BOARD OF GOVERNORS

Executive Committee Meeting

March 26, 2025 • 2:00 PM

Lobby Conference Room 100

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

L.A. Care offices have moved to 1200 W. 7th Street, Los Angeles, CA 90017.
Public meetings will continue to be held in the Board Room at 1055 W. 7th Street.

DRAFT

AGENDA

Executive Committee Meeting
Board of Governors

Wednesday, March 26, 2025, 2:00 P.M.
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 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=m2887cac61bb32f7b6b632ebc863c663c
To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number 2488 643 5882 Password: lacare

Teleconference Site
Ilan Shapiro, MD
Hyatt Place Houston, 1114 Texas Avenue
Houston, TX 77002

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.
The process for public comment is evolving and may change at future meetings.
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
1.	Approve today's Agenda	*Chair*
2.	Public Comment *(Please read instructions above.)*	*Chair*
3.	Approve the January 22, 2025 Meeting Minutes p.5	*Chair*
4.	Chairperson's Report	*Chair*
5.	Chief Executive Officer Report	Martha Santana-Chin *Chief Executive Officer*
	• Government Affairs Update	Cherie Compartore *Senior Directors, Government Affairs*
Committee Issues		
6.	Consider Board Officer nominations	*Chair*

7. Ratify executed Amendment No. 58 to the Plan Partner Services Agreement between L.A. Care and Blue Shield Promise Health Plan which updates the 2022 National Committee for Quality Assurance (NCQA) delegation standards **(EXE 100)** p.27 — Shirley Perez, *Project Manager III, Accreditation, Quality Improvement*

8. Human Resources Policies HR-203 (Attendance and Punctuality), HR-216 (Recording of Time), and HR-229 (Workplace Bullying) **(EXE A)** p.114 — Terry Brown, *Chief Human Resources Officer*

9. Approve Consent Agenda Items for April 3, 2025 Board of Governors Meeting — *Chair*
   - March 6, 2025 Board of Governors Meeting Minutes
   - Ratify executed Amendment No. 58 to the Plan Partner Services Agreement between L.A. Care and Blue Shield Promise Health Plan which updates the 2022 National Committee for Quality Assurance (NCQA) delegation standards
   - Approve Regional Advisory Community Committees (RCACs) membership

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

ADJOURN TO CLOSED SESSION (Est. time: 40 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: *March 2027*

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

13. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant Exposure (3 cases)
Pursuant to paragraph 2 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act

14. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
Department of Health Care Services (Case No. Unavailable)

15. THREAT TO PUBLIC SERVICES OR FACILITIES
Government Code Section 54957
Consultation with: Acacia Reed, *Chief Operating Officer*, Noah Paley, *Chief of Staff*, Terry Brown, *Chief Human Resources Officer*

16. THREAT TO PUBLIC SERVICES OR FACILITIES
Government Code Section 54957
Consultation with: Terry Brown, *Chief Human Resources Officer*, Augustavia J. Haydel, Esq., *General Counsel*

17. 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

18. 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: Martha Santana-Chin

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

The next Committee meeting is scheduled on Wednesday, April 23, 2025 at 2:00 p.m.
and may be conducted as a teleconference meeting.
The order of items appearing on the agenda may change during the meeting.

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.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:

1. At L.A. CARE'S Website: http://www.lacare.org/about-us/public-meetings/board-meetings
2. L.A. Care's Reception Area, Lobby, at 1055 W. 7th Street, Los Angeles, CA 90017, or
3. by email request to BoardServices@lacare.org

Any documents distributed to a majority of the Committee Members regarding any agenda item for an open session after the agenda and meeting materials have been posted will be available for public inspection by email request 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 – January 22, 2025
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

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

**Absent*

Management/Staff
Martha Santana-Chin, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Alex Li, MD, *Chief Health Equity 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 at 2:17 pm the regular and supplemental special meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee. The meetings were held simultaneously. He welcomed everyone to the meetings and wished everyone a Happy New Year. He hopes that everybody is safe given what has happened over the past few weeks because of the fires, affecting your families, friends, and neighborhoods. He invited everyone to keep in their thoughts those that are affected and hope for a speedy resolution to the difficult situations in which they find themselves. He welcomed Martha Santana-Chin, *Chief Executive Officer*, to her first meeting of the L.A. Care Board of Governor's Executive Committee. He thanked her for joining L.A. Care to take on the CEO role, especially at this time. Ms. Santana-Chin commented that it's a pleasure to be here and she thanked Board Members for offering support in a variety of different ways. Going into this role, she knew she would be working with an awesome team, and they are going into the year ready to tackle it. Chairperson Ballesteros thanked the executive team of L.A. Care for their hard work over the past year. The new year has already started out very tough and there is much to be done this year. There is an awesome leadership team at L.A. Care. If there is any team that is going to get L.A. Care through the year, it will be this team. The Board has	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	full confidence in and is happy to have this team, especially at times like this. He wanted to say up front in the meeting that he was thinking a lot about them the past few weeks and knows that they have given everything, and particularly during the fire emergency. He knows they worked long hours to be available because there was a lot going on in our communities with our members. People need L.A. Care. He noted that their work is seen and is appreciated. Some of the best people work in this organization, and he is so happy to be a board member with L.A. Care. He provided information on how to submit public comments.	
APPROVE MEETING AGENDA	The agenda for today's meeting was approved.	**Approved unanimously.** **5 AYES (Ballesteros, Booth, Raffoul, Roybal, and Shapiro)**
PUBLIC COMMENT	There was no public comment.	
APPROVE MEETING MINUTES	The minutes of the November 20, 2024 meeting were approved.	**Approved unanimously.** **5 AYES**
CHAIRPERSON'S REPORT • Discuss the ad hoc Nomination Committee to carry out the process for nominating a member to the L.A. Care Board.	Chairperson Ballesteros noted that one Board seat is appointed by the L.A. Care Board of Governors. The Board will look for individuals that fit the criteria the Board is looking for. He suggested forming an ad hoc committee to find interested individuals. Applicants will be sought, and the committee will decide which individual to recommend for nomination to the Board. In 2014, there was an ad hoc nominating committee of five individuals representing members, Los Angeles County Department of Health Services, health centers, clinics and other stakeholder groups. He recommended that the Board proceed in the same way. He will recommend to the Board on February 6 to establish an ad hoc nominating committee to carry out the process for nominating a member to the L.A. Care Board. No board vote would be needed. The ad hoc committee and nominating process would be reviewed regularly with the Board. He asked for input on the members to invite to the ad hoc nominating committee so he could inform the Board who the Committee members will be. Once the ad hoc committee members have been recruited, the ad hoc committee will meet to determine the 2025 process. Board Services will support the ad hoc nominating committee through the process.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In response to a question about the number of meetings, Chairperson Ballesteros responded it will meet to determine a process and when applicants have been gathered, a meeting would be held to review the applicants and determine a recommended nominee. The committee is going to identify a person based on the interests defined by the Board. He emphasized that it will be very important that Board Members are comfortable with the process. Board Member Shapiro noted that the committee process is a good way to proceed. Chairperson Ballesteros asked about existing criteria for the seat. Augustavia Haydel, *General Counsel,* responded that there is a description, and the committee could develop more detail. Board Member Shapiro suggested that a nominee have experience in legislative affairs and advocacy. L.A. Care will continue to need that type of experience. Ms. Santana-Chin suggested that the process include a set of criteria recommendations from staff for the Board to consider in determining the profile. Ms. Haydel indicated that there is no limitation on the CEO's participation in making recommendations to the Board about how they want to move forward to determine a nominee for the Board seat. The Board could establish an ad hoc committee to make a recommendation about how that process should go forward. Board Member Raffoul suggested it would be helpful to have information about Mr. De La Torre's background in developing the criteria for a nominee. Board Member Roybal suggested gathering input from prior board members who participated in the process in 2014. If the Board members have no objection, the Board could delegate to the Chairperson the authority to establish the ad hoc. The Board can then provide support, including receiving recommendations from staff and the CEO. It could be the discretion of the ad hoc committee to reach out for additional information.	
CHIEF EXECUTIVE OFFICER'S REPORT • Fire Disaster Response and Recovery Support Efforts	Ms. Santana-Chin thanked the Chairperson and Committee members. When she joined L.A. Care on January 6, the entire team had very big plans to strengthen the core operations, deliver meaningful value to L.A. Care members and the communities that it serves and prepare to advocate to protect the advances that were made in coverage and addressing whole person care considering the new federal administration and its new agenda. A couple of days later unfortunately all attention shifted to responding to the wildfires. The wildfires forced evacuation of more than 200,000 people from their homes, impacted close to 59,000 L.A. Care members and 237 of L.A. Care employees. 12,000	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	structures were destroyed and tragically more than 25 lives lost as of today. The significant magnitude of the emergency is felt very deeply in the community, and it will take a significant time to recover. She is grateful for the L.A. Care team and how they showed up in that moment. They took time to make the best of the crisis to strengthen the response and testing the business continuity plan, mobilizing the teams to support the members and providers in the community. • The website was updated with emergency contact information, ensuring continuity of care by suspending prescription refill limitations across lines of business, enabling access to out-of-network providers, and replacing medical equipment. By engaging with the CalAIM network through Enhanced Care Management and Community Supports, L.A. Care served the highest risk members. Special efforts have been made to connect with the most vulnerable, including proactive outreach, transportation for evacuations and medical appointments, and behavioral health support. Additionally, L.A. Care is addressing the long-term public health concerns associated with wildfires, such as increased respiratory and mental health challenges. Studies have shown a 30% rise in respiratory illnesses with a heightened demand for mental health services following major wildfire events and L.A. Care is preparing to meet this challenge moving forward. Extensive work was done to conduct outreach to individuals that had mobility issues, were homebound or were classified as high risk for other reasons. L.A. Care made sure that they knew what to do with the evacuation orders, that they had access to medical appointments as several provider sites were impacted and provided access to behavioral health and other support. L.A. Care will continue to support members with resources to address respiratory issues, mental health and other needs that arise up because of the trauma that communities are facing. She is proud to share that members were cared for, including members that had to be transitioned from a facility. People continued to get prescriptions and durable medical equipment. L.A. Care maintained compliance through the process. L.A. Care is continuing to be vigilant and diligent about support. • L.A. Care employees were also impacted. Emergency communication channels were activated with employees through text messaging and email to make sure L.A. Care's	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	leadership knew where employees were, that they were safe, and the extent that they needed support of any kind. The team very quickly mobilized to allow for flexible work arrangements for impacted individuals, ensuring that they were connected with employee assistance programs and providing direct support for employees who lost their home. • The provider network team did a phenomenal job in partnership with Health Services in working with Los Angeles County and others, connecting with all the providers that are actively caring for members to understand any disruption in services and access to care, offering logistical and other support, and making sure that resources were available to continue to serve members. One thing that the hospitals had specifically reached out to L.A. Care very quickly was about suspending authorization requirements for individuals that were in the process of discharge. Those flexibilities remain in place and will continue. L.A. Care is continuing to partner with physicians and other providers including nursing facilities, trying to understand what it will take to fully recover. • L.A. Care assessed service availability, offered logistical and financial support, and allocated critical resources to address staffing shortages and supply needs. Authorization requirements for hospital discharge services were suspended to streamline care delivery. • In collaboration with Blue Shield Promise, Community Resource Centers were opened to provide protective masks and other resources for the entire community, not just L.A. Care members. In partnership with the Center of Hope Church, L.A. Care is accepting essential item donations at the Community Resource Centers, with donations routed to fire relief organizations. Field medicine teams were enlisted to support unhoused individuals. • L.A. Care ensured operations were strong and would continue to operate should the business continuity plan be activated. Emergency communication channels were activated to provide timely updates and resources. Flexible work arrangements, financial support, and counseling services were offered through the Employee Assistance Program (EAP). Direct support was provided to employees who lost homes. With these actions, the L.A. Care team was able to maintain timely processing of prior authorizations and thorough care coordination with the provider network. She is very proud of the way the team came together. She noted that for her personally coming into a new organization, there is nothing like a crisis to appreciate how the	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	leadership team comes together and how the entire organization rallies to make sure that it continues to be of service. She is grateful for the opportunity to witness that firsthand. L.A. Care maintains open lines of communication with the state regulators, with Los Angeles County agencies, community-based organizations, and disaster relief partners to make sure to address needs that arise, as opposed to duplicating efforts. It will take a long time to recover. Advocacy and policy will be a critical focus. L.A. Care has a strategic planning session with the Local Health Plans of California, an association of similar health plans. California Health & Human Services Secretary Kim Johnson will join to allow health plans to speak about the experience in Los Angeles County and appeal for ongoing and sustained support. Some requests will include asking her to be alert for requests for additional flexibility and recognize when setting rates, the events happening now will have consequences in the near and distant future. The policy for rate setting must be sound and take this disaster into account. Ms. Santana-Chin will continue to update Board members. She invited chief officers to add their comments. Sameer Amin, *Chief Medical Officer*, commented that was a great list of activities. He noted there has been talk about the physical health concerns with the members in the areas that have been evacuated. There was also a significant mental health toll. L.A. Care has begun activating behavioral health outreach, including disaster management protocols, such as no additional cost sharing for out of network services and behavioral health facilities. L.A. Care has waived prior authorization requirements for behavioral health and extended claims filing deadlines. A countywide crisis support line was opened, shared with Pasadena Public Health. School based telehealth offerings have expanded for counseling and urgent care needs across impacted school districts including Los Angeles Unified School District (LAUSD) and Pasadena USD. A call center *frequently asked questions* was developed along with protocol to help ensure continuity of home-based autism treatment for displaced families. Health Services worked with communications staff to disseminate wildfire information on lacare.org. The emergency affected not just physical health, also mental health. With the pandemic and the housing crisis in Los Angeles County, the County and City agencies have been through a lot. L.A. Care needs to serve mental health needs. Board Member Shapiro commented that he has heard amazing things from L.A. Care's CEO and CMO. He thinks that the communications department should take note of it	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	and should disseminate information about the efforts. L.A. Care is a silent witness of all these things and is doing the good life changing work. From providing autism treatment directly at home for the displaced to supporting providers. It should be highlighted. Few health plans are doing that work, along with outreach and everything else. This is the moment to make sure this important work is communicated, a reflection of the things that L.A. Care is already doing. Noah Paley, *Chief of Staff,* responded that just before he walked in today, he reviewed a list of items to be communicated on the website and through direct communications. The communications team is also aware of the motions to be discussed with this committee later in this meeting. He thanked Ms. Santana-Chin and Dr. Amin for doing a great job surveying the efforts that L.A. Care is undertaking. He added, as Ms. Santana-Chin said, this will be a sustained effort, and that is why the motions will be presented later. It will include an evaluation of L.A. Care's readiness to contribute to the total effort to rebuild and restore what has been devastated by the wildfires.	
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: President Trump issued a host of executive orders, proclamations, and other documents on his first day in office. Staff is currently reviewing the details and will coordinate with state and national trade associations and reach out to congressional offices. There will be more clarity in the coming days and a more detailed discussion will be prepared for the February 6 Board meeting. Ms. Compartore provided high level information about the potential impact on L.A. Care's members in the Los Angeles community. She will not cover the effect of every executive order, just some of the key ones. About Covered California (also referred to as the marketplace), the President reversed President Biden's executive order that encouraged states to extend open enrollment periods and protect people with pre-existing conditions. President Trump did not mention elimination of subsidies. Going back in time, L.A. Care worked at the state level where protections were included in state law, such as no pre-existing conditions and the individual mandate. California does have some subsidies, whether those will be included in the State budget remains to be seen. Some of those protections will protect the marketplace to some degree, according to legal analysis. There was not a significant mention of Medicaid in the executive orders, but that's because the Trump administration has ideas in place already. They will be going through existing regulations	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	as well as the final rule on enrollment and eligibility. There will likely be proposals around for block grants or per capita grants. There may be a reduction in the federal match, which is 50% in California, to no more than 40%, adding work requirements, increasing enrollment hurdles such as eliminating continuous eligibility or scaling back for those states that did not go forward with Medicaid expansion. It is not known what could be done regarding Medicaid. The magnitude of the Medicaid proposals could be significant. It should be remembered that in the US Congress, the House of Representatives clearly could have the votes to do some of the more restrictive cuts while it remains to be seen whether the Senate could pass something. It is hoped that the Republicans that depend on Medicaid expansion will not enact cuts. Some states depend on the marketplace and would not want to repeal the Affordable Care Act (ACA). It is hoped that will influence proposed legislation. L.A. Care Government Affairs staff is engaging with members of the US Congress and will travel to Washington, DC soon. There will be meetings with a member in Energy and Commerce, as well as Immigration areas. Staff can also reach out to high level committee members as well as the Los Angeles Congressional delegation. As expected, the President is making major changes to US immigration policy. A plan was announced yesterday to revoke birthright citizenship for children born to unauthorized immigrants. He declared a national emergency and ordered military deployments to the southern border and is restating previous policies like requiring the asylum seekers to remain in Mexico while the cases are being processed. As is understandable, the immigrant community is incredibly alarmed. In California, the fear of deportation roundups is growing, adding to anxiety that many already feel. California joined a coalition with 18 other states and filed a lawsuit yesterday against the Trump administration arguing that ending birthright citizenship is a violation of the 14th amendment of the US Constitution. During the previous Trump administration, California filed or joined over 100 lawsuits, with 25 of those lawsuits in healthcare, immigration and LGBTQ areas. Of those 25 lawsuits, 15 are still pending, seven were won and three were lost. More information will be provided in the February 6 Board meeting packet. California has approved, as part of a special state legislative session, a $50 million fund to support state and local efforts addressing immigration issues. Of the $50 million, and $25 million will go to state and local defense funds. The other $25 million will be used to defend immigrants and provide information against deportation and detention.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	There were not many new proposals related to the California State Budget, because of the money needed to fight the Trump administration. A state budget summary will be provided in the Board meeting packet detailing the proposals potentially impacting L.A. Care. It is too soon to know which proposals will pass. Ms. Santana-Chin thanked Ms. Compartore for the comprehensive overview. She added that the proposed items affect things that Californians have fought for and had believed that progress was being made. L.A. Care employees, members, and communities are experiencing anxiety. One thing about the US democracy is that there are checks and balances. The execution of many proposals will take time, and the lawsuits have already started. There is a process for approving Medi-Cal changes and there will be a lot of negotiation. She would like to believe that the agenda that was put forth is a negotiation strategy, the extreme position is an anchor to negotiate to a reasonable position. For L.A. Care that means a few things. Ms. Compartore and the Government Affairs team will work in partnership with coalitions and lobbyists, and the work continues to be important and will be a priority. Communications, bringing facts to the table and make sure that the provider network, employees, and members are well informed is important. There could be chaos and people working at cross purposes. L.A. Care will work on making sure that people understand the situation and how to proceed. Leveraging coalitions will be important, because legal aid entities, along with the state and the county agencies, are already organized. L.A. Care will collaborate and add to the message with a smart workforce that knows how to support members and providers. From a communications perspective, going back to Board Member Shapiro's earlier comment, if one stays silent, others will make up the narrative. L.A. Care will focus on advocating and will have a very logical plan. She invited Board Members to provide their perspectives. Many organizations are working through similar issues and organizing, so if there is anything that L.A. Care should consider, please share it with Ms. Compartore, Mr. Paley, and her. Board Member Shapiro noted that coalition building will be interesting, and he suggested organizations that could be non-traditional partners, the American Academy of Pediatrics and the National Association for Community Health Centers (NACHC). Those are top of mind because they align with the idea of Medicaid and Medi-Cal as an important part of L.A. Care activities. In two weeks NACHC will hold the Policy & Issues Forum 2025 in Washington DC.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member Roybal noted that when they tried to get rid of the ACA before, Senator John McCain of Arizona was a key no vote. The attempt was made through simple majority in a reconciliation bill. Later, it was revealed that Senator McCain talked to his governor and was told the state would lose a lot of funding for rural hospitals, and those facilities would suffer. A main reason Senator McCain voted like he did, along with other reasons, was that he knew that his state would lose a lot of resources for rural areas in Arizona. In California and with the new Congress, the majority is razor thin. He suggested working on a statewide level to help educate people, and especially people who live and are represented by Republican House members, to understand the effects if those programs were diminished, taken apart or demolished. It will take a couple people in California, a couple of people nationally to vote one way or the other in the House to make a difference. He encouraged making sure to work on coalitions like that. In other counties of California, particularly rural counties with district hospitals where they are dependent on Medi-Cal and other funding streams that will be affected by any cuts that occur, the coalitions really need to help educate folks about what is going on and help them inform their representatives understand how it would affect their communities. Mr. Paley responded that it is a tremendous idea to show the state impact and to also point out not just the issues relative to revenue, but the impact on public services that will arise from certain requirements like work requirements, that will have to be administered by the states.	
COMMITTEE ISSUES		
Approve changes to regular meeting schedule of Technical Advisory Committee and Compliance & Quality Committee meetings	Ms. Haydel noted that a couple of meeting dates are rescheduled for various reasons and approval of the Board is needed to assure that these are considered regular meetings. **<u>Motion EXE 100.0225</u>** **Approval of the following changes to 2025 Board and Committee regular meeting schedules:** **1. Technical Advisory Committee January 9, 2025 meeting moved to January 30, 2025 at 2:00 PM, and** **2. Compliance & Quality Committee June 19, 2025 moved to Monday, June 16 due to Juneteenth Holiday.**	**Approved unanimously.** **5 AYES** **The Committee approved to add EXE 100.0225 to the Consent Agenda for February 6, 2025 Board of Governors meeting.**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Human Resources Policy HR 214 (Employee Conduct and Discipline)	Terry Brown, *Chief of Human Resources,* summarized a motion to approve revisions to HR 214 (Employee Conduct and Discipline). The word aggressive was removed on the advice of counsel to provide flexibility depending on the severity of a violation. The revisions to the document include updated code violations that are most likely to create an issue, as those change over time. The disciplinary process is updated so managers must include the HR business partner before disciplinary action can take effect. The structure of the document was changed a little bit. Prior to this meeting he had a conversation with Board Member Booth, and he will include clarifications that will not change the intent or meaning of the document. **<u>Motion EXE A.0125</u>** **To approve the Human Resources Policy HR-214 (Employee Conduct & Discipline), as presented.**	**Approved unanimously.** **5 AYES**
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for February 6, 2025 Board of Governors Meeting. • December 5, 2024 Board of Governors Meeting Minutes • Changes to regular schedule of Technical Advisory Committee and Compliance & Quality Committee meetings • OptumInsight, Inc. Contract Amendment to continue to support L.A. Care with post-payment Data Mining services • Delegate to Martha Santana-Chin, Chief Executive Officer, discretionary authority to approve vendors to perform capital improvements and purchase equipment to build-out floors 1, 5, 6 and 7 in the 1200 W. 7th Street Building • 2025 Compliance Work Plan • 2025 Compliance Program Plan	**Approved unanimously.** **5 AYES**
PUBLIC COMMENTS ON CLOSED SESSION ITEMS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 3:11 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:11 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: *January 2027* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LIT Significant Exposure (3 cases) Pursuant to paragraph 2 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Acacia Reed, *Chief Operating Officer,* Noah Paley, *Chief of Staff,* Terry Brown, *Chief Human Resources Officer* *From the Supplemental Special Meeting Agenda* THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Acacia Reed, *Chief Operating Officer,* Noah Paley, *Chief of Staff,* Terry Brown, *Chief Human Resources Officer, and* Augustavia Haydel, *General Counsel* CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) 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: Martha Santana-Chin	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:45 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:45 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:

_____
Álvaro Ballesteros, MBA, *Board Chairperson*
Date: _____

California Association of
Health Plans

1415 L Street, Suite 850
Sacramento, CA 95814
916.552.2910
www.calhealthplans.org

March 18, 2025

California Congressional Delegation
U.S. House of Representatives
Washington, D.C. 20515

Dear Members of the California Congressional Delegation:

The California Association of Health Plans (CAHP) is a statewide trade association representing public and private health care plans that provide coverage to more than 26 million Californians including over 14 million enrolled in Medi-Cal managed care. We are writing today to emphasize the foundational importance of the Medi-Cal program to California's health care system and to urge you to support the program and maintain its stability.

California's Medi-Cal enrollees include women, children, the aged, blind and disabled, very low income and the homeless. They depend on the support of the federal government to keep this program stable and ensure that they receive critical health care.

California's health plans organize the health care delivery system through our contracts with thousands of health care providers and hospitals that span the entirety of the state. Health plans provide coverage to individuals, employers, CalPERS, Covered California, Medicare, and Medi-Cal. We have a firsthand view of the importance of Medi-Cal to our healthcare system because we provide coverage in all 58 counties, with over 230,000 employees, in 56 different California cities and towns.

Cuts to Medi-Cal could cause millions of Californians to lose access to care, destabilize rural hospitals and the state budget. As budget legislation is considered in Congress, Medicaid should be supported and strengthened, not undermined.

Medi-Cal is crucial to low-income people and working families. If their Medi-Cal coverage is disrupted, they will lose access to primary care and be unable to fill prescriptions, many of which are necessary to treat chronic illnesses. Without the necessary health care, many will end up in emergency rooms. This will increase the amount of uncompensated care, increase the costs of care for everyone, and keep people from working.

In addition, California's rural and underserved hospitals and clinics are already under financial distress due to existing government reimbursement rates. These hospitals and clinics serve a significant Medi-Cal population, and if they buckle under additional financial stress, it will have a direct effect on the ability of Californians to access healthcare in their community. Reductions in federal support will hit these communities hardest. The hospital closure in Madera is an example of what will happen in rural communities when funding is inadequate to pay for care.

The impact of an underfunded Medi-Cal program goes beyond just poorer access to health care. The Medi-Cal program spends $188 Billion a year paying hospitals, clinics, and doctors to treat Medi-Cal patients. In fact, Medi-Cal funding supports a wide array of facilities across the state that generate well-paying jobs, economically benefiting local communities. Unfortunately, low Medi-Cal reimbursement rates for providers have led to shifting costs onto other insurance markets. This leads to increased premiums for Californians who purchase coverage through their employer or on their own. Reduced federal support will make things worse by further increasing premiums and reducing local jobs.

The Medi-Cal program is important to all Californians and its value extends to all our communities. We urge you to support the Medi-Cal Program and to oppose proposals that would destabilize it.

