Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

The New Provider Orientation Handbook

L.A. Care HEALTH PLAN®

Revised: 10/14/15

LA1456 10/15

Dear L.A. Care Contracted Provider,

L.A. Care Health Plan (L.A. Care) has created this provider orientation handbook to ensure that your L.A. Care contracted Participating Provider Group (PPG) or Management Services Organization (MSO) has the necessary tools to train you, the Primary Care Physicians and/or Specialists, on the Medi-Cal Managed Care program and L.A. Care's policies and procedures.

According to L.A. Care's contract with the State of California's Department of Health Care Services, new contracted providers MUST be trained within 10 business days of active status.

The information provided will allow you and your staff to gain a broad understanding of L.A. Care's mission, the importance of positive customer service experiences, member benefits, and member rights and responsibilities. If you would like more information, please reference the L.A. Care Provider Manual by visiting **www.lacare.org**.

Additionally, if you need clarification on any of the information provided, please contact your PPG or MSO for further guidance.

Welcome to the L.A. Care Health Plan Network!

Table of Contents

L.A. Care's History

Established in 1997, L.A. Care is an independent local public agency created by the state of California to provide health coverