. A valid DEA or CDS certificate, if applicable. and m[DN41][AV42] *Must able to dispense schedules 2 through 5 or schedules applicable to the provider's speciality.* • *Pending DEA certificates and practitioners who do not have schedules 2 through 5, if applicable:* *The organization may credential a practitioner whose DEA certificate is pending or missing schedules if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending or missing schedules until the practitioner has a valid DEA certificate and able to dispense schedules appropriate to the practitioners specialty type.* 3. Education and training as specified in the explanation. *The organization verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate:* • *Board certification* • *Residency* • *Graduation from medical or professional school.* 4. Board certified status, if applicable. • *The organization verifies current certification status of practitioners who state that they are board certified.* *The organization documents the expiration date of the board certification in the*	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status), the organization verifies that board certification is current and documents the date of verification. 5. Work history. *The organization obtains a minimum of the most recent five years of work history as a health professional through the practitioner's application or CV. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date. Gaps in work history. The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods* 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. • *The organization obtains confirmation of the past five years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The five-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship* DHCS APL 19-004: Medi-Cal FFS enrollment. [*Anthem supports this requirement under its Network Management operations.]* • Verification of practioner enrollment of DHCS FFS. • Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network. All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
Sanction Information (NCQA 20212020 CR 3) State Contract 6.5.4.2	**Element B: Sanction Information** The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, and limitations on scope of practice. 2. Medicare and Medicaid sanctions. *The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.*	
CR Application (NCQA 20212020 CR 3) State Contract 6.5.4.2	**Element C: Credentialing Application** Applications for credentialing include the following: 1. Reasons for inability to perform the essential functions of the position 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary action. 5. Current malpractice insurance coverage. 6. Current and signed attestation confirming the correctness and completeness of the application. *6.*	
Re-credentialing Cycle Length (NCQA 20212020 CR 4) State Contract 6.5.4.2	**Element A: Recredentialing Cycle Length** Recredentialing all practitioners at least every 36-months.	
Ongoing Monitoring and Interventions (NCQA 20212020 CR 5) State Contract 6.5.4.2	The organization Ddevelops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. **Element A: Ongoing Monitoring and Interventions** The organization implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the delegate b. What type of monitoring is being performed c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	4. Collecting and reviewing information fromidentified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: Requesting what action will be taken by the Delegate. What type of monitoring is being performed. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA 20212020 CR 6) State Contract 6.5.4.2	The organization uses objective evidence and patient-care consideration when deciding on a course of action for dealing with a practitione who does not meet its quality standards. **Element A: Actions Against Practitioners** The organization has policies and procedures for: 1. The range of actions available to organization. • *Specify that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare.* • *Specify the range of actions that may be taken to improve practitioner performance before termination.* • *Specify that the organization reports its actions to the appropriate authorities.* 2. Making the appeal process known to practitiones. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
CR Assessment of Organizational Providers (NCQA 20212020 CR 7) State Contract 6.5.4.2	**Element A: Review and Approval of Provider** The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. *acceptable to Delegate, including which accrediting bodies are acceptable;* 3. Conducts an onsite quality assessment is conducted if the provider is not accredited. by an accrediting body *acceptable to Delegate, including which accredited bodies are acceptable;*	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate; Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. **Element B: Medical Providers** The ~~Delegate~~ -organization includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Free-standing surgical centers. *Hospices. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA). *Comprehensive Rehabilitation Facilities (CORFs). *Outpatient Physical Therapy and Speech Pathology Providers. *Providers of end-stage renal disease services. *Providers of outpatient diabetes self-management training . *Portable X-Ray Suppliers. *Rural Health Clinic (RHCs). Federally Qualified Health Center (FQHCs). **Element C: Behavioral Healthcare Providers** The organization ~~Delegate~~ includes behavioral health care facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory.[DN43][AV44] **Element D: Assessing Medical Providers** The organization ~~Delegate~~ assesses contracted medical health care providers against the	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	requirements and within the time frame in Element A. .[DN45][ND46] **Element E: Assessing Behavioral Healthcare Providers** The organization ~~Delegate~~ assesses contracted behavioral healthcare providers against the requirement and within the time frame in Element A.[DN47][AV48]	
~~Sub-~~Delegation of CR (NCQA 2021~~2020~~ CR 8) State Contract 6.5.4.2	**Element A: Delegation Agreement** If the organization (Anthem) sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterlyreporting to Delegate 4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its obligations, including revocation of the sub-delegation agreement. Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of Delegate's Credentialing Activities** For sub-delegation arrangements in effect for 12 months or longer, the Delegate:	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	1. Annually reviews its sub-delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. 3. Annually evaluates the Sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually. 4. Evaluates regular reports from Sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre delegation audit reveals deficiencies identified that are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA 20212020 ME 1)	**Element B:Element B. Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Element A:Element A: Rights and Responsibilites Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities 2. A right to be treated with respect and recognition of their dignity and right to privacy 3. A right to participate with practitioners in making decisions about their health care 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage 5. A right to voice complaints or appeals about the organization or the care it provides

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
		6. A right to make recommendations regarding the organization's member rights and responsibilities policy 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA 20212020 ME 2)		**Element A: Subscriber Information** The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care. **Element B: Interpreter Services** Based on linguistic need of its subscribers, the organization provides interpreter or bilingual services in its Member Services department and telephone functions. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA 20212020 ME 3)		**Element A: Materials and Presentations** All organizational materials and presentations accurately describe the following information: 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures. **Element B: Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **Element C: Assessing Member Understanding** **The organization systematically takes the following steps:**

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
		1. Assesses how well new members understand policies and procedures. 2. Implements procedures to maintain accuracy of marketing communication. 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA 20212020 ME 4)	**Element B: Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid 5.	
Pharmacy Benefit Information (NCQA 20212020 ME 5)	**Element A: Pharmacy Benefit Information-Website** Members can complete the following actions on the organization's website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. SB1052: Anthem shall post the formulary on its internet website and update that posting on a monthly basis. **Element B: Pharmacy Benefit Information Telephone** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes.	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	Element C: QI Process on Accuracy of Information The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **Element D: Pharmacy Benefit Updates** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA 20212020 ME 6)	**Element A: Functionality – Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable **Element B: Functionality Telephone** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2.1. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Element C: Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information it provides to its members via the webs and telephone, by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **Element D: E-mail Response Evaluation** The organization:	

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience ~~Applicable L.A. Care Policy: QI-0031~~ (NCQA 2021~~2020~~ ME 7)	**Element A:~~Element A:~~ Policies and Procedures for Complaints** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken. 2. Investigating of the substance of complaints 3. Notification to members of the resolution of complaint and, if there is an adverse decision, the right to appeal. 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the complaint process. **Element B:~~Element B:~~ Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals. 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate. 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. **Element C:~~Element C:~~ Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. **Element D:~~Element D:~~ Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from the Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	Element E:Element E: Annual Assessment of Behavioral Healthcare and Services Using valid Methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **Element F:Element F: Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2.Identifying opportunities for improvement. 3.Implementing interventions, if applicable. 4.Measuring effectiveness of interventions, if applicable.	
Sub-Delegation of ME (NCQA 2021 2020 ME 8)[DN49][ND50]	**Sub-Delegation Agreement** The written sub-delegation agreement: Is mutually agreed upon Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities. Requires at least semiannual reporting by the delegated entity to the organization. Describes the process by which the organization evaluates the delegated entity's performance. Describes the process for providing member experience and clinical performance data to its delegates when requested. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **Review of Performance** For delegation arrangements in effect for 12 months or longer, the organization: Semiannually evaluates regular reports as specified in the sub-delegation agreement. Annually evaluates delegate performance against NCQA standards for delegated activities. **Opportunities for Improvement**	**Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested * 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement **Element A: Delegation Agreement** **The written delegation agreement:** **1. Is mutually agreed upon.** **2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.** **3. Requires at least semiannual reporting by the delegated entity to the organization.** **4. Describes the process by which the organization evaluates the delegated entity's performance** **5. Describes the process for providing member experience and clinical performance data to its delegates when requested ***

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.~~	~~6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement**~~ **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation begins. ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation begins.~~ **Element C: Review of Performance** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports, as specified in Element A. 2. Annually evaluates delegate performance against NCQA standards for delegated activities.Element C: Review of Performance For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports, as specified in Element A. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that organization identified and followed up on opportunities for improvement, if applicable. ~~**Element D: Opportunities for Improvement**~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that organization identified and followed up on opportunities for improvement, if applicable.~~ ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's*

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
		Policies and Procedures securing PHI through applicable protections, e.g, encryption. ~~* L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption~~
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2 Knox-Keene 1348.8)	Plan shall provide telephone medical advice services to its enrollees and subscribers. The staff hold a valid California license as a registered nurse or a valid license in the state within which they provide telephone medical advice services as a physician and surgeon or physician assistant, and are operating in compliance with the laws governing their respective scopes of practice. A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors (Knox-Keene, 1348.8; 1. Is available 24 hours a day, 7 days a week by telephone. (Title 28 CA Code of Regulations; 1300.67.2.2) 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. (Knox-Keene; 1367.04) 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. (1300.67.2.2) **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. ~~2.~~ Link member contacts to a contact history.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	2. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone and website statistics at least quarterly. 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion (1300.67.2.2)** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Pan Partner Services Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
(previously Quality [AV51]Assurance Program Quality Assurance Program) (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Quality Assurance Program (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities[DN2][ND3]	Retained by L.A. Care
	identified and corrected for all provider entities.	
Quality Improvement Performance DHCS APL 19-017 Applicable L.A. Care Policy: QI-008 DHCS DHCS APL Supplement to All Plan Letter 19-017 *	1. Annually measures performance and meets the NCQA 25th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 25th percentile is not met the plan will identify and follow up on opportunities for improvement. * DHCS supplement to All Plan Letter (APL) 19-017 is to provide Medi-Cal managed care health plans (MCPs) with adjustments to quality and performance improvement requirements as a result of the current public health emergency resulting from COVID-19. These adjustments are consistent with recent allowances from the National Committee for Quality Assurance (NCQA).	L.A. Care will retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood[AV52] Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016[DN53][DN54][AV55]	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016. 2. Identify, on at least a quarterly basis (i.e. January-March, April-June, July-September, October-December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required, *L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis. Plan reporting is contingent of receiving CLPPB data in DHCS released format. DHCS retire annual report for 2024 (April 10.2023 notice to HPs)	
HEALTH[AV56][ND57][ND58][ND59][AV60] EDUCATION		
CULTURAL & LINGUISTIC[AV61][ND62][ND63][AV64] SERVICES		

CLAIMS[AV65][ND66][ND67][ND68][AV69] PROCESSING REQUIREMENTS

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy Reporting requirements for additional delegated activities 1. NCQA UM related [Part 1] a. **UM 4E:** Practitioner Review of Pharmacy Denials b. **UM 5:** Timeliness of Pharmacy UM Decision Making c. **UM 5C:**Notification of Pharmacy Decisions d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials 2. NCQA UM related [Part 2] a. **UM 7I:** Pharmacy Notice of Appeals Rights/Process b. **UM 9A** Preservice and Postservice Pharmacy Appeals c. **UM 9B:** Timeliness of the Pharmacy Appeal Process d. **UM 9C:** Pharmacy Appeal Reviewers e. **UM 9D:** Notification of Appeal Decision/Rights for Pharmacy f. **UM 12A:** UM Denial System Controls 3. NCQA UM related [Part 3] a. **UM 5G(factors5&6)**: UM Timeliness Report (Pharmacy) 4. DHCS Related a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA decisions within 24 hours of receipt/Total PAs .- includes approval and denials, excludes all	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) – Compliance Folder. Plan will also have the option to submit via email to remain compliant with due date.	1-3. L.A. Care Reporting Format with data elements as defined in the Anthem Pharmacy Report Templates workbook, and 4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

early close and administrative denials b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs .- includes approval and denials, excludes all early close and administrative denials 5. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded. b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded **c.** Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 6. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization.			
NCQA Pharmacy ME related reporting requirements 1. **ME:** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME:** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 - 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) – Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission

~~APPEALS & GRIEVANCES~~

APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 12th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F 1. **Analysis of Member Experience, if delegated, to include:** Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories along with oppurtunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with oppurtunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. e. Quality of Practitioner Office Site	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder / Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** 1. Assess the cultural, ethnic, racial and linguistic needs of its members 2. Adjust the availability of practitioners within its network, if necessary	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission

NET 1B **Availability of Practitioners, if delegated:** Formal assessment of primary care, behavioral healthcare and specialty care practitioners (SCP) availability to include: 1. Adjustment of practitioners availability within its network to meet the cultural, ethnic, racial and linguistic needs of its members 2. Quantifiable and Measurable Standards for the number of each type of practitioner providing primary care. 3. Quantifiable and Measurable Standards for Geographic Distribution of each type of practitioner providing primary care. 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 1C **Formal assessment of Practitioners Providing Specialty Care, if delegated, to include:** 1. Identification of High Volume Specialty Providers, one of which must be OB/GYN; and Identification of High Impact Specialty Providers, one of which must be Oncology 2. Quantifiable and Measurable Standards for the number of each type of high-volume specialists. 3. Quantifiable and Measurable Standards and Distribution by Geographic Distribution of High Volume SCPs and High Impact SCPs; and 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 1D **Assessment of Practitioners Providing Behavioral Healthcare, if delegated, to include:** 1. Identification of High-Volume behavioral healthcare practitioners 2. Quantifiable and Measurable Standards for the number of each type of High-Volume behavioral healthcare practitioner. 3. Quantifiable and Measurable Standards for the geographic distribution of each type of High-Volume behavioral healthcare practitioners. 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission

NET 2A **Access to Primary Care, if delegated:** Analysis of data that measures: 1. Regular and Routine Care Appointments 2. Urgent Care Appointments 3. After-Hours Care	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2B **Access to Behavioral Healthcare, if delegated:** Analysis of data that evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent Care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care within a time frame defined by the organization	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2C **Access to Specialty Care, if delegated:** Analysis of data that evaluate access to appointments for : 1. High-Volume specialty care. 2. High-Impact specialty care.	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3 **Assessment of Network Adequacy** 1. Assessment of Member Experience Accessing the Network by: a. Analyzing data from complaints and appeals about network adequacy for non-behavioral and behavioral healthcare services b. Using aspects of analysis from (b) to determine if there are issues specific to particular geographic areas or types of practitioners or providers 2. Analyze opportunities to improve access to non-behavioral healthcare services by: a. Prioritizing opportunities for improvement from analysis of availability, accessibility and	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date	Compliant with NCQA in accordance to Plan's accreditation submission

CAHPS survey results and member complaints and appeals b. Implement interventions on at least one opportunity, if applicable c. Measure the effectiveness of interventions, if applicable 3. Analyze opportunities to improve access to behavioral healthcare services by: a. Prioritizing improvement opportunities identified from analyses of availability, accessibility, complaints and appeals, or member experience b. Implementing interventions on at least on opportunity, if applicable c. Measures the effectiveness of the interventions, if applicable			
QI 2A Practitioner Contracts[AV70] [DN71] Boilerplate templates and provider manuals or policies may be shared in lieu of provider contracts[AV72]	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ubcsc/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
~~**QI 3A**~~ ~~Identifying Opportunites~~ ~~**QI 3B**~~ ~~Acting on Opporunities~~ ~~**QI 3C**~~ ~~Measuring Effectiveness~~ **QI 3 A-C & 4 A-C** Annual Assessment and Improvement Actions taken for Continuity and Coordination of Care across the health care network[DN73][AV74] 1. Continuity and Coordination of Medical Care analysis 2. Continuity and Coordination Between Medical Care and Behavioral Healthcare analysis[DN75][AV76].	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder ~~home/ubcsc/infile/Quality Improvement/~~ Plan will also have the option to submit via email to remain compliant with due date ~~to quality@lacare.org~~ .	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare

~~a~~**Quality Improvement Quarterly reporting requirements** 1. **QI Workplan Update** ~~1. Workplan updates should goals, objectives, QI activities and responsible party related to the MCAS MPL measures.~~ 2. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	1 – 2. Quarterly 1st Qtr – ~~April June~~ April 30 2nd Qtr – July 25 ~~July 25Sep 30~~ 3rd Qtr – Oct 25 ~~Oct 25Dec 30~~ 4th Qtr – Jan 25~~Jan 25Mar 30~~ ~~2.Quarterly PQI Report~~ ~~1st Qtr – April 25~~ ~~2nd Qtr – July 25~~ ~~3rd Qtr – Oct 25~~ ~~4th Qtr – Jan 25~~[DN77][AV78]	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder ~~home/ubcsc/infile/Quality Improvement/~~ ~~.~~ Plan will also have the option to submit via email to remain compliant with due date ~~to quality@lacare.org.~~	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Workplan *(if the activities are not included in the QI Workplan)*	1 – 4. Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder ~~home/ubcsc/infile/Quality Improvement/~~ Plan will also have the option to submit via email to remain compliant ~~to quality@lacare.org.~~ The PHM reporting element is part of Anthem's UM operations – copy of its UM Workplan will be shared with LA Care's Quality Improvement Team during the annual PP audit.	Acceptable formats: • ICE Reporting Format
ME 1B: Distribution of Member Rights & Responsibilities Statement to New Practitioners	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 & Q2)	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder ~~home/ubcsc/infile/Quality Improvement/~~ Plan will also have the option to submit via email to remain	Mutually agreed upon format

		compliant to quality@lacare.org.	
PHM 1A: PHM Strategy Element A: Element A:Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Population Idenification Data integration **PHM 2B: Population Identification** Element B: Element B: Population Assessment **PHM 2C** Activites and Resources **PHM 2D** Element D: Element D: Segmentation	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant to quality@lacare.org	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6:A Population Health Management Impact : Population Health Management Impact Element A: Element A:Measuring Effectiveness **Element BPHM6B:** -Element B:Improvement and Action	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain complianto quality@lacare.org ..	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2 **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1. L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Regulatory Reports/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format

2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	2. Annually during PP Audit	2. L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant.	
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 25th percentile for the Managed Care Accountability Set and the 25th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities. ~~* DHCS supplement to All Plan Letter (APL) 19-017 is to provide Medi-Cal managed care health plans (MCPs) with adjustments to quality and performance improvement requirements as a result of the current public health emergency resulting from COVID-19. These adjustments are consistent with recent allowances from the National Committee for Quality Assurance (NCQA).~~	Annually during PP Audit. ~~The PDSA tool is due 90 calendar days after findings are received.~~	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder ~~home/ubcsc/infile/Quality Improvement/.~~ Plan will also have the option to submit via email to remain compliant ~~to quality@lacare.org~~	The PDSA tool provided by DHCS
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Annually during PP audit 2-3. May 31	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	1. Narrative 2. HICE Quarterly Reporting format 3. HICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care ~~Annual and~~ Quarterly UM Activity (HICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K	~~Annual 2022 Evaluation and 2023 Work Plan – February 15, 2023~~ Quarterly 1st Qtr – May 31 ~~31~~ 2nd Qtr – Aug 31~~31~~ 3rd Qtr – Nov 30~~30~~	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder. Plan will also have the option to submit via email to remain	ICE Quarterly Reporting Format

d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	4th Qtr – Feb-2828	compliant with due date.	
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) (Compliance folder.) Plan will also have the option to submit via email to remain compliant with due date.	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly	Anthem supports its compliance via its encounter submission	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care**--**member transition to other care, **a.** When their benefits end. **b.** During transition from pediatric care to adult care. ~~(MM 22 Element D)~~	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder	L.A. Care TOC Reporting ~~Document and COC Log Template~~ Format

		Plan will also have the option to submit via email to remain compliant with due date.	
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to Credinfo@lacare.org to remain compliant with due date.	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (HICE Format)
yCOMPLIANCE			
• 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) 274 folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS required formatting.
• Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	No specific template. All DHCS reports submitted to L.A. Care within the month must be listed and signed by Plan Partner President
• Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 575 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder.	DHCS approved template

		Plan will also have the option to submit via email to remain compliant with due date.	
AB1455[AV79][ND80] Quarterly Reporting: –Claims Timeliness Reports • Provider Dispute Resolution (PDR) • -Disclosure of Emerging Claims Payment Deficiencies (DoECPD) [KF81][ND82]	Quarterly – Due to LA Care 45 calendar calendar days after quarter *The effective date will be based on the last date signed by the parties to support the full execution of this delegation agreement.	[KF83][ND84][AV85]L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DMHC DMHC HICE [KF86]approved template
• Call Center Report Mandated by APL 14-012 *DHCS retired effective December 31, 2019. However, Anthem to continue its submission directly to LA Care.	Quarterly – Due 30 days after quarter end	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date. [MF87][ND88][AV89]Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
• Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 575 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
• Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder.	DHCS approved template

		Plan will also have the option to submit via email to remain compliant with due date.	
• Coordinated Care Initiative – Long-Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
~~• Encounter Data Letters – CAP response~~	~~Quarterly - Due to L.A. Care 30 business days after receipt of CAP request~~	~~L.A. Care Regulatory Reporting via email~~	~~No specific template~~
~~• Grievance Report~~ ~~Mandated by APL 14-013~~	~~Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS~~	~~L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~DHCS approved template~~
• Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012~~APL 14-010~~	Quarterly - Due to L.A. Care ~~5~~57 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
~~• Out-of-Network (OON) Report~~[DN90][AV91] • Out of Network (OON) Report	~~Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS~~ Quarterly – Due to L.A. Care 5 business days prior to submission to DHCS	~~L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports~~ L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports ~~Plan will also have the option to submit~~	~~DHCS approved template~~ DHCS approved template

		via email to remain compliant with due date. Plan will also have the option to submit via email to remain compliant with due date.	
• Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually – contingent of DHCS notice	DHCS SFTP with copy to LA Care Medical Payment Systems and Services Reporting	DHCS approved template
• Pharmacy Formulary Changes Reports 14. Pharmacy Formulary Changes [DN92][AV93]Reports	Annually - Due to L.A. Care 5 business days prior to submission to DHCS Annually - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date. L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template DHCS approved template
• Health Homes Program DHCS Required Reporting *DHCS retired effective December 31, 2021*	Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
• CBAS Monthly Wavier Report	Monthly -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain	DHCS approved template

		compliant with due date.	
• Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
• Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
• Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
• Prop 56 Directed Payments for Valued Base Payment Program (APL 20-014)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
• Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS Template based on APL reporting requirements

		Plan will also have the option to submit via email to remain compliant with due date.	
• Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
• MMDR MER Exemption Review Denial Report	Monthly - Due to L.A. Care 5 business days prior to submission to DHCS This deliverable is contingent of receiving a member list from L.A Care to support monthly report.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Reporting template
• MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The[PT94][DN95] Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously***	Monthly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements

submitted by your plan as the MMDR Report) • Other types of continuity of care data in ad-hoc Excel templates Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report***			
• Third[AV96] Party Liability	Due 25 days from the date LA Care submits case file.	L.A. Care Regulatory via its Secure File Transfer Protocal (SFTP) TPL folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
• Acute Care at Home Hospital Report [SA97][DN98][ND99] APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS Reporting Template
• Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS[PT100][JS101][SA102]	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
• Third Party Liability	Due 25 days from the date LA Care submits case file.	L.A. Care Regulatory via its Secure File Transfer Protocal (SFTP) TPL folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
• New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS *The effective date will be based on the last date signed by the parties to support the full execution of this delegation agreement.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
• Disaster[AV103] and Recovery Plan / Test Results	Contingent of DHCS notice	L.A. Care Regulatory via its Secure File Transfer Protocol	DHCS template DHCS template

L.A. Care will communicate all data elements as outlined by DHCS due to an emergency declared by the Governor. below including but not limited to: LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	~~Annually during PP audit and ad-hoc~~ Contingent on government notice; Ad-hoc	(SFTP) Regulatory Reports folder Plan will also have the option to submit via secure email to remain compliant with due date. ~~EnterpriseRiskManagement@lacare.org~~ ~~home/PPName/infile/Regulatory Reports/~~ ~~EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org~~	~~Word Document, Non-Specific template~~ ~~Template may change upon regulators request.~~
FINANCIAL COMPLIANCE			
1. PPG Solvency Report 627	Quarterly - Due to L.A. Care 75 calendar days after each quarter end	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via secure email to remain compliant with due date.	Excel/PDF
2. Annual Audit Report 628	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted in the reporting quarter	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via secure email to remain compliant with due date.	Excel/PDF
DELEGATION OVERSIGHT			
1. New Member Welcome Kit Mailing Reports	Due to L.A. Care by the 15th of each month	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain	

		compliant with due date.	
CULTURAL & LINGUISTIC SERVICES[AV104]			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care by January 31st of each year[DN105][DN106]	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	Plan Partner can submit their own format of C&L program description and work plan.
2. C&L Program Evaluation[NY107][DN108] NCQA HE Standard 7	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	Plan Partner can submit their own format of C&L program evaluation
3. Bilingual Staff List[NY109][DN110][AV111] NCQA HE Standard 7	Annually – ~~due to L.A. Care January 31st of each year-~~ during the audit.	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
4. Translated Documents / Alternative Formats Tracking Log[NY112][DN113][AV114] NCQA HE Standard 7	Annually during the audit. ~~Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter:~~ ~~Q1 due 4/25~~ ~~Q2 due 7/25~~ ~~Q3 due 10/25~~ • ~~Q4 due 1/25~~	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
5. Interpreting Utilization Report (Face-to-face and Telephonic interpreting)[NY115][DN116][AV117] NCQA HE Standard 7	Annually during the audit. Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format

6. C&L Referral Report[DN118]	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format

HEALTH[AV119] EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and ~~i~~Work Plan	Annually – due to L.A. Care January 31st of each year[DN120]	Via email to designated Health Education contact	As appropriate per Plan Partner model.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: ________________________
John Baackes
Chief Executive Officer

Date: ______________________, 202~~2~~3

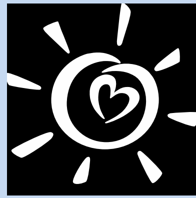
By: ________________________
~~Hector De La Torre~~Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: _____________________, 202~~2~~3

Blue Cross of California dba Anthem Blue Cross
A California health care services plan

By: ___________________________
Les Ybarra
President,
Medicaid Health Plan for California

Date: _______________________, 202~~2~~3



Board of Governors
MOTION SUMMARY

Date: January 24, 2024

Motion No. **EXE A.0124**

Committee: Executive

Chairperson: Alvaro Ballesteros, MBA

Requesting Department: Human Resources

Issue: L.A. Care Policy HR-501 requires that the Executive Committee annually review substantial changes to the Human Resources Policies.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

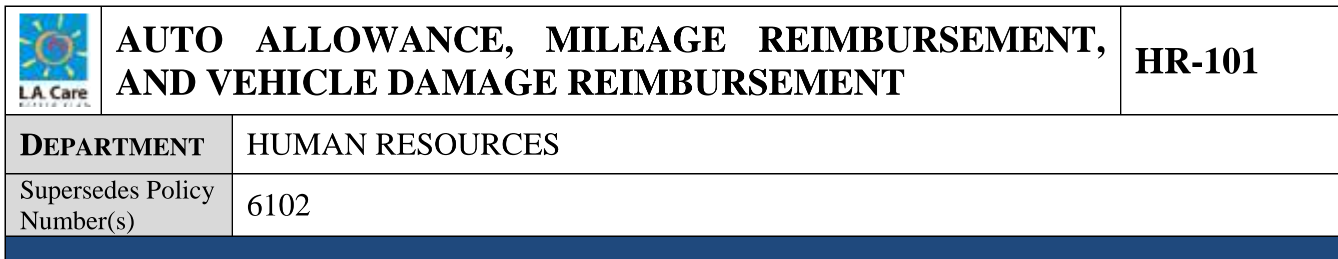
Background: The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care's practices.

Policy Number	Policy	Section	Description of Modification
HR-101	Auto Allowance Mileage Reimbursement, and Vehicle Damage Reimbursement	Total Rewards	Review; clarified processes; changed Monitoring and Reporting sections to standard verbiage
HR-122	Transportation Allowance	Total Rewards	Removed "tokens" and "annual TAP pass; changed Reporting and Monitoring sections with standard verbiage

Member Impact: L.A. Care members will benefit from this motion by receiving more efficient service from L.A. Care staff members, who will be thoroughly versed on L.A. Care Human Resource policies

Budget Impact: None

Motion: **To approve revisions to Human Resources Policies HR 101 (Auto Allowance Mileage Reimbursement, and Vehicle Damage Reimbursement) and HR 122 (Transportation Allowance), as presented.**



	AUTO ALLOWANCE, MILEAGE REIMBURSEMENT, AND VEHICLE DAMAGE REIMBURSEMENT	HR-101
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)	6102	

DATES					
Effective Date	10/1/1997	Review Date	~~10/31/2023~~	Next Annual Review Date	
Legal Review Date	12/26/2023	~~Committee Review Date~~	~~10/28/2019~~		

LINES OF BUSINESS			
☐ Cal MediConnect	☐ L.A. Care Covered	☐ L.A. Care Covered Direct	☐ MCLA
☐ PASC-SEIU Plan	☒ Internal Operations		

DELEGATED ENTITIES / EXTERNAL APPLICABILITY			
☐ PP – Mandated	☐ PP – Non-Mandated	☐ PPGs/IPA	☐ Hospitals
☐ Specialty Health Plans	☐ Directly Contracted Providers	☐ Ancillaries	☐ Other External Entities

ACCOUNTABILITY MATRIX			

ATTACHMENTS
➢ Professional License, Automobile License and Liability Insurance Certification

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, Human Resources, Total Rewards

AUTHORITIES

- HR-501 Executive Committee of the Board: HR Roles and Responsibilities
- California Welfare & Institutions Code Section 14087.9605
- L.A. Care By-Laws, Section 10.1 Purchasing, Hiring, Personnel etc.
- California Labor Code Section 2802

REFERENCES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
1/25/2017	Revision
8/22/2018	Revision, no fault property damages increased from up to $250.00 to a maximum of $1,000.00
~~10/28/2019~~	~~Review~~
~~3/30/2020~~10/31/2023	Review; clarified processes; changed Monitoring and Reporting sections to standard verbiage

DEFINITIONS

~~Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures~~

1.0 OVERVIEW:

1.1 To ensure that employees at L.A. Care Health Plan (L.A. Care) whose jobs require travel are compensated for the use of their personal vehicles, auto allowance, mileage, and/or for property damages to their vehicles that are incurred while on official business.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the “Definitions” below.

2.1 N/A

3.0 POLICY:

3.1 Employees who use their personal vehicles for official business purposes may be eligible for a mileage reimbursement.

3.2 Mileage reimbursement is based on the current IRS-defined business mileage rate and is provided to all employees who use their personal vehicles for official business purposes. Employees will be reimbursed for the total miles traveled for official business purposes. However, if an employee is traveling to a different location in lieu of traveling to the employee’s regularly assigned office location, the employee will be reimbursed for the total miles traveled less the number of miles the employees typically drives to and from the employee’s home to the employee’s regularly assigned office location.

3.2.1 Officers receiving a monthly auto allowance as compensation for the expense of using their personal vehicles for official business purposes are not eligible for mileage reimbursement.

3.3 Reimbursement for other expenses related to driving for official business purposes, such as toll road fees and parking fees, may be requested by officers and employees.

3.4 Costs associated with the regular operation of a vehicle including but not limited to fuel, automobile repairs, and insurance are non-reimbursable. The reimbursement of such expenses incurred from the use of personal vehicles for official business purposes is expected to be covered by the auto allowance or mileage reimbursement.

3.5 To the extent that the auto allowance or mileage reimbursement is insufficient to cover the necessary expenses incurred by the employees’ use of personal vehicles for official business purposes, employees are to immediately advise their supervisors and their Human Resources Business Partner (HRBP) so that further review may be conducted to ensure that employees are being appropriately reimbursed for such expenses.

3.6 Property damages to an employees' personal vehicle that are incurred without fault or cause on the part of the employees while using their personal vehicle while on official business may be compensated by L.A. Care.

3.7 All employees using their personal vehicles for official business purposes must sign the "Professional License, Automobile License and Liability Insurance Certification" form when hired and/or prior to use of personal vehicles for official business purposes. This form certifies that the employees will maintain their state issued driver's license and automobile insurance in current, valid, active status while employed in a position that requires driving on official business

4.0 PROCEDURES:

4.1 Auto Allowance

4.1.1 The Auto Allowance is a taxable benefit and is added to each officer's or eligible employees' paycheck subject to required taxes.

4.2 Mileage Reimbursement

~~4.2~~

4.2.1 Mileage Reimbursement is available for employees who use their personal vehicles for official business purposes but do not receive an auto allowance.

~~4.2.1~~

4.2.2 The rate of reimbursement is based on the current IRS-defined business mileage rate.

~~4.2.2~~

4.2.3 Employees will be reimbursed for the total miles traveled for official business purposes, less the number of miles the employees typically drive to and from the employees' home to the employees' regularly assigned office location.

~~4.2.3~~

4.2.4 The mileage reimbursement is non-taxable and is provided on a separate check through ~~Accounts Payable~~[AB1] the ~~T~~travel ~~R~~reimbursement s~~S~~ystem.

4.3 Other Reimbursements

~~4.3~~

4.3.1 Officers and employees may also request reimbursement through the ~~T~~travel ~~R~~reimbursement ~~S~~system for other expenses related to driving for official business purpose such as toll road fees and parking fees[AB2].

~~4.3.1~~

4.3.2 Costs associated with the regular operation of a vehicle, including but not limited to fuel, automobile repairs, and insurance, are non-reimbursable. The reimbursement of such expenses incurred from the use of personal vehicles for official business purposes is expected to be covered by the auto allowance or mileage reimbursement.

~~4.3.2~~

4.3.3 To the extent that the auto allowance or mileage reimbursement is insufficient to cover the necessary expenses incurred by the employees' use of personal vehicles for official business purposes, employees are to

immediately advise their supervisor and their HRBP so that further review may be conducted to ensure that employees are being appropriately reimbursed for such expenses.

4.4 Driver's License and Insurance

~~4.4~~

4.4.1 All employees using their personal vehicles for official business purposes must maintain valid driver's licenses and ~~appropriate~~ automobile insurance.

~~4.4.1~~

4.4.2 Employees must sign the "Professional License, Automobile License and Liability Insurance Certification" form. Their ~~acknowledging their~~ responsibility is to maintain valid driver's licenses and ~~appropriate~~ automobile insurance for as long as the employee is in a position that requires the employee to drive for official business purposes, as well as the requirement to advise their supervisors of any change in status, including but not limited to the lapse or revocation of either.

~~4.4.2~~

4.4.3 Employees must sign the "Professional License, Automobile License and Liability Insurance Certification" form when hired and/or prior to use of personal vehicles for official business purposes. Employees may also be required to re-sign the "Professional License, Automobile License and Liability Insurance Certification" form to reaffirm this acknowledgement from time to time.

4.5 ~~Concur~~ Travel Reimbursement System

~~4.5~~

4.5.1 The ~~Concur~~t~~T~~ravel r~~R~~eimbursement s~~S~~ystem is used to log information related to employees' use of personal vehicles for official business purposes.

~~4.5.1~~

4.5.2 Employees must log all mileage for official business purposes.

~~4.5.2~~

4.5.3 Employees must also retain all receipts for any reimbursement requested related to driving for official business purposes, such as toll road receipts and receipts for parking fees. Employees must submit such receipts upon request.

~~4.5.3~~

4.5.4 Employees must obtain their supervisor's approval prior to submitting such receipts to Accounts Payable.

4.6 Property damages to an employees' personal vehicle incurred without fault or cause on the part of the employees while using their personal vehicle while on official business may be compensated for up to $1,000.00 or the amount of the employees' insurance deductible, whichever is the lesser amount. This requires approval from Human Resources.

5.0 MONITORING:

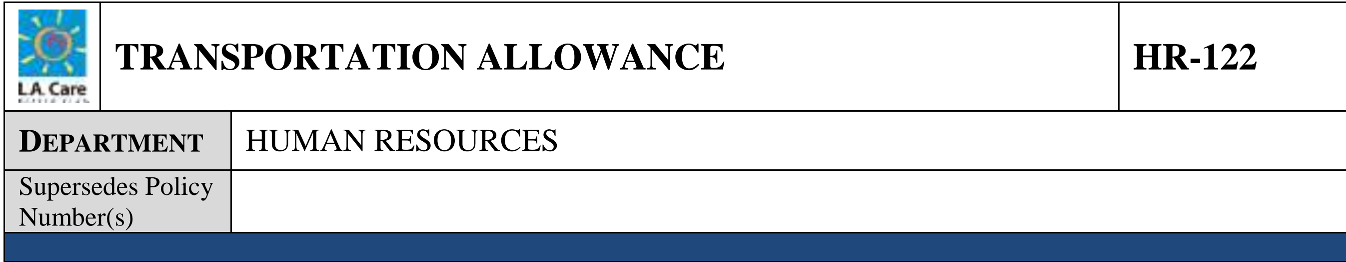
5.1 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy

~~5.1 Human Resources reviews its policies routinely to ensure that they are updated appropriately and has processes in place to ensure that the appropriate required steps are taken under this policy.~~

6.0 <u>REPORTING</u>:

6.1 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.



	TRANSPORTATION ALLOWANCE	**HR-122**
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)		

DATES					
Effective Date	~~11/16/2011~~11/16/2011	Review Date	Click here to enter a date.	Next Annual Review Date	Click here to enter a date.
Legal Review Date	12/26/2023	Committee Review Date	Click here to enter a date.		

LINES OF BUSINESS			
☐ Cal MediConnect	☐ L.A. Care Covered	☐ L.A. Care Covered Direct	☐ MCLA
☐ PASC-SEIU Plan	☒ Internal Operations		

DELEGATED ENTITIES / EXTERNAL APPLICABILITY			
☐ PP – Mandated	☐ PP – Non-Mandated	☐ PPGs/IPA	☐ Hospitals
☐ Specialty Health Plans	☐ Directly Contracted Providers	☐ Ancillaries	☐ Other External Entities

ACCOUNTABILITY MATRIX			

ATTACHMENTS

- Transportation Allowance Form for 1055 W. 7th Street
- Transportation Allowance Form for ~~the Garland Center~~1200 W. 7th Street
- Standard Parking Access Card Request Parking Regulations for ~~Headquarters~~ 1055 and ~~Garland Center~~1200 buildings

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, Human Resources Total Rewards

AUTHORITIES
➢ HR-501 Executive Committee of the Board: HR Roles and Responsibilities ➢ California Welfare & Institutions Code Section 14087.9605.

REFERENCES
➢ HR-126 Parking Policy ➢ HR-220 Telecommuting (Work from Home) Policy

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
March 2014	Revision
3/28/2018	Revision – eligible employees updated and defined.
8/26/2019	Review
7/30/202010/31/2023	Removed "tokens" and "annual TAP pass; changed Reporting and Monitoring sections with standard verbiage

DEFINITIONS
Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures

1.0 OVERVIEW:

1.1 To identify the rules and regulations related to the receipt of L.A. Care Health Plan's (L.A. Care) monthly transportation allowance to offset the cost of subsidized parking, MTA purchase, Metrolink passes or assist with other modes of transportation selected by the Eligible Employee to get to and/or from work.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Eligible Employees -** Employees in positions classified as "regular" or "assignment with limited duration" (ALD) who are scheduled to work 30 hours or more per week.

3.0 POLICY:

3.1 L.A. Care will provide a monthly transportation allowance to all Eligible Employees for use to offset the cost of on-site parking, the cost of public transportation or cost of arriving to work under other eligible means.

3.1.1 Telecommuters who work from home at least three days per week or receive airfare reimbursement are not eligible for the transportation allowance.

3.1.2 Interns, per diem employees and all temporary staff are not eligible for the transportation allowance.

3.2 Each Eligible Employee will receive the same amount of monthly transportation allowance which will be prorated based on hire or re-hire date.

3.3 Human Resources will purchase monthly MTA, Foothill, Commuter Express, LADOT, ~~tokens~~ or Metrolink passes at the request of the Eligible Employees. ~~This includes the purchase of the annual Tap card related to MTA travel.~~

3.4 Eligible Employees will be given the option to have the cost of their monthly MTA, Foothill, Commuter Express LADOT, ~~tokens,~~ Metrolink pass ~~or their annual TAP Pass,~~ or their on-site parking cost deducted from their pay as pre-taxed dollars, up to allowable amount, during the month of the occurrence.

3.5 Eligible Employees who select on-site parking as an option, may park in any unreserved or tandem (not available at the ~~Garland~~ 1200 building) parking space on a first-come first-served basis, determined by their monthly parking fee.

3.6 Eligible Employees who select on-site parking will be held accountable to the rules and regulations established by the parking vendor. Violation of any on-site parking rules or regulations could result in loss of parking privileges. ~~as stated in Parking policy (HR-126).~~.

4.0 PROCEDURES:

At the time of hire or re-hire during the on-boarding process, each Eligible Employee will be asked to identify his/her mode of transportation to and from work. At that time, the Human Resources staff will assist the employee in identifying alternative eligible modes of public transportation.

4.1

4.2 Each Eligible Employee will be given the opportunity to sign-up for the monthly purchase of MTA, Foothill, Commuter Express, LADOT, ~~tokens~~ or Metrolink pass ~~or the annual TAP pass~~ through Human Resources. If this option is selected, the Eligible Employee will then be asked to submit either the Electronic Monthly Metro Pass Authorization Form or the Monthly Mobile Metrolink Authorization Form to Human Resources authorizing L.A. Care to deduct the cost of the monthly from the employees' paycheck during the month(s) in which the occurrence occurs

~~**4.1** If this option is selected, the Eligible Employee will then be asked to send an email to Human Resources authorizing L.A. Care to deduct the cost of the monthly or annual pass from the employees' paycheck during the month(s) in which the occurrence occurs.~~

~~**4.2**~~**4.3** If the Eligible Employee wishes to park on-site, the employee will be provided a parking card. There will be a ~~minimum $10.00~~ non-refundable deposit for the parking card.

5.0 MONITORING:

5.1 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy.

~~**5.1** A report is ran monthly by the Supervisor, HR Support Services showing all employees who are eligible for the transportation allowance. A separate report is ran monthly one week prior to the first pay period of the month by the Employee Relations Representative showing all telecommuting staff who are eligible for the transportation allowance.~~

6.0 REPORTING:

6.1 Any suspected violation of this policy should be reported to your Human Resources Business Partner or the Human Resources Department~~.~~

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

Parking Form/Transportation Allowance Program

(Submit Completed Form to the **Facilities Services** Department)

Name: ________ Employee I.D. #: ________ (Please print) Date: ________

L.A. Care Health Plan provides a variety of commute options and subsidies for its employees. I understand I will receive a transportation allowance of $46.15/per pay check, taxes applied to use to help defray my transportation expenses, or for any other reason I choose. Temporary employees on L.A. Care payroll are not eligible to receive the transportation allowance, but can participate in the parking payroll deduction (Policy # 305 Employment Status).

Once you have decided on your transportation choice, please complete this form below.

Please check one of the following Transportation Allowance Options (**L.A. CARE Employees Only**):

☐ **Single Parking (HQ) - 1055 W. 7th Street, Los Angeles, CA 90017** ☐ **Cancellation (HQ)**

I will drive to work alone and will park at the 1055 W. 7th Street. I understand I will be charged $99.23/per pay check, pre-tax for as long as I have a parking card, in pay period increments. **Parking Card Issued:** I authorize a one-time payroll deduction of $10.00 as a non-refundable fee for the parking card I am receiving. I understand that if I lose the card I must pay a $10.00 replacement fee.
Parking Card #: ________

☐ **Tandem Parking (HQ) - 1055 W. 7th Street, Los Angeles, CA 90017** ☐ **Cancellation (HQ)**

I will drive to work alone and will park at the 1055 W. 7th Street in a designated parking space shared with another L.A. Care employee through mutual agreement. I understand I will be charged $73.85/per pay check, pre-tax for as long as I have a parking card, in pay period increments. **Parking Card Issued:** I authorize a one-time payroll deduction of $10.00 as a non-refundable fee for the parking card I am receiving. I understand that if I lose the card I must pay a $10.00 replacement fee.
Parking Card #: ________ ________
Name (please print) of other tandem space employee

☐ **Carpool (HQ) - 1055 W. 7th Street, Los Angeles, CA 90017** ☐ **Cancellation (HQ)**

I will carpool to work with other L.A. Care employee(s), allowing me to be eligible to park in the building's parking garage, if a card is available. I understand I will be charged $73.85*/per pay check, pre-tax for as long as I have a parking card, in pay period increments. *I certify that the carpool participant(s) named below are accurate and I will notify Facilities Services immediately should a change occur. *per person*
Parking Card #: ________ ________
Name (please print) of other carpooler

☐ **Single Parking (Garland) - 1200 W 7th St, Los Angeles, CA 90017** ☐ **Cancellation (Garland)**

I will drive to work alone and will park at Garland Center Building which is located at 1200 W. 7th Street, Los Angeles, CA 90017. I understand I will be charged $79.25/per pay check, pre-tax for as long as I have a parking card, in pay period increments. **Parking Card Issued:** I authorize a one-time payroll deduction of $25.00 as a non-refundable fee for the parking card I am receiving. I understand that if I lose the card I must pay a $25.00 replacement fee.
Parking Card #: ________

I authorize L.A. Care to initiate a payroll deduction for a non-refundable parking card fee and the recurring parking charges as selected in this form. I understand that there will be no changes or cancellations for the first 3 months after selecting or changing my parking election. I understand the terms of the L.A. Care Transportation Allowance Program and the parking garage rules & regulations. After 3 months if I want to change my current parking arrangement, I will complete another parking form indicating my change and submit it to the Facilities Services Department in a timely manner.

________ ________
Employee Signature Date

1055 W. 7th Street

Phone (213)624-8280 Fax (213)624-3824

ACCESS CARD REQUEST/CHANGE FORM

TYPE OF REQUEST: (check one)

- ☐ New ($10.00 fee required)non-refundable
- ☐ Change on Existing Card
- ☐ Termination
- ☐ Replacement/Lost Card ($10.00) Charge
- ☐ (Other),(lost card)

CARDHOLDER INFORMATION:

Name

Company Name

Address

Suite Number   Phone #

OFFICE USE ONLY

Access Card No.

Account #

Monthly Rate

Effective Date

VEHICLE INFORMATION:

	Make/Model	Year	Color	License Plate
Vehicle 1				
Vehicle 2				
Vehicle 3				

Parking Agreement – This contract limits our liability. Please read it.

1. Parking space is rented on a calendar month basis, running from the first through the last day of the month. The monthly rental is payable on (1) month in advance. It is due and payable on the first day of the month and must be paid not later than five (5) days after due date. Failure to do so will automatically cancel this Agreement, the card will be de-activated and the customer will be charged the prevailing daily parking rate. No deductions or allowances from monthly rate will be made for days customer does not use parking facility. **INT:**
2. SP Plus (SP+) and Jamison Services are offering parking spaces for rent and thus is a park and lock location only during hours of operation posted at this location. Vehicles left during unattended times are left at customer's own risk. Customer agrees to hold SP+ harmless as SP+ is renting space only and no bailment is created. SP+ is not liable for damage to or theft of vehicle under any circumstances at any time. **INT:**
3. In both self-park and attendant parking areas, the customer agrees not to leave articles of personal property of any value in the vehicle, and specifically agrees not to hold SP+ and Jamison Services responsible for any damages resulting from the loss of or damage to said articles of personal property left in vehicle in violation of this Agreement. **INT:**
4. When an entry card (one card per contracted vehicle parked) is supplied by SP+, card shall be used to enter and exit automatic-system-equipped facilities. Prevailing daily rate will be charged vehicle operator if key card is not used as directed. Any attempt at manipulation of monthly parking procedures will result in cancellation of monthly parking privileges and charging of daily rate. Access key cards are not transferable. All access cards are the property of SP+. Whenever you are no longer parker at the facility, it is your responsibility to return the card to the Parking Office or the Building Office. **INT:**
5. All Claimed damage or loss must be reported and itemized by customer to location staff and be recorded in writing before vehicle is taken from the facility. **INT:**
6. Customer's information must be kept current at all time. **INT:**
7. A $10.00 charge will be imposed for replacement of any lost, stolen, or damaged cards. **INT:**
8. Location Supervisor or attendants are not authorized to make or allow any exceptions to this Agreement and operating regulations.
9. SP+ may terminate this agreement upon 15-day notice to the customer, posted at location.
10. A 10% late fee will be applied if payment is not received by the 5th of the Month. **INT:**
11. No overnight parking. Vehicles must be moved daily unless overnight parking is approved in writing with the parking office. **INT:**
12. Each vehicle must park in one space only. Stalls that are marked "compact" are for compact cars only (SUV's, vans and trucks are considered as non-compact vehicle. **INT:**
13. Vehicles parked in this garage must be in good working order, drivable, and display valid registration. No leaking fluids, broken glass, protruding objects. Clean-up of any hazardous materials may be charged back to vehicle owner. **INT:**
14. Customer agrees to abide by the rules and regulations as established from time to time.
15. NO CAR STORAGE. VIOLATORS WILL BE TOWED AT THEIR OWN EXPENSE. **INT:**

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE TERMS AND CONDITIONS.

YOU MUST SIGN THIS FORM OR YOUR APPLICATION WILL NOT BE PROCESSED

By: Customer Signature   Office Manager Authorized Signature

Date: **Date:**

1200 WEST SEVENTH STREET

MONTHLY PARKING APPLICATION

1200 West 7th Street, Los Angeles CA 90017

OFFICE USE ONLY

LOT NUMBER	2256	NEW		ADD		EFFECTIVE DATE	
INDIVIDUAL		COMPANY		BOTH		CANCELLATION DATE	

APPLICANTS INFORMATION

FIRST NAME	LAST NAME	COMPANY NAME
		L.A. Care Health Plan
BILLING ADDRESS 1200 West 7th Street, LA CA 90017		BUSINESS PHONE
SUITE #	KEY CARD # 2501	CONTACT NAME

VEHICLE INFORMATION

MAKE	MODEL	YEAR	COLOR	LICENSE PLATE #

Supervisor Approval: *Regina Black*	Date:

IF TAX EXEMPT, INDICATE TAX EXEMPT NUMBER:

THIS CONTRACT LIMITS OUR LIABILITY - PLEASE READ IT CAREFULLY

The undersigned ("licensee") is hereby given the right to park the automobile or alternate vehicle identified above at the location desired. This license is personal to licensee and is not transferable. This license is applicable only to the automobile or alternate vehicle identified above and permits the parking of only one automobile at any given time.

Licensee parks and locks his or her own vehicle. Therefore, neither 1200 W. 7th Street, Los Angeles CA 90017, **HRRP Garland, LLC, Rising Realty Partners, LP, BREF V SERIES B, LLC** nor **PCA Management** collectively, ("licensor") shall be responsible for fire, theft, damage to or loss of such automobile or any articles left therein.

Licensee agrees to indemnify and hold harmless licensor for any liability or damage resulting from mechanical failure, including the failure to securely close automobile doors and to activate brakes properly.

Licensee acknowledges and agrees that all of the notice requirements set forth in Civil Code Section 1630 have been complied with and such of said requirements which have not been complied with by licensor are hereby waived by licensee since licensee is aware of them. Licensee hereby waives all claims, demands and causes of action arising from the exercise of license hereby granted and relieves licensor of all liability for damages to his or her vehicle or person arising from the exercise of license hereby granted.

Licensee shall pay a monthly basis at the prevailing rate charge, which shall be paid monthly, on the first day of each calendar year. If licensee does not pay the fees due hereunder on the due date, a 10 % late fee will be apply and licensor may immediately cancel all rights hereunder.

If neither party hereto notifies the other in writing prior to the end of any monthly term, this agreement shall be automatically renewed at the end of such term for an additional monthly period at the same charge and subject to the same terms contained herein. Any unearned license fees shall be repaid to licensee upon termination. Licensor shall have the right to increase the license fee payable hereunder by giving written notice prior to the end of any monthly term.

Licensee's signature below certifies that he or she had read the above, has received a copy of the rules and regulations relating to parking at garage use and agrees to comply with the same as amended or modified from time to time. Licensee understands that failure to comply with the rules and regulations may result in withdrawal of this license to park on licensor's private property and hereby authorizes licensor to tow away licensee's vehicle if parked in violation of the provisions of this license or the rules and regulations. Licensee agrees that licensor may revise the rules and regulations from time to time.

A $25.00 fee non-refundable is required for all new activation keycards and for the replacement of lost or damaged keycards.

APPLICANTS SIGNATURE	DATE	APPROVED BY
		Javier Matute

THIS FORM MUST BE SIGNED PRIOR TO ISSUANCE OF PERMIT TO PARK

Please email this form to javier.matute@risingrp.com or return it to the parking office