Sincerely,

Charles Bacchi
President and CEO
California Association of Health Plans

March 3, 2025

The Honorable Mike Crapo, Chairman, Committee on Finance, U.S. Senate
The Honorable Brett Guthrie, Chairman, Energy and Commerce Committee, U.S. House of Representatives
The Honorable Ron Wyden, Ranking Member, Committee on Finance, U.S. Senate
The Honorable Frank Pallone, Ranking Member, Energy and Commerce Committee, U.S. House of Representatives

Dear Congressional Leaders,

As a coalition of stakeholders serving individuals relying on the Medicaid and Children's Health Insurance Programs (CHIP), we write to convey the critical importance of these programs, and to encourage you to continue to strengthen both in the years to come. The flexibility, efficiency and positive impact of Medicaid in every state across the country is a hallmark of how federal-state partnerships can deliver results tailored to local needs.

As you know, Medicaid serves a broad spectrum of Americans across all walks of life, including children, mothers, the aged, blind and disabled, individuals with substance use disorder (SUD), persons with mental health conditions and mental illness, and low-income individuals, all of whom depend on the program to provide them with access to health care services and life-saving treatments.

Medicaid shines as a bright example of what can be accomplished when the Federal government works with state partners to deliver for the American people. The flexibility and accountability of the program enables efficient coverage for over 79 million individuals in 50 states and the District of Columbia, as of October 2024. The Medicaid program allows states the ability to tailor their programs to meet the needs of their unique populations, while creating efficiencies and innovations that might not be possible in other delivery systems.

With the ability to design their own programs, states have leveraged the Medicaid program to ensure access to care for our most vulnerable populations; populations that would have no other source of insurance coverage. Individuals with disabilities rely on the Medicaid program to receive long-term services and supports, both at in person nursing facilities and through home and community-based services, allowing them to find employment and serve as active members of their communities. Medicaid plays a key role in providing mental health and SUD services, as 40% of the nonelderly adult Medicaid population (13.9 million enrollees) had a mental health condition or SUD in 2020. And more than 37 million children receive health coverage through Medicaid and CHIP, representing 47.4% of overall Medicaid and CHIP program enrollment. Nearly two out of every three adult women enrolled in Medicaid are in their reproductive years, and Medicaid currently covers about 42% of all births in the United States. Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit keeps children healthy and provides them with critical behavioral health services. EPSDT is also a benefit with strong bipartisan support that was recently strengthened by the Safer Communities Act.

In addition to the vulnerable populations covered by Medicaid, it is a crucial source of coverage for many safety net facilities and the clinicians relied on by patients in these settings. Insurance coverage through Medicaid ensures that our safety net facilities, including rural hospitals, health centers, mental health centers, nursing homes, critical access hospitals, and others, remain open and can provide primary and specialty care services, as well as 24/7 emergency care, to the communities surrounding them. Without comprehensive Medicaid coverage these facilities may be forced to close, and millions of people would need to travel hundreds of miles to access a health care facility to receive necessary care from trusted clinicians.

It is vital that Medicaid and CHIP continue to receive strong support from the Federal government, so that the program can continue to serve mothers, children, the aged, blind and disabled, individuals with SUD, persons with mental health conditions and mental illness, and low-income Americans, all who depend on the program to stay healthy and to receive life-saving treatments. Interruptions in health coverage, even temporary, have been shown to lead to a deterioration of

health conditions which later leads to higher costs for payers, challenging the sustainability of the program and making it more difficult for Americans depending on Medicaid to continue to work and contribute as members of their communities. Further, reductions in Medicaid funding could lead to hospital closures and reduced access to healthcare providers in rural and underserved areas, that are already struggling to meet the needs of their populations. Medicaid and CHIP have historically received bipartisan support, and we respectfully encourage you to continue this tradition, in order to strengthen and enhance this vital program serving millions of Americans across the country.

We sincerely thank you for your consideration and remain available to work with you and your colleagues to continue to meet the needs of the American people through a flexible, accountable, and efficient Medicaid program.

Respectfully,

National
Advocates for Community Health
Alliance of Community Health Plans
Allies for Independence
American Academy of Pediatric Dentistry
American Association of Nurse Practitioners
American Association on Health and Disability
American Dental Association
American Nurses Association
Association for Community Affiliated Plans
Association of Clinicians for the Underserved (ACU)
CommunicationFIRST
Federation of American Hospitals
Institute for Exceptional Care
Lakeshore Foundation
Medicaid Health Plans of America (MHPA)
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Disability Rights Network (NDRN)
National Health Care for the Homeless Council
National MLTSS Health Plan Association
The National Council of Urban Indian Health

State
Access Living (Illinois)
Coalition of New York State Public Health Plans (New York)
Kentucky Association of Health Plans (Kentucky)
Local Health Plans of California (California)
Michigan Association of Health Plans (Michigan)
Minnesota Association of County Health Plans (Minnesota)
National Council on Independent Living (District of Columbia)
Ohio Association of Health Plans (Ohio)
Pennsylvania's Medicaid Managed Care Organizations (PAMCO) (Pennsylvania)

Medi-Cal Matters to Californians

L.A. Care HEALTH PLAN

Who Medi-Cal Covers

14.5M Californians, as well as:

39% of all births in CA

5M children (nearly half of CA's kids)

41% (4M) residents in Los Angeles County

2.3M seniors & people with disabilities (900,000 receive coverage for essential long-term services, like nursing home stays, through Medi-Cal)

*At $147,000 a year, nursing home care is unaffordable for most families without Medi-Cal.

3.4M working Californians (1 in 5 workers)

Top industries enrolled:

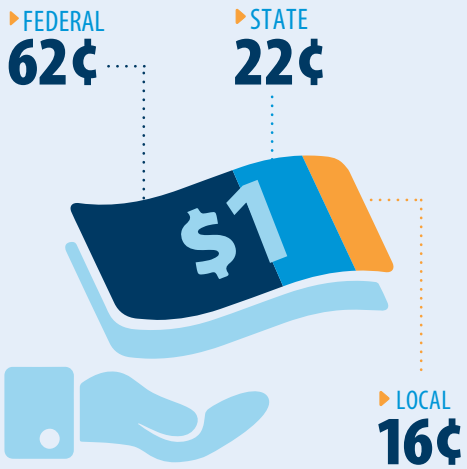
- **Agriculture** (32%)
- **Restaurants** (31%)
- **Other Services** (27%)

*Percentages show how many people in each industry depend on Medi-Cal for healthcare

What Medi-Cal Covers

- Doctor Visits & Hospital Care
- Prescription Drugs
- Mental Health & Substance Use Care
- Dentist and Eye Care
- Long-Term Care & In-Home Support
- School-based & Community Health Services
- Transportation and other Services

For every dollar that is used to fund Medi-Cal



Federal Cuts Could Cost CA $10B–$20B Each Year

- California will be forced to dramatically reduce Medi-Cal coverage, benefits, and funding
- Cuts in long-term care, mental health, & public hospital services
- Loss of healthcare for low-income adults & 2.3M seniors/disabled residents
- Cuts to school-based health support for children
- Any Medi-Cal cuts that occur have the potential to impact **ALL** Medi-Cal recipients

Medi-Cal Strengthens California's Economy

- Medicaid represents nearly **$1** out of every **$5** spent on health care in the U.S., and it helps create jobs that support critical healthcare roles. Healthcare is one of L.A. County's fastest-growing employment sectors, with over 787,300 jobs.

The bottom line is clear: a strong Medi-Cal program creates jobs, strengthens families, and fuels economic growth. Medi-Cal is essential to California's health and future.

lacare.org

DES3012 03/25

Medi-Cal es de importancia para los Californianos

L.A. Care HEALTH PLAN

¿A Quién Cubre Medi-Cal?

14.5M de californianos, incluyendo:

39% de todos los nacimientos en CA

5M de niños (casi la mitad de los niños en CA)

41% (4M) de residentes del condado de Los Ángeles

2.3M de adultos mayores y personas con discapacidades (400,000 personas viven en residencias de ancianos o reciben atención en enfermerías)

*Con un costo de $147,000 dólares al año, la atención en un hogar de ancianos resulta inaccesible para la mayoría de las familias que no tienen Medi-Cal.

3.4M de trabajadores (1 de cada 5 trabajadores)

Principales industrias:

- **Agricultura** (32%)
- **Restaurantes** (31%)
- **Otros Servicios** (27%)

*Los porcentajes muestran cuántas personas en cada industria dependen de Medi-Cal para recibir atención médica.

¿Qué Cubre Medi-Cal?

- Visitas al médico y atención hospitalaria
- Medicamentos recetados
- Tratamiento de salud mental y abuso de sustancias
- Atención dental y de la vista
- Cuidado a largo plazo y apoyo en el hogar
- Servicios de salud comunitarios y en escuelas
- Transportación y otros servicios

Por cada dolar que se usa para pagar por Medi-Cal

FEDERAL **62¢**

ESTATAL **22¢**

LOCAL **16¢**

Los Recortes Federales Podrían Costarle a California $10B–$20B Cada Año

- California se verá obligada a reducir drásticamente la cobertura, los beneficios y la financiación de Medi-Cal
- Recortes de cuidados a largo plazo, salud mental y servicios en hospitales públicos
- Pérdida de cobertura para adultos de bajos ingresos y 2.3M de adultos mayores/personas con discapacidades
- Recortes en servicios de salud escolar para niños
- Cualquier recorte de Medi-Cal que ocurra tiene el potencial de afectar a todos los beneficiarios de Medi-Cal

Medi-Cal fortalece la economía de California

- Medicaid representa casi **$1** de cada **$5** que se gastan en atención médica en EE.UU. y contribuye a la creación de empleos que respaldan funciones esenciales de atención médica. La atención médica es uno de los sectores de empleo de mayor crecimiento en el condado de Los Ángeles, con más de 787,300 empleos.

La conclusión es clara: un programa Medi-Cal sólido crea empleos, fortalece a las familias e impulsa el crecimiento económico. Medi-Cal es esencial para la salud y el futuro de California.

lacare.org

DES3012 SP 03/25

California Hospital Association

Medicaid Provider Taxes Protect Californians' Access to Care

Medicaid provider taxes are a cornerstone of the Medicaid financing structure.

Without federal revenue generated from these taxes, reimbursement for care provided to patients covered by Medicaid would be woefully insufficient and health care access would be at grave risk. For many hospitals, losing this revenue would mean closure of service lines; for others, it would threaten their viability altogether.

Cutting Medicaid means millions of Americans — regardless of what type of insurance they have — would lose access to their health care providers.

Medicaid and California's hospital tax

- In California, Medicaid pays 80 cents for each dollar spent on care; without the additional payments from the hospital tax, reimbursement would drop to just 70 cents on the dollar.
- The **federal Medicaid statute expressly authorizes provider taxes** as permissible sources of funding the nonfederal share of program expenditures, in recognition of finite state revenue sources.
- State Medicaid agencies work closely with CMS to ensure provider taxes comply with all federal requirements and CMS must approve every program year after year. California's hospital tax program has been approved for more than 10 years.
- Forty-five states rely on a form of a hospital tax. California's hospital tax program is broadly similar to states such as Indiana, Tennessee, West Virginia, Georgia, and Nebraska.
- Approximately one-third of Californians are covered by Medicaid — nearly 15 million people. Without the hospital field's ability to self-finance additional payments via the hospital tax, some 150 hospitals in California would lose money — greatly increasing the risk of service line and facility closures.
- Hospitals pay provider taxes to the state before receiving any federal funds to care for patients. This is increasingly difficult to do with more than half of hospitals in California currently losing money.

FAST FACTS ABOUT MEDICAID PROVIDER TAXES

- They are part of 49 state Medicaid programs.
- They are rigorously reviewed by the Centers for Medicare & Medicaid Services (CMS).
- They are vital to ensuring access to health care services.
- They are a financial pillar for urban and rural safety net providers.

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 ▪ Office: (202) 488-3740 ▪ FAX: (202) 488-4418

1215 K Street, Suite 700, Sacramento, CA 95814 ▪ Office: (916) 443-7401 ▪ www.calhospital.org

February 24, 2025

TO: Members of the California Congressional Delegation
RE: Protect Access to Care and Oppose Medicaid Cuts

On behalf of the undersigned organizations and the 15 million Medi-Cal (California's Medicaid program) patients we serve, we urge you to reject the severe proposed Medicaid funding cuts that would harm the care that is delivered to all Californians, not just those on Medicaid.

California's Medi-Cal program is among the most efficient and cost effective in the nation, thanks in part to the critical role of local Medi-Cal managed care plans. Adjusted for cost of living, California ranks 14th lowest in per-enrollee Medicaid spending nationwide.

Ultimately, the proposed Medicaid cuts amount to an added tax burden on all Californians, as newly uninsured patients are forced to forgo vital preventive care and instead end up in hospital emergency departments with more costly, difficult-to-treat conditions — leading to higher health care costs for everyone.

In particular, the health care of our patients – children, pregnant women, seniors, disabled individuals, veterans, and low-income working families who cannot afford insurance or are not offered it by employers will be directly impacted. Additionally, having a regular source of care that includes preventive care and treatment for chronic conditions plays an important role in family stability and productivity. Medicaid provides essential health care services, and it must be protected. Medicaid is particularly important in rural areas, where 50% of Californians would lack health care coverage without it.

With nearly 40% of Californians enrolled in Medi-Cal, California voters have made clear that we need to protect this health care coverage, and increase funding, not tear it down. In November 2024, voters overwhelmingly supported increased funding for Medi-Cal, through Proposition 35, the Protect Access to Health Care Act, which passed with 68% of the vote and strong bipartisan support.

Three-fourths of Americans have favorable views of Medicaid, including a majority of Republicans, Independents, and Democrats and a recent Hart Poll shows two-thirds of Trump voters believe Medicaid is an important source of health coverage for people who could not otherwise afford healthcare.

The proposals to reduce federal Medicaid matching funds, establish per capita caps that end the guarantee of Medicaid, and eliminate managed care organization and provider levies—

which are dedicated to health care in California—disproportionately harm California's rural and at-risk communities that rely on Medicaid. These significant cuts would shift the health care burden to physicians and other healthcare providers, may result in the closure of more hospitals and their services, along with physician/healthcare provider practices, strain community health centers that care for one third of all Medi-Cal enrollees in our state and make it more difficult for us to care for Medi-Cal patients and those who lose coverage.

California's healthcare system serves everyone. Medi-Cal, 15 million people enrolled, is a critical funding source and critical to the health and well-being of your constituents. It protects our most vulnerable by providing essential services to half of California's children. It ensures vital access to primary and preventive care, improving health outcomes and reducing overall costs by keeping people out of emergency rooms.

Medicaid cuts will hurt California disproportionately. A vote to strip funding away from California is a vote against what California voters supported when they passed Proposition 35. We urge you to protect your constituents by rejecting Medicaid cuts that threaten patient care, coverage, and California provider viability. Please protect our Medicaid program.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: March 26, 2025 **Motion No. EXE 100.0425**

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

Issue: Request to ratify the execution of an Amendment to the Plan Partner Services Agreement (PPSA) (Amendment No. 58) which incorporates the 2022 National Committee for Quality Assurance (NCQA) delegation standards for Blue Shield Promise Health Plan (BSP)

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

Background: The delegation standards exhibit of the PPSA has been revised to incorporate the 2022 NCQA criteria. Note that staff brought this amendment to the Board for approval in October 2023; after that time, additional substantive changes were made to the amendment, such that staff is bringing the revised amendment back for Board approval (please see the attached matrix indicating the changes that were made between October 2023 and November 2024). In addition, staff is requesting ratification rather than approval because the Plan and BSP needed to execute and operationalize the requirements that date from 2022.

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

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

Motion: **To ratify the executed Amendment No. 58 to the Plan Partner Services Agreement between L.A. Care and Blue Shield Promise Health Plan which incorporates the 2022 National Committee for Quality Assurance delegation standards.**

Blue Shield Promise- 2022-2023 PPSA Summary of Changes: Delegation

#	Standard	Element	Change Summary from 2021 to 2022	Type of Change	Reason for Change
1	QI 1	A: QI Program Structure	removed factor 6: Objectives for serving a culturally and linguistically diverse membership	Requirement removed	NCQA eliminated QI 1A, factor 6 in the 2022 guidelines
2	QI 2	A: Practitioner Contracts	Added language from Policies and Procedures Section 2-Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about treatment options regardless of benefit coverage limitations	language update	Added language from (NCQA Policies and Procedures Section 2, Accreditation Scoring and Status Requirements)
3	QI 3	D: Transition to Other Care	Added element statement language	language addition	Added element statement language from the QI 3D 2022 standard guidelines.
4	QI 4	A: Data Collection	Added language for Factor 6: Special needs of members with serious mental illness or serious emotional disturbance	language addition	Added factor 6 lanaguage updates from the QI 4A 2023 standard guidelines.
5	PHM 2	D: Segmentation	Added intent statement language	language addition	Added intent statement language from the PHM 2D 2022 standard guidelines.
6	PHM 3	A: Practitioner or Provider Support	Added language for Factor 6: Providing training on equity, cultural competency, bias, diversity or inclusion	language addition	Added factor 6 language updates from the PHM 3A, Factor 6 2022 standard guidelines.
7	PHM 5	D: Initial Assessment	Added intent statement language	language addition	Added intent statement language from the PHM 5D 2022 standard guidelines.
8	UM 2	A: UM Criteria	Added language for Factor 5: Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.	language addition	Added factor 5 language from the UM 2A 2022 standard guidelines.
9	UM 5	D: Timeliness Report	removed factors 1, 3, and 5	Requirement removed	NCQA eliminated UM 5D, factors 1, 3, and 5 from the 2022 guidelines.
10	UM 7	A: Discussing a Denial With a Nonbehavioral Healthcare Reviewer	Updated standard statement language	language update	updated standard statement language from the UM 7A 2022 guidelines.
11	UM 7	B: Written Notification of Nonbehavioral healthcare Denials	Updated intent statement language	language update	updated standard statement language from the UM 7B 2022 guidelines.
12	UM 7	F: Written Notifications of Pharmacy Appeals Rights/Process	Updated intent statement language	language update	updated standard statement language from the UM 7F 2022 guidelines.
13	UM 8	A: Internal Appeals	Updated language for factor 8	language update	updated factor language from the UM 8A 2022 guidelines.
14	UM 9	B: Timeliness of the Appeal Process	Updated intent statement language	language update	updated intent statement language from the UM 9B 2022 guidelines.
15	UM 12	C: UM Appeal System Controls	Added UM Appeal System Control standard language	language addition	NCQA added NEW UM 12C Appeal system controls language in the 2022 guidelines,
16	UM 12	D: UM Appeal System Control Oversight	Added UM Appeal System Control oversight standard language	New Requirement	NCQA added NEW UM 12D Appeal system controls oversight language in the 2022 guidelines,
17	CR 1	A: Practitioner Credentialing Guidelines	Added intent statement language	language addition	CR 1A did not have intent statement language in the PPSA.
18	CR 1	B: Practitioner Rights	Added intent statement language	language addition	CR 1B did not have intent statement language in the PPSA.
19	CR 1	C: Credentialing System Controls	Added intent statement language and updated language for factor 1	language addition	CR 1C did not have intent statement language in the PPSA. Updated factor 1 language.
20	CR 2	C: Credentialing System Controls Oversight	Added CR 1C Credentialing Oversight System Controls language	New Requirement	NCQA added NEW CR 1C Credentialing Oversight System controls language in the 2022 guidelines,
21	ME 5	Pharmacy Benefit Information	Removed ME 5A standard language	Requirement removed	Removed because Pharmacy benefits are carved out to Medi-Cal RX (Magellan/DHCS)

21 Total
11 language additions
5 language updates
2 new requirements
3 requirement removed

Blue Shield - 2022-2023 PPSA Summary of Changes: Reporting					
#	Standard	Element	Change Summary from 2021 to 2022	Type of Change	Reason for Change
1	UM	Pharmacy	Removed Pharmacy UM Reports	Requirement removed	Removed because Pharmacy benefits are carved out to Medi-Cal RX (Magellan/DHCS)
2	ME	Pharmacy	Removed Pharmacy ME Reports	Requirement removed	Removed because Pharmacy benefits are carved out to Medi-Cal RX (Magellan/DHCS)

Amendment No. 58
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 58 is effective as of July 1, 2022, 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 Shield of California Promise Health Plan***, 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:

I. <u>Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.</u>

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 58 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

Signed by:
By: Martha Santana-Chin
DD3916B18F644F0...
Martha Santana-Chin
Chief Executive Officer
1/20/2025 | 12:12 PM PST
Date: _____, 2025

DocuSigned by:
By: Alvaro Ballesteros
AA470E43B1BB4A1...
Alvaro Ballesteros
Chairperson
L.A. Care Board of Governors
1/17/2025 | 3:30 PM PST
Date: _____, 2025

Blue Shield of California Promise Health Plan,
A California health care services plan

DocuSigned by:
By: [signature]
9AE0D7770A434C7...
Kristen Cerf
President and Chief Executive Officer
1/2/2025 | 1:48 PM PST
Date: _____, 2025

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

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2022-June 30, 2023
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 Blue Shield of California Promise Health Plan (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, (vii) claims recovery., and (viii) financial solvency and claims processing compliance. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Blue Shield of California Promise Health Plan 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. Blue Shield of California Promise Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Blue Shield of California Promise Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Blue Shield of California Promise Health Plan as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Blue Shield of California Promise Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Blue Shield of California Promise Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Blue Shield of California Promise Health Plan, in whole or in part, in accordance with Exhibit 5, herein. L.A. Care will provide delegate with Member Experience data: complaints, CAHPS, survey results or other data collected on members' experience with the delegate's services. In addition, will also provide Clinical performance data: HEDIS measures, claims and other clinical data collected by the organization. L.A. Care may provide data feeds for relevant claims data or clinical performance measure results 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 delegate 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.

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY MANAGEMENT AND IMPROVEMENT	
Program Structure and Operations: Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026 (NCQA QI 1)	**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	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	Retained by L.A. Care
	Annual Work Plan 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. **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 performance in the quality and safety of clinical care and quality of service 3. Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **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 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 QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities 2. Practitioners allow the organization to use their performance data. **Provider Contracts** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this	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	Retained by L.A. Care
	requirement to submit documentation for renewal surveys. Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities. 2. Practitioners allow the organization to use their performance data.	
Continuity and Coordination of Medical Care: Applicable L.A. Care Policy: QI-0026 (NCQA QI 3)	**Identifying Opportunities** The organization annually identifies opportunities to improve continuity and coordination of medical care across the network by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and qualitative 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. **Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity for improvement identified in Element A, factor 4-7 2. Acting on the second opportunity for improvement identified in Element A, factor 4-7 3. Acting on the third opportunity for improvement identified in Element A, factor 4-7. **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. 3. The third opportunity identified in Element B. **Transition to Other Care** The organization helps with members' transition to other care when their benefits ends, if necessary. Refer to Utilization Management Delegated Activities Section	

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination Between Medical Care and Behavioral Healthcare: Applicable L.A. Care Policy: QI-0026 (NCQA QI 4)	**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 serious mental illness or serious emotional disturbance. **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 qualitative 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 **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.	

Standard	Delegated Activities	Retained by L.A. Care
Standards 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	
Sub-Delegation of QI: Applicable L.A. Care Policy: QI-007 (NCQA QI 5)	**<u>Sub-Delegation Agreement</u>** **LAC will ask Delegate of its sub-delegate (Blue Shield Promise Health Plan Plan Participating Providers) during the annual audit.** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-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 delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **<u>Predelegation Evaluation</u>** 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.	

Standard	Delegated Activities	Retained by L.A. Care
	Review of QI Program For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in 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.	
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA PHM 1) (CalAIM PHM Strategy) (APL 23-021) (DHCS PHM Policy Guide)	**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. 6. How the organization promotes health equity. **NCQA 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 **CalAIM PHM Program Strategy** Support L.A. Care as requested in completing the DHCS required PHM Program Strategy documents. Actively participate in the collaboration with L.A. Care and the Local Health Department CHA/CHIP process, for which L.A. Care directs the focus of the PNA.	Although L.A. Care delegates the noted activities in support of the CalAIM Program Strategy, 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	Retained by L.A. Care
		• Coordinating needed resources (staffing/funding data) by the LHJs. • Submitting the Los Angeles County annual PHM Strategy to DHCS.
Population Identification (NCQA PHM 2)	**NCQA Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy (Physician Administered Drugs) claims 3. Laboratory results 4. Health appraisal results 5. Electronic health records 6. Health Services programs within the organization 7. Advanced data sources **NCQA Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **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 need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs. **Segmentation** At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention:	

Standard	Delegated Activities	Retained by L.A. Care
(APL 19-011) (APL 23-021) (DHCS PHM Policy Guide)	1. Segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology. **DHCS Population Needs Assessment** Actively participate in the collaboration with Local Health Department CHA/CHIP process, for which L.A. Care directs the focus of the PNA.	L.A. Care is responsible for the PNA submission to DHCS and works with its Delegates to complete the requirements as detailed in APL 19-011, APL 23-021 and the PHM Policy Guide.
Delivery System Supports (NCQA PHM 3)	**Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering 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. Providing training on equity, cultural competency, bias, diversity or inclusion 7.	**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.
Wellness and Prevention (NCQA PHM 4)	**Frequency of Health Appraisal Completion** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer a health appraisal (HA) annually. **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 use cessation. 3. Encouraging physical activity. 4. Healthy eating. 5. Managing stress. 6. Avoiding at-risk drinking. 7. Identifying depressive symptoms.	

Standard	Delegated Activities	Retained by L.A. Care
Complex Case Management (NCQA PHM 5)	**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. **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 the individual ID and date and time of action on the case when interaction with the member occurred; and 3. Automated prompts for follow-up as required by the case management plan. **Case Management Process** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. 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 and considers 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	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	Retained by L.A. Care
	14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans. 17. A process to assess members' progress against case management plans. **Initial Assessment** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for completing the following within 60 calendar days: 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. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including 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.	

Standard	Delegated Activities	Retained by L.A. Care
	5. Assessment of progress against case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA PHM 6)	**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. **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.	
Sub-Delegation of PHM (NCQA PHM 7)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate (Blue Shield Promise Health Plan Plan Participating Providers) during the annual audit.** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-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 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: 1. Annually reviews its sub-delegate's PHM program	

Standard	Delegated Activities	Retained by L.A. Care
	2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. 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.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization annually: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including 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. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types 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.	

Standard	Delegated Activities	Retained by L.A. Care
	4. Establishes measurable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually. **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 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against standards annually	
Accessibility of Services (NCQA NET 2)	**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 **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.	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.
	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	

Standard	Delegated Activities	Retained by L.A. Care
Assessment of Network Adequacy (NCQA NET 3)	**<u>Assessment of Member Experience Accessing the Network</u>** 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 ME 7, Element E. 3. Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **<u>Opportunities to Improve Access to Nonbehavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement from analyses of availability (NET 1, Elements A, 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.	
	<u>Opportunities to Improve Access Behavioral Healthcare Services</u> The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of the interventions, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
Continued Access to Care (NCQA NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section Note: Review process is managed by L.A. Care Utilization Management team.	
Physician and Hospital Directories (NCQA NET 5)	**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 **Physician Directory Updates** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **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. **Identifying and Acting on Opportunities** Based on results of the analysis performed in Element C, at least annually the organization: 1. Identifies opportunities to improve the accuracy of the information in its physician directories. 2. Takes action to improve the accuracy of the information in its physician directories.	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	Retained by L.A. Care
	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 **Hospital Directory Data** The organization has a web-based hospital directory that includes the following: 1. Hospital name 2. Hospital location and phone number 3. Hospital accreditation status 4. Hospital quality data from recognized sources **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **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 **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	

Standard	Delegated Activities	Retained by L.A. Care
	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 NET 6)	**Sub-Delegation Agreement** **LAC will ask Delegate of its sub-delegate (Blue Shield Promise Health Plan Plan Participating Providers) during the annual audit.** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-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 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: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in 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	

Standard	Delegated Activities	Retained by L.A. Care
	delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4 and QI 3)	**Notification of Termination (NET4)** The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. **Continued Access to Practitioners (NET 4)** If a practitioner's contract is discontinued the organization allows affected members continued access to practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (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. **Transition to Other Care (QI 3)** The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**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 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 used to make determinations of benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. **Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary.	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	Retained by L.A. Care
Clinical Criteria for UM Decisions (NCQA UM 2)	**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 UM criteria and the procedures for applying them and updating them and updates the criteria when appropriate. **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **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 UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) 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 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA UM 4)	**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.	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

Standard	Delegated Activities	Retained by L.A. Care
	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 and professional experience in medical or clinical practice 2. A current clinical license to practice or an administrative license to review UM cases without restriction. **Practitioner Review of Nonbehavioral healthcare Denials** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses that a physician or appropriate behavioral healthcare practitioner to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **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 for medical necessity determinations.	provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Timeliness of UM Decisions (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners 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 within 72 hours of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners 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 within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 5 business days of receipt of information reasonably necessary to render a decision, not to exceed 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace)	

Standard	Delegated Activities	Retained by L.A. Care
	Timeliness Report The organization monitors and submits a report for timeliness of: 1. Notification of non-behavioral UM decisions 2. Notification of behavioral UM decisions 3. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. ***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***	
Clinical Information (NCQA UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **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 (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices (NCQA UM 7)	**Discussing a Denial With a Nonbehavioral Healthcare Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. **Written Notification of Nonbehavioral healthcare Denials** The organization's written notification of each non-behavioral healthcare denials, provided to members and their treating practitioners contains the following information: 1. The specific reason for denial, in easily understandable language	

Standard	Delegated Activities	Retained by L.A. Care
	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. **Written Notification of Nonbehavioral Healthcare Appeal Rights/Process** The organization's written non-behavioral denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the members' rights to representation and appeal time frames 3. A description of the expedited appeal 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. **Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decisions with a physician appropriate behavioral healthcare reviewer or pharmacist reviewer. **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 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 **Written Notification of Behavioral Healthcare 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:	

Standard	Delegated Activities	Retained by L.A. Care
	1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including members' right to representation and appeal time frames 3. A description of the expedited appeal 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. **Discussing a Pharmacy Denial with a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist **Written Notifications of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand. 2. A reference to the benefit provision guidelines protocol or 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. **Written Notification of Pharmacy Appeal 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 member's right to submit written comments documents or other information relevant to the appeal. 2. An explanation of the appeal process including the member's right to representation and the 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 appeal process for urgent care	

Standard	Delegated Activities	Retained by L.A. Care
	Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Policies for Appeals (NCQA UM 7 NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (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. Full investigation 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 an appeal, who was not involved in the initial determination 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 specialty 7. The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request. 8. For Medicaid only, the decisions for postservice appeals and notifications to the members must be 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 members 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 14. Allowing an authorized representative to act on behalf of the member 15. Continued coverage pending the outcome of an appeal.	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	Retained by L.A. Care
Appropriate Handling of Appeals (NCQA UM 9)	**Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **Timeliness of the Appeal Process** The organization adheres to the following time frames for notification of preservice, postservice and expedited appeal decisions: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **Appeal Reviewers** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **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 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 free of charge upon request. 5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures.	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	Retained by L.A. Care
	Final Internal and External Appeal Files N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022 and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA UM 11)	**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. **Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet website	

Standard	Delegated Activities	Retained by L.A. Care
	and update that posting with changes on a monthly basis (SB1052) 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 process for generic substitution, therapeutic interchange and step-therapy protocols. **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 thirty (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. **Reviewing and Updating Procedures** 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. Updates the list of pharmaceuticals, as appropriate, and **SB 1052** Post the list with changes on its Internet website on a monthly basis **Considering Exceptions** The organization has exceptions policies and procedures that describe the process for: 1. Making 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 request 5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	

Standard	Delegated Activities	Retained by L.A. Care
UM System Controls (NCQA UM 12)	**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 titles or roles of 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 monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **UM Denial System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **UM Appeal System Controls** 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 titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.	

Standard	Delegated Activities	Retained by L.A. Care
	5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from authorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1-6 at least annually and takes appropriate action, when applicable. **UM Appeal System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	
Sub-Delegation of UM (NCQA UM 13)	**Sub-Delegation Agreement** **LAC will ask Delegate of its sub-delegate (Blue Shield Promise Health Plan Plan Participating Providers) during the annual audit.** 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. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.	

Standard	Delegated Activities	Retained by L.A. Care
	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 NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. At least annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures. 6. At least annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **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.	
	CREDENTIALING	
Credentialing Policies (NCQA CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners, non-physician medical practitioners (NMPs) and non-medical/clinical providers (NCPs) to provide care to its members by developing and implementing credentialing policies and procedures which specify: **Practitioner Credentialing Guidelines** The organization has a rigorous process to select and evaluate practitioners: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions.	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.

Standard	Delegated Activities	Retained by L.A. Care
	5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority 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. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions within sixty (60) calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility for, 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 other materials for members are consistent with credentialing data including education training board certification and specialty. **Practitioner Rights** The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing or recredentialing application 2. The right of practitioners to correct erroneous information including: • The timeframe for making corrections. • The format for submitting corrections. • The person to whom the corrections must be submitted.	

Standard	Delegated Activities	Retained by L.A. Care
(DHCS APL22-013)	3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. **<u>Credentialing System Controls</u>** The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, stored, reviewed, tracked and dated. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of 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. 5. How the organization monitors its compliance with the processes and procedures in factors 1–4 at least annually and takes appropriate action when applicable. **<u>Credentialing System Controls Oversight</u>** At least annually, the organization demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **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 process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for ensuring and verifying Medi-Cal enrollment prior to contracting.	

Standard	Delegated Activities	Retained by L.A. Care
	3. The process for practitioners whose enrollment application is in process. 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, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee: a. Includes representation from a range of participating practitioners to provide advice and expertise for credentialing decisions. b. Has the opportunity to review the credentials of all practitioners being credentialed or re-credentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. c. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria. d. Ensures that all license accusations, sanctions or restrictions are reviewed by the credentialing committee for action.	
Credentialing Verification (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the regulatory and NCQA prescribed time limits, through primary or other regulatory and NCQA-approved sources prior to credentialing and recredentialing by: Verifying that the following are within the prescribed time limits: 1. Current, valid license to practice (develop a process to ensure providers licenses are kept current at all times).	

Standard	Delegated Activities	Retained by L.A. Care
	2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate. • Require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications. 3. For physicians, verification of the highest of the following three levels of education and training obtained by the practitioners as appropriate: • Board certification if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. • Completion of a residency program. • Graduation from medical or professional school. 4. For Non-Physician Medical Practitioners (NMPs) and Non-Clinical Providers (NCPs), the Delegate verifies the provider has met the qualifications to render services based on the provider type including but not limited to, a current and valid license, registration, certification or the education/training equivalent. 5. Work history. 6. Current malpractice insurance/professional liability coverage for physicians ($1 million/$3 million). 7. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 8. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 9. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 10. CLIA Certifications, if applicable. 11. NPI number. 12. Medicare number, if applicable 13. Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current.	

Standard	Delegated Activities	Retained by L.A. Care
	Delegate shall maintain credentialing and/or other monitoring processes to assure that licensure and professional status of each Participating Provider is verified on an ongoing basis. Pursuant to the performance of its credentialing, recredentialing, auditing, monitoring and/or other processed, which include confirmation relating to the following: ▪ Each Participating Provider/Practitioner is and shall remain duly licensed, registered or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the ability of Participating provider/practitioner to provide Health Care Services to LAC members as required under the Agreement. ▪ Each Delegate's participating provider/practitioner shall maintain professional liability insurance, either independently or through Contractor or some other entity, in a dollar amount that is sufficient for his/her/its practice and as may be required by law or accrediting entities. The Delegate's participating providers must also have general liability insurance in a dollar amount appropriate for their business practice. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing. a. State sanctions, restrictions on licensure, or limitations on scope of practice. Review of information must cover the most recent 5-year period available. If a practitioner is licensed in more than one state, in the most recent 5-year period, the query must include all states in which they worked b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. f. Debarment g. Decertification	

Standard	Delegated Activities	Retained by L.A. Care
	Providers must not be terminated, sanctioned, suspended, debarred, disenrolled/decertified, convicted of a felony related to healthcare program fraud or excluded from participation in any federal or state funded programs. L.A. Care does not contract, credential, refer, or pay claims to Practitioners or Providers who have opted out of participation in the Medicare and Medicaid programs; or with individuals or businesses that have been convicted of a felony related to healthcare program fraud, federally or state terminated, sanctioned, suspended, debarred, disenrolled/decertified, excluded, or have appeared on any sanction reports, or on any order issued by judicial authority. Such Practitioners, Providers, individuals, or businesses are ineligible from participation in Medi-Cal, Medicare, federal or state funded programs. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice/professional liability insurance coverage for physicians. ($1million/$3 million). f. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions within 30 calendar days of its release. In areas where reporting entities do not publish sanction	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

Standard	Delegated Activities	Retained by L.A. Care
	information on a set schedule, the Delegate must query for this information at least every 6 months 2. Collecting and reviewing accusations, sanctions or limitations on licensure and report actions taken against any identified practitioners to Plan. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. b. 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. c. 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,	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	Retained by L.A. Care
	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. 6. 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. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network. 8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify: a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. All final adverse actions determined to be reportable pursuant to applicable law, must be reported by the Delegate to the National Practitioner Data Bank (NPBD) and the appropriate State Medical Boards. Upon the filing of NPBD reports and 805 reporting, the Delegate must notify the Plan within 5 business days from the date the reports are filed. Providers must notify the Delegate, in writing, of any adverse or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network as	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	referenced in the California Participating Physician Application Information Release Acknowledgments. Upon notification from a contracted or employed provider, the delegate must notify L.A. Care immediately or no later than 5 business days from the date when practitioners are identified on any ongoing monitoring reports. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA CR 7) DHCS, DMHC, CMS	The Delegate'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 if the provider is not accredited. 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. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs). f. Any other ancillary provider types outlined in the delegate's contract with the Plan	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers. The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DHCS, DMHC, CMS	**<u>Subdelegation Agreement:</u>** **LAC will ask Delegate of its sub-delegate (Blue Sheid Promise Health Plan Plan Participating Providers) during the annual audit.** If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: 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 quarterly reporting to Delegate. 4. Describes the process by which Delegate evaluates sub-delegate'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 delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **<u>Presubdelegation Evaluation:</u>** 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	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 that would be part of the L.A. Care provider network.

Standard	Delegated Activities	Retained by L.A. Care
	Review of Subdelegates Credentialing Activities: For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures. b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from NCQA CR 8, Element C, factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **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 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 ME 1)	**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.	**Rights and Responsibilities 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

Standard	Delegated Activities	Retained by L.A. Care
		providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their 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. 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 goals to the degree possible. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**<u>Subscriber Information</u>** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services.

Standard	Delegated Activities	Retained by L.A. Care
		Distribution of Subscriber Information The organization distributes its subscriber information to the following groups: 1. New members, upon enrollment. 2. Existing members, annually. **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ME 3)		**Materials and Presentations** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **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 **Assessing Member Understanding** The organization systematically takes the following steps:

Standard	Delegated Activities	Retained by L.A. Care
		1. Assesses how well new members understand policies and procedures. The right to approve the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. The member's cost. 5. The date paid **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	
Personalized Information on Health Plan Services (NCQA ME 6)	**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 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **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.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated 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. **E-mail Response Evaluation** The organization: 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-031 (NCQA ME 7)	**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. Investigation of the substance of complaints and actions taken. 3. Notification to members of the resolution of complaints 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. **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.	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. **Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to

Standard	Delegated Activities	Retained by L.A. Care
	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. **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. **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. **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.	pursue based on analysis of the following information: 1. Member complaint and appeal data from Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.
Sub-Delegation of ME (NCQA ME 8)	**Sub-Delegation Agreement** **LAC will ask Delegate of its sub-delegate (Blue Shield Promise Health Plan Plan Participating Providers) during the annual audit.** The written sub-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.	

Standard	Delegated Activities	Retained by L.A. Care
	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: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. **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.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2)	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: 1. Is available 24 hours a day, 7 days a week, by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 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. **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. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone 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.	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	Retained by L.A. Care
	5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. **D. Policies and Procedures** 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan 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)	
Potential Quality of Care Issue Review (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 Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th 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 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	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	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening

Standard	Delegated Activities	Retained by L.A. Care
	Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 APL 22-030 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis. 11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

Standard	Delegated Activities	Retained by L.A. Care
	Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC REQUIREMENTS		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated:	

Standard	Delegated Activities	Retained by L.A. Care
	2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

Standard	Delegated Activities	Retained by L.A. Care
	assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis. c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C)	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week,	

Standard	Delegated Activities	Retained by L.A. Care
DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial orientation training/education on cultural and linguistic requirements to new providers within first ten business days of active status and annual education/training thereafter, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters.	

Standard	Delegated Activities	Retained by L.A. Care
	d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. b. Awareness that culture and cultural beliefs may influence health and health care delivery. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. d. Skills to communicate effectively with diverse populations e. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines:	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language	

Standard	Delegated Activities	Retained by L.A. Care
OMH CLAS Standards, Standard 4	assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	

Standard	Delegated Activities	Retained by L.A. Care
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues. b. Trending of interpreting and translation utilization. c. Member satisfaction with the quality and availability of language assistance services and culturally competent care. d. Plan staff and providers' feedback on C&L services. 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	
Authority: Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter 17-004DHCS All Plan Letter 21-004	**Oversight of *Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services) 2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with	

Standard	Delegated Activities	Retained by L.A. Care
	the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. ***"Subcontractor" may include, but is not limited to, Blue Shield of California Promise Health Plan provider groups, specialty health plans, telehealth, transportation vendors, etc.***	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral*** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. **3.** Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	
FINANCIAL SOLVENCY AND CLAIMS PROCESSING REQUIREMENTS		
Financial Solvency (Title 28 California Code of Regulations Sections 1300.75.1, 1300.75.4.1(a)(5) & (6), 1300.75.4.2(a), 1300.76, 1300.76.1, 1300.77.1 & 2, 1300.78, and 1300.76.3).	**Financial Solvency** 1. Maintain a cash-to-claims ratio > 0.75. 2. Maintain positive working capital. 3. Maintain a minimum Tangible Net Equity (TNE). 4. Document and record the liability for incurred but not reported (IBNR) claims on a monthly basis. 5. Submit the quarterly financial statements no later than 45 calendar days after the close of each quarter end to L.A Care. 6. Submit the annual financial statements audited by an independent Certified Public Accounting firm no later than 120 calendar days after each fiscal year end to L.A. Care. **Administrative Costs** 1. Maintain administrative costs no greater than 15% of the revenue. **Commissioner Deposits** 1. Maintain at least $300,000 deposit with the Commissioner, with any FDIC insured bank. **Quarterly Risk-Sharing Reports** 1. Distribute the quarterly risk-sharing report detailing the amounts allocated to the Plan Participating	

Standard	Delegated Activities	Retained by L.A. Care
	Providers (PPPs) under each risk-sharing arrangement no later than 45 calendar days after each quarter end. 2. Distribute the annual preliminary payment risk-sharing report detailing the amounts allocated to the PPPs under each risk-sharing arrangement no later than 150 calendar days after the contract year. 3. Remit payment due under risk-sharing arrangements to the PPPs no later than 180 days after the contract year. **Risk Management** Maintain the following insurance at all times: 1. Reinsurance or Stop-Loss or Parental Guarantee 2. Malpractice or Professional Liability 3. General Liability 4. Errors & Omissions 5. Workers Compensation 6. Fidelity Bond **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
	Financial Viability Oversight of the Plan Participating Providers (PPPs) 1. Obtain and analyze quarterly financial statements and annual audited financial statements of the PPPs. 2. Perform financial audit of the PPPs at least once a year including the issuance of audit reports. 3. Request a written or monitor a corrective action plan (CAP) from PPPs that do not meet the financial solvency requirements. **Claims Processing Oversight of the PPPs** 1. Perform claims processing audit of the PPPs at least once a year including the issuance of audit reports. 2. Perform annual ER claims and applicable ER follow-up audits for the PPPs that are delegated for the ER claims payment functions. 3. Request a written corrective action plan (CAP) from PPPs that do not meet the claims processing requirements.	

Standard	Delegated Activities	Retained by L.A. Care
	Policies and Procedures Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims**: Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time.	

Standard	Delegated Activities	Retained by L.A. Care
	Accurate and Clear Written Explanation Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Provider Dispute Resolution (PDR) Processing and Payments requirement.	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes.	

Standard	Delegated Activities	Retained by L.A. Care
(Title 28 California Code of Regulations Section 1300.71.38)	b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Annual Plan Claims Payment and Dispute Resolution Mechanism Report" Cal. Code Regs. tit. 28 § 1300.71.38(k) Cal. Code Regs. tit. 28 § 1300.71.38(k)(1) Cal. Code Regs. tit. 28 § 1300.71.38(k)(2)	1. "Information on the number and types of providers using the dispute resolution mechanism. 2. "A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and…	

Standard	Delegated Activities	Retained by L.A. Care
Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)	3. A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans.1	
DMHC Provider Disputes Document/Information Requests	Plan Partner to respond to document/information requests from L.A. Care for DMHC provider disputes within 5 days, urgent requests within 2 days.	
PROVIDER NETWORK REQUIREMENTS		
DHCS Agreement Exhibit A, Attachment 7 (5)(A)(B)	**Provider Education & Training** 1. Plan has approved policies and procedures for training newly contracted/hired providers within ten (10) business days of the effective date of contract/hire. The training must include, but is not limited to: (DHCS Agreement, Exhibit A, Attachment 7, Provision 5; DHCS Agreement, Exhibit A, Attachment 13, Provision 1), and the NCQA 2017 Standards and Guidelines (NCQA, Element A), NCQA RR 1. a. 1. Federal and State statutes and regulations to ensure providers' full compliance b. 2. Medi-Cal Managed Care services c. 3. Applicable policies and procedures d. 4. Medi-Cal marketing guidelines e. 5. Member rights and responsibilities f. 6. Member services, including the member's right to full disclosure of health care information and the member's right to participate actively in health care decisions education/training on C&L requirements, for providers. 2. Plan Partner must evidence a process to provide information to and train providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines for Seniors and Persons with Disabilities or chronic conditions a. 1. Process includes an educational program for providers regarding health needs specific to Seniors and Persons with	

[1] Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)

Standard	Delegated Activities	Retained by L.A. Care
	Disabilities or chronic conditions population b. 2. Educational program uses a variety of educational strategies, including, but not limited to, posting information on websites and other methods of educational outreach to providers	

Exhibit 8
Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
QUALITY IMPROVEMENT			
NET 1A Cultural Needs and Preferences Assessment **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A Access to Primary Care **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	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
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A Sub-Delegation Agreement **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly reporting requirements</u> 1. **QI Workplan Update** **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	QI Workplan Update - Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. PQI Report - Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format **Naming convention for PQI Reports** *Plan Partner Name YYYY Q# PQI Report*

Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. **QI 1B:** Annual Work Plan 4. PHM Work Plan (if the activities are not included in the QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 &Q2)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format  ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP)	Compliant with NCQA in accordance to Plan's

PHM 7B Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement		home/ucfst/infile/Quality Improvement/	accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **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 2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18 2. Annually during PP Audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
DELEGATION OVERSIGHT - UTILIZATION MANAGEMENT AND MEMBER RIGHTS			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission

1. 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: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue e. Quality of Practitioner Office Site			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Delegation Oversight to review. Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. HICE Quarterly Reporting format 3. HICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity Health Industry Collaboration Effort (HICE) reporting format including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K 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)	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	HICE Quarterly Reporting Format

b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics			
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's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	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's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions Log	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care approved reporting template
QI 3D: Transition to Other Care**--**member transition to other care, a. When their benefits end, if necessary b. During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
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.	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)

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			
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards Policies and Procedures b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards Policies and Procedures c. Exhibit A-3 Oversight of Plan-to-Plan Contracts Policy and Procedures d. Exhibit B-1 Quality Assurance Monitoring related to Time-Elapsed Standards Policies and Procedures e. Exhibit B-2 Quality Assurance Monitoring related to All Other Time-Elapsed Standards Policies and Procedures f. Exhibit D-1 Non-Compliance Policies and Procedures g. Exhibit D-2 Incidents of Non-Compliance Resulting in Substantial Harm to an Enrollee h. Exhibit D-3 Patterns of Non-Compliance i. Exhibit D-4 Prior Incidents or Patterns of Non-Compliance not Previously Submitted j. Exhibit E-1 Policies and Procedures for Advanced Access Program k. Exhibit F-1 Triage l. Exhibit F-2 Telemedicine m. Exhibit F-3 Health I.T. n. Exhibit G-1 Provider Satisfaction Survey Methodology o. Exhibit G-2 Provider Satisfaction Survey Results	Due Date: 4/17/2023	L.A. Care's Secure File Transfer Protocol (SFTP) /ucfst/infile/compliance	

p. Exhibit G-2 Enrollment Satisfaction Survey Methodology q. Exhibit G-4- Enrollee Satisfaction Survey r. Exhibit H-1 Quality Assurance Report s. Exhibit C-1 Contact List Report Forms for each Provider Survey Type Exhibit C-1 Contact List Report Forms for each Provider Survey Type t. Exhibit C-2 Raw Data Report Forms for each applicable Provider Survey Type u. Exhibit C-3 Results Report Form v. APNR Form PCP w. APNR Form Specialists x. APNR Form Mental Health y. APNR Form Hospitals and Clinics z. APNR Form Other Outpatient Provider aa. APNR Form Grievances bb. APNR Form Third Party Telehealth (if applicable)	Due Date: 9/1/2022 Due Date: 2/6/2023		
2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 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) /home/ucfst/infile/274	DHCS required formatting.
2. 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's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.

3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 22-008	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
4. Health Industry Collaboration Effort AB1455 Quarterly Reports a. M/Q Medi-Cal Claims Timeliness ReportQuarterly Provider Dispute Resolution (PDR) Report b. Disclosure of Emerging Claims Payment Deficiencies (DoECPD)	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/AB1455	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September • Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
7. Dental General Anesthesia Report Mandated by APL 15-012 (Report retired on 03/29/2023)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
8. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 22-024	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or	DHCS approved templates

		Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	
10. Enhanced Care Management DHCS Required Reporting	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
11. Community Supports DHCS Required Reporting	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
13. MOT Post Transitional Monitoring	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
14. Prop 56 Directed Payment for Physician Services Mandated by APL 19-015	Quarterly- Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Financial Compliance provided Template based on APL reporting requirements
15. Prop 56 Hyde Reimbursement Requirements for specific Services Mandated by APL 23-015	Quarterly- Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
16. Prop 56 Directed Payments for Developmental Screening Services Mandated by APL 23-016	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements

17. Prop 56 Directed Payments for Valued Base Payment Program Mandated by APL 23-014	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Prop 56 Directed Payments for Family Planning Mandated by APL 23-008	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
19. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services Mandated by APL 23-017	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
20. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) Mandated by APL 20-017 The 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 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)***	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

21. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 22-027	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
22. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
23. Third Party Liability APL 21-007	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
24. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
25. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined 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; 26. 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; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) 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.
27. Encounter Data	Monthly, at a minimum	L.A. Care's Secure File Transfer Protocol (SFTP)	
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			

1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Delegates' Quarterly Timeliness Reporting will be included in 1(a) above. Note: Delegates consist of Blue Shield of California Promise Health Plan Plan Participating Providers and capitated hospitals.	Quarterly – Due to L.A. Care 75 calendar days after each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF
2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates*** Note: Delegates consist of Blue Shield of California Promise Health Plan Plan Participating Providers and capitated hospitals.	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates Note: Delegates consist of Blue Shield of California Promise Health Plan Plan Participating Providers and capitated hospitals.	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of fieldwork conducted by BSC PHP.	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			

New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end Q1 due 4/15 Q2 due 7/15 Q3 due 10/15 Q4 due 1/15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH 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 Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	As appropriate per Plan Partner model.

CULTURAL AND LINGUISTC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor**.**
2. C&L 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) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

[Signature block appears on the following page]

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

Signed by:
By: Martha Santana-Chin
DD3916B18F644F0...
Martha Santana-Chin
Chief Executive Officer

Date: 1/20/2025 | 12:12 PM PST, 2025

DocuSigned by:
By: Alvaro Ballesteros
AA470E43B1BB4A1...
Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: 1/17/2025 | 3:30 PM PST, 2025

Blue Shield of California Promise Health Plan
A California health care services plan

DocuSigned by:
By: Kristen Cerf
9AE0D777A434C7...
Kristen Cerf
President and Chief Executive Officer

Date: 12/23/2024 | 2:12 PM PST, 2024

Blue Shield - 2022-2023 PPSA Summary of Changes: Reporting					
#	Standard	Element	Change Summary from 2021 to 2022	Type of Change	Reason for Change
1	UM	Pharmacy	Removed Pharmacy UM Reports	Requirement removed	Removed because Pharmacy benefits are carved out to Medi-Cal RX (Magellan/DHCS)
2	ME	Pharmacy	Removed Pharmacy ME Reports	Requirement removed	Removed because Pharmacy benefits are carved out to Medi-Cal RX (Magellan/DHCS)

Board of Governors
MOTION SUMMARY

Date: March 26, 2025 **Motion No. EXE A.0325**

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

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 policy is 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-203	Attendance and Punctuality	Employee Relations	Minor edits to wording
HR-216	Recording of Time	Employee Relations	Added section 4.10
HR-229	Workplace Bullying	Employee Relations	Clarified definitions and made edits to the Procedure section.

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 the Human Resources Policies HR-203 (Attendance and Punctuality), HR-216 (Recording of Time), and HR-229 (Workplace Bullying), as presented.**

	ATTENDANCE AND PUNCTUALITY	**HR-203**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6302

DATES					
Effective Date	5/30/1996	Review Date	~~6/14/2023~~ ~~8/27/2024~~10/21/2~~4~~3/14/2025	Next Annual Review Date	~~6/14/2024~~ ~~8/27/2025~~10/21/2~~025~~3/14/2026
Legal Review Date	~~2/14/2022~~11/7/2024	Committee Review Date	~~6/28/2023~~3/26/2025		

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

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	Jyl Russell
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Business Support Services, Learning Experience and Organizational Effectiveness

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

REFERENCES
HR-112 LEAVE OF ABSENCE POLICY

POLICY HISTORY	
REVISION DATE	**DESCRIPTION OF REVISION**
05/20/2009	Revision
04/01/2014	Review
10/25/2017	Revision: Tardiness grace period changed from more than seven minutes to more than 10 minutes. Clarification that weather and/or transportation problems will not excuse tardiness or absence.
4/4/2018	Tardiness grace period removed from policy.
6/14/2023	Revision: Occurrence Chart added. New definitions added: Tardy, Pattern Attendance, Kin Care
~~8/27/2024~~10/21/~~2024~~3/14/2025	Minor edits to wording

1.0 OVERVIEW:

L.A. Care Health Plan (L.A. Care) has defined ~~the ek~~standards of acceptable attendance and punctuality to ensure that our members and customers receive the highest level of service, and that work is completed on time as assigned.

2.0 DEFINITIONS:

2.1 Tardy: When an employee arrives and/or clocks in after their scheduled start time.

2.2 Early Departure: When an employee leaves work prior to the end of assigned/scheduled work time without prior supervisory approval.

~~**2.2** , or takes an extended meal or rest break period without approval.~~

2.3 Unscheduled Absence: When an employee is absent from work without receiving prior approval from their manager before their absence.

2.4 Pattern ~~Attendance~~Absences: When an employee demonstrates repeated Unscheduled A~~a~~bsences that fall on similar days or times during the month. This Pattern Attendance may include Tardy, Early Departure and/or before or after holidays.

2.5 Occurrence: An Occurrence is documented as an absence, Tardy, or missed time clock in/out. While an absence refers to a single failure to be at work, and Occurrence may cover consecutive absent days when an employee is out for the same reason.

2.6 ~~**2.6**~~ **Kin Care**: ~~"~~Under the existing Kin Care law (Labor Code section 233), Employees in California can use up to half of their annual paid time off (PTO) for K~~k~~in C~~e~~are leave under the California Family Rights Act. Kin care leave is ~~a type of paid sick leave that~~time off from work ~~which allows~~for an employee to care for family members who are ill, including spouses, children, parents and domestic partners.

~~**2.6** California employers who provide sick leave or Paid Time Off (PTO) to employees are required to allow an employee to take up to one-half of their annual accrual of such sick leave/PTO to attend to illness for the following family members: Parent, Child, Spouse, Registered Domestic Partner, Grandparent, Grandchild or Sibling.~~

3.0 POLICY:

3.1 Attendance and punctuality are essential elements of job performance. The purpose of this policy is to ensure proper notification is given to the supervisor by the employee of employee's absences and/or tardiness to minimize disruption of work schedules; allow for management planning of schedules, and maximize efficiency and productivity within the department.

3.2 E~~An e~~xamples of ~~an~~ Occurrences are~~is~~ ~~W~~when an employee arrives and/or clocks in after their scheduled start time; leaves work prior to the end of assigned/scheduled work time without prior supervisory ~~approval, or~~approval or takes an extended meal or ~~rest~~ break period without approval.

~~3.2~~3.3 An employee may demonstrate Pattern Absences when employee has repeated Unscheduled Absences that fall on similar days or times during the month. This Pattern ~~Attendance~~ Absences may include Tardy, Early Departure and/or before or after holidays.

~~3.3~~3.4 All non-exempt employees are required to record their hours through the automated time record system. All non-exempt employees must record the accurate time they start work and the time they leave work. Additionally, all non-exempt employees must record the time they leave for their meal ~~or rest~~ break and the time they return from the meal ~~or rest~~ break (HR-216). A combination of excessive Unscheduled Absences and t~~T~~ardiness, including Pattern ~~Attendance~~Absences, and failure to clock in and out, may result in disciplinary action, up to and including termination of employment. All disciplinary actions must be documented on Human Resources approved forms and should not be issued without the review and consent of Human Resources.

~~3.4~~3.5 L.A. Care provides employees with Paid Time Off rather than Paid Sick Leave, therefore,~~.~~ w~~W~~e follow the 50 percent allocation of Paid Time Off hours as Kin Care allowance as required by law.

4.0 PROCEDURES:

4.1 The chart below provides an understanding of what may constitute Occurrences either individually and/or in combination with one another (see section 2.4). This chart is to be used to determine appropriate levels of discipline steps and actions.

	Occurrences/Days	Discipline Step and Action
Occurrence 1 Occurrence is equal to: - 1 Unscheduled Absence **OR** - 2 Tardies/Early Departure **OR** - 2 Missed Punches **OR**	3 Occurrences 6 Occurrences 9 Occurrences 12 Occurrences	Step 1: Verbal Warning Step 2: Written Warning Step 3: Final Warning Step 4: Termination

- Up to 4 Consecutive Days Absent		
No Call/No Show Consecutive/Non-Consecutive (section 4.3)	1 Day 2 Days 3 Days	Step 1: Written Warning Step 2: Final Warning Step 3: Resignation/Job Abandonment

4.2 The employee is responsible for reporting to the employee's supervisor the reason for the Unscheduled Absence or ~~t~~tardiness. If it is an Unscheduled Absence, the manager is responsible to enter the reason code on the employees timecard as 'Unscheduled Absence'. Any change in work schedule, including, but not limited to, Early Departures from work, deviations in scheduled meal or rest periods (deviations must still comply with California law), or overtime must be approved in advance by the supervisor. Before providing disciplinary actions ~~.~~to an employee, to ensure consistency and accuracy, please consult with your HR Business Partner.

~~4.2~~4.3 Employee demonstrating six (6) T~~t~~ardies and/or ~~e~~Early ~~d~~Departures within a rolling ~~30-day~~30-day period~~s~~ or three (3) U~~u~~nscheduled ~~a~~Absences within rolling 90 days is considered excessive.

~~4.3~~4.4 Any disciplinary action provided to an employee for attendance will be active for 6 months. If the employee does not have any additional attendance occurrences that warrant discipline at the six-month mark, the level of discipline defaults to the previous (last) level of discipline issued, ~~is~~ known as the "Rollback Period."

~~4.4~~4.5 Notification to the employee's supervisor or the supervisor's designee that the employee may be absent or Tardy does not mean that the absence or tardiness is excused. An absence or tardiness shall be deemed excused only if the employee obtains the supervisor's prior approval in advance. Excessive absenteeism and tardiness, excused and/or unexcused, may result in disciplinary action, up to and including termination.

~~4.5~~4.6 Generally, unforeseeable events, (e.g., natural disasters, weather, childcare and transportation problems) are not considered to be valid reasons for Unscheduled Absence, Tardy or Early Departure.

~~4.6~~4.7 If an employee is absent from work for more than one scheduled day, the employee must follow the employee's department's procedure for notifying the employee's supervisor or supervisor's designee each day of the absence unless a date for return was identified by a healthcare provider or approved by the supervisor in advance. Calling in and speaking with a co-worker is not acceptable. Unreported absences of three scheduled workdays constitute job abandonment and voluntary resignation.

~~4.7~~4.8 Employees requesting Kin Care may be referred to the Leave of Absence partner for further information pertaining to any other leave options or resources that may be available to the employee.

~~4.8~~4.9 An employee with insufficient Paid Time Off hours available for Kin Care is subject to this policy for tracking time off. Unscheduled absences will not be eligible for Kin Care without the requisite Paid Time Off hours available. (~~.~~ Progressive discipline may apply where warranted).

~~4.9~~4.10 For an absence due to illness or injury, regardless of length, an employee may be required to furnish Human Resources Leave of Absence Partner with a physician's certification releasing the employee to return to work. In some instances (non-protected leave related), the absence or tardiness may not be excused although a physician's certificate was provided. When absences are due to illness or injury of three or more scheduled workdays, a written physician's certification releasing the employee to return to work may be required. The physician's certification must specify the date the illness began or the date the injury occurred, the probable duration of the condition, and whether the employee is able to perform the essential functions of the employee's job, either with or without reasonable accommodation. The physician's certification must be provided to Human Resources Leave of Absence Partner to avoid delays to return to work. An employee should not discuss details of a medical condition with the employee's supervisor or manager designee.

~~4.10~~4.11 This policy makes a distinction between scheduled and unscheduled time off. If an employee is absent from work, arrives late or leaves early, and has advance approval from the manager, the absence, lateness or Eearly Ddeparture is considered scheduled and approved. If the employee is absent from work, arrives late, or leaves early, and does not have advance approval from the manager, it is generally considered unscheduled and unapproved. In the instance that a non-exempt employee clocks-in late to work and it is unplanned, the employee will need to obtain managers' approval to work past their scheduled stop time, as make-up time. Unscheduled Absences, incidents of Tardy or Early Departures can affect an employee's attendance record and can be used as a negative factor toward disciplinary action. However, certain types of time off, although unscheduled (and generally cannot be scheduled in advance) will not impact the employee's attendance

record or be used as a negative factor toward disciplinary action. ~~-~~These include absences, incidents of Tardy ~~-~~and Early Departures covered under the Leave of Absence Policy (HR-112) where available ~~paid~~ PTO is used or other Federal, state or local laws; or not limited to ~~result from an~~ approved Worker's Compensation claim; or approved under the California Family Rights Act, Pregnancy Disability, Military Leave, Time Off for School Visits, Time off for Voting or Time Off to Appear in Court (Violent Crime Victim).

~~5.0~~ MONITORING:

~~5.1~~5.0 It is the supervisor's responsibility to monitor the employee's attendance and punctuality. The supervisor has the responsibility to counsel an employee as appropriate with regard to absence/tardiness.

~~6.0~~ REPORTING:

~~6.1~~6.0 Any suspected violations to this policy should be reported to your Human Resources Business Partner.

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

	RECORDING OF TIME	**HR-216**
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)	6315	

DATES					
Effective Date	11/17/2006	Review Date	~~4/26/2019~~3/28/2024~~3~~3/17/2025	Next Annual Review Date	~~4/26/2020~~3/28/2026~~3~~3/17/2026
Legal Review Date	~~4/15/2019~~11/7/2024	Committee Review Date	~~4/22/2019~~3/26/2025		

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

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	~~Ruben Simental~~Jyl Russell
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Business Supp Svcs, Learning Experience and Organizational Excellence~~, Human Resources~~~~Senior Director, HR Business Support Services~~ ~~Sr. Dir. HR Business Support, Learning Ex, Center of Excellence~~

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

REFERENCES

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
4/13/2009	Revision
April 2014	Review
5/24/2017	Revision
4/22/2019	Revision, reference to Payroll's Time Exception Report removed as it is no longer valid.
3/~~28~~17/2024~~5~~	~~Removed rounding verbiage.~~ Added section 4.10

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 all L.A. Care Health Plan (L.A. Care) employees ~~are compensated appropriately~~record their time worked properly in accordance with Federal and State Laws, and Wage and Hour Regulations.

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 It is L.A. Care's policy to comply with Federal and State laws and regulation governing record keeping for the payment of wages. L.A. Care's non-exempt employees are required to provide a complete and accurate record of hours worked during a pay period via the automated time management system.

4.0 PROCEDURES:

4.1 All non-exempt employees are required to record their hours through the automated time record system~~. All non-exempt employees must record~~ including the accurate time they start work, and the time they leave work, and~~. Additionally, all non-exempt employees must record the~~ the time they leave for and return from their meal break ~~.and the time they return from the meal break.~~

4.2 No employee is permitted to record hours for another employee. ~~Violators may be subject to disciplinary action, up to and including termination of employment.~~

4.3 All overtime must be recorded and must have prior approval of the non-exempt employee's manager or supervisor. Violators may be subject to disciplinary action, up to and including termination of employment.

4.4 ~~In accordance with Federal and State law, L.A. Care rounds recorded time to the nearest applicable fraction of an hour for non-exempt employees.~~ Employees shall not begin work more than seven minutes before their scheduled shift begins or leave work seven minutes after their scheduled shift ends. Exceptions are permissible only when an employee has received advance approval by his/her manager or supervisor to work overtime.

4.5 All employees are required to complete a time off request for all non-worked time such as Paid Time Off (PTO), bereavement, jury duty, volunteer time, etc., through the automated time record system, and have their manager or supervisor approve the request. In the event the employee is unable to request time off prior to his/her time

off, he/she must record the time immediately upon his/her return unless the manager or supervisor has recorded the time off on their time record.

4.6 All employees who have to make changes or corrections to their time record, but are unable to do so before the automated time management system is locked must immediately work with their manager or supervisor to amend and approve their time record.

4.7 All non-exempt employees who miss a time punch(es) for a pay cycle that is closed must work with their manager or supervisor to amend and approve their time record.

4.8 All time records through the automated time management system are official and legal documents. The time records, when completed and approved, constitute the only basis on which a paycheck is produced. Time record shall not be falsified. All time records are to be retained by the Finance department for at least four years. Falsification of a time record may result in disciplinary action, up to and including termination of employment.

4.9 Workday schedules are normally eight hours and workweek schedules are normally 40 hours in duration and may be adapted or modified as determined by management based on business needs. L.A. Care may utilize alternative work shifts for certain positions.

4.10 Non-exempt employees performing work outside of their scheduled work hours must record that time worked in the automated time management system. In the event that a ~~non-exempt~~non-exempt employee performs work during scheduled PTO, the employee's manager will need to adjust the employee's ~~time card~~timecard to reflect actual time worked.

~~**4.10**~~**4.11** Any violation(s) of this policy may result in disciplinary action, up to and including termination of employment.

~~**5.0**~~ **MONITORING:**

~~**5.1**~~**5.0** Human Resources reviews its policies routinely to ensure they are updated appropriately and has processes in place to ensure the appropriate required steps are taken under this policy.

~~**6.0**~~ **REPORTING:**

~~**6.1**~~**6.0** Any suspected violations to this policy should be reported to your Human Resources Business Partner.

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

	WORKPLACE BULLYING	HR-229
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)		

DATES					
Effective Date	1/6/2014	Review Date	~~12/21/2018~~9/26/2024~~3~~/12/2025	Next Annual Review Date	~~12/21/2019~~9/26/2025~~3~~/12/2026
Legal Review Date	~~12/12/2018~~11/7/2024	Committee Review Date	~~n/a~~3/26/2025		

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

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	~~Ruben Simental~~Jyl Russell
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Business Supp Svcs, Learning Experience and Organizational Excellence ~~Senior Director, Human Resources Business Support Services~~

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

REFERENCES
➢ HR-211 Non-Retribution/Non-Retaliation

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
11/1/2017	Revision: Workplace B~~b~~ullying definition expanded to include examples of bullying or abusive behavior. Non-retaliation for good faith reporting added. Violations reporting procedures updated.
12/21/2018	Review - combined policy and procedures and non-substantial editing changes made.
~~9/26/2024~~3/12/2025	~~Added 2.2.5~~Clarified definitions and made edits to the Procedure section.

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 L.A. Care Health Plan (L.A. Care) strives to maintain a work environment that is professional, productive, and characterized by mutual respect. Workplace Bullying or Abusive Conduct can create ~~s~~ a threatening, intimidating, or ~~humiliating~~ hostile work environment that undermines the philosophy and policies of L.A. Care, and will not be tolerated.

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**~~ **"Workplace Bullying" or "Abusive Conduct"**: ~~–~~ is conduct ~~by an employer or employee~~ in the workplace ~~which~~ that targets another ~~employee~~ person or group ~~,t with malice, t~~hat a reasonable person would find intimidating, hostile, offensive, and unrelated to an employer's legitimate business interests. Abusive Conduct may include repeated infliction of verbal abuse, such as the use of derogatory or demeaning remarks, insults, and epithets; unwelcome or uninvited physical conduct such as gestures, physical contact or, blocking movement; unwelcome or uninvited conduct such as hazing or displaying or posting objectionable images, pictures, photographs, cartoons, or other actions of an intimidating, humiliating, or threatening nature or other actions that a reasonable person would find threatening, intimidating, or humiliating, or the gratuitous sabotage or undermining of a person's work performance. A single act shall not constitute Abusive Conduct, unless the act is especially severe and egregious. ~~Abusive Conduct or Workplace Bullying is separate and distinct from the conduct of persons who merely do not like each other or do not "get along". Abusive Conduct or Workplace Bullying does not include reasonable supervision correction action orand appropriate disciplinary actione. Workplace Bullying or Abusive Conduct must:~~

~~**2.1.1** be severe or pervasive, and~~

~~**2.1.2** substantially interferes with the target's work performance, or3~~

~~**2.1.3** create an intimidating, hostile, or offensive work environment.~~

~~**2.2** The conduct described in Sections 2.1.1-2.1.3 above, need not be based on a protected class status as identified by Federal and/or State Employment Discrimination laws. Some examples of Workplace Bullying or Abusive Conduct may include, but are not limited to, the following verbal and non-verbal conduct by a person or a group, which meets the criteria in Sections 2.1.1-2.1.3, above:~~

~~**2.2.1** Unsolicited and abusive verbal conduct, such as personal insults, epithets, profane or demeaning comments, threats, jokes, or other actions of an intimidating, humiliating, or threatening nature.~~

~~2.2.2~~2.1 ~~Unwelcome or uninvited physical conduct such as gestures, physical contact, blocking movement or other actions of an intimidating, humiliating, or threatening nature.~~

~~**2.2.3** Unwelcome or uninvited conduct such as hazing or displaying or posting of objectionable images, pictures, photographs, cartoons, other activities, or actions of an intimidating, humiliating, or threatening nature.~~

~~Unwelcome or uninvited communications-related conduct, such as postings or communications on electronic, internet-based, or other forms of communication, including but not limited to, person to personal conversations, telephone, voicemail, email, text messaging, instant messaging, and social media.~~

~~Any inappropriate conduct that unreasonably interferes with another's work performance or creates an intimidating, offensive, or hostile environment and which is inconsistent with L.A. Care's standards of professionalism, sound judgment, and respect for employees and others with whom L.A. Care does business.~~

~~**2.2.4**~~

~~2.3~~2.2 **Good Faith ~~Complaint~~:** ~~–~~ acting honestly and/or with sincerity of intention. ~~is a sincere and honest complaint that is made without malice or the desire to defraud another employee.~~

3.0 POLICY:

3.1 L.A. Care prohibits Workplace Bullying or Abusive Conduct toward ~~its employees~~others. Furthermore, retaliation of any kind against individuals who make a complaint in G~~g~~ood F~~f~~aith or who assist in an L.A. Care investigation is prohibited. Employees who violate this policy are subject to disciplinary action, including termination of employment. (Please see HR-211 Non-Retribution/Non-Retaliation)

~~**3.1**~~ Among L.A. Care's values, ~~is~~ are adherence to the highest standards of personal and professional conduct at all times, and maintenance of a work environment that is professional and respectful. ~~Nothing in this policy shall prevent employees or any person subject to this policy from exercising any right guaranteed by state or federal law.~~ Nothing in this policy shall prohibit L.A. Care from exercising reasonable supervision and discipline of employees.

3.2 ~~L.A. Care's policy prohibits unlawful retaliation, retribution or any form of unlawful harassment against any other employee for reporting, in good faith, such a concern relating to potential violation of applicable laws or L.A. Care's policies, or for providing information related to such a concern or a complaint in good faith (HR-211 Non-Retribution/Non-Retaliation) also applies to issues related to Workplace Bullying.~~

~~3.3 L.A. Care prohibits Workplace Bullying or Abusive Conduct toward its employees. This policy applies to all management and non-management employees of the organization. Furthermore, this policy prohibits retaliation of any kind against individuals who make a complaint in good faith or who assists in an L.A. Care investigation. Employees who violate this policy are subject to disciplinary action, up to and including termination of employment.~~

~~3.4~~3.3 This policy applies to all conduct by all employees of L.A. Care as well as conduct between an employee and a third party (such as a vendor, representative, consultant, and/or member of the Board of Governors) on L.A. Care's premises and to all conduct off premises that ~~has an effect upon~~affects the employee.

This policy does not supersede or alter the provisions and requirements of other policies, including without limitation HR-202 Anti-Discrimination/Anti-Harassment.

3.4

~~3.5 Nothing in this policy shall prevent employees or any person subject to this policy from exercising any right guaranteed by state or federal law.~~

4.0 PROCEDURES:

~~4.1~~ Any ~~employee who is subjected to offensive comments, or acts, or who witnesses such comments or acts, is encouraged to notify the person engaged in such conduct that their behavior is unacceptable; if the employee is not comfortable doing so, the employee and is encouraged should to report the offensive comments, or acts to~~suspected violations of this policy should be reported to your ~~their~~ supervisor, any manager or department head, any member of the L.A. Care's Leadership Team, Human Resources, Human Resources Business Partners at ~~my~~HRBusinesspartner~~partner~~@lacare.org ~~or ext. 6947 (myhr)~~, Compliance Helpline at (800) 400-4889, or Legal Department. Any person may take these steps without fear of retaliation.

~~4.2 Workplace bulling or abusive conduct by an employer or employee which targets another employee or group, with malice, that a reasonable person would find hostile, offensive, and unrelated to an employer's legitimate business interests is not tolerated by L.A. Care.~~

4.1

~~4.2.1 A single act shall not constitute abusive conduct, unless the act is especially severe and egregious. Abusive conduct or workplace bullying is separate and distinct from the conduct of persons who merely do not like each other or do not "get along".~~

~~4.2.2 Abusive conduct or workplace bullying does not include reasonable supervision and discipline.~~

~~4.2.3 Workplace bullying or abusive conduct must:~~
~~4.2.3.1 be severe or pervasive, and~~
~~4.2.3.2 substantially interfere with the target's work performance, or~~
~~4.2.3.3 create an intimidating, hostile or offensive work environment.~~

~~4.2.4 The conduct described in Sections 2.2.1-4 above, need not be based on a protected class status as identified by Federal and/or State Employment Discrimination laws. Some examples of workplace bullying or abusive conduct include, but are not limited to, the following verbal and non-verbal conduct by a person or a group, which meets the criteria in Sections 2.2-1.4, above:~~
~~4.2.4.1 Unsolicited and abusive verbal conduct, such as personal insults, epithets, profane, or demeaning comments, threats, jokes, or other actions of an intimidating, humiliating or threatening nature.~~
~~4.2.4.2 Unwelcome or uninvited physical conduct such as gestures, physical contact, blocking movement or other actions of an intimidating, humiliating or threatening nature.~~
~~4.2.4.3 Unwelcome or uninvited other conduct such as hazing or displaying or posting of objectionable images, pictures, photographs, cartoons other activities or actions of an intimidating, humiliating or threatening nature.~~
~~4.2.4.4 Unwelcome or uninvited communications-related conduct, such as postings or communications on electronic, internet- based or other forms of communication, including but not limited to, person to person conversations, telephone, voicemail, email, text messaging, instant messaging and social media.~~

~~4.3~~4.2 Upon receipt of a complaint, the supervisor or manager must report the complaint to the Human Resources Department. A complaint can be verbal or written. All complaints must be made in Ggood Ff~~f~~aith ~~and should be sincere and honest~~, without ~~malice~~ improper motive or the ~~desire~~ intent to defraud another employee.

~~4.4~~4.3 Employees are at all times held accountable to perform their jobs regardless of whether they have made a complaint under this policy.

~~4.5 Any form of retaliation that includes, but is not limited to, derogatory comments against individuals making complaints, or against witnesses, or against any other involved employee, is prohibited.~~

~~4.6~~4.4 L.A. Care provides ~~Prevention of Abusive Conduct training, as a component of training and education to prevent sexual harassment to all supervisory employees every two years.~~ various trainings to educate employees of all levels to recognize and prevent harassment and W~~w~~orkplace B~~b~~ullying.

4.74.5 These procedures do not supersede or alter the provisions and requirements of the policies and desktop procedures, including without limitation HR-202 Anti-Discrimination/Anti-Harassment.

4.85.0 **MONITORING:** Human Resources has processes and guidelines in place for maintaining relevant information about concerns and complaints raised under this policy.

5.06.0 **REPORTING:**

5.16.1 Any employee who is subjected to offensive comments or acts, or who witnesses such comments or acts, is encouraged to notify the person engaged in such conduct that their behavior is unacceptable; and is encouraged to report the offensive comments or acts to their supervisor, any manager or department head, any member of the L.A. Care's Leadership Team, Human Resources, Human Resources Business Partners at ~~my~~HRBusiness~~partner~~partner@lacare.org ~~or ext. 6947 (myhr),~~ , Compliance Helpline at (800) 400-4889, or Legal Department.

5.26.2 Employees who violate this policy are subject to disciplinary action, up to and including termination of employment.

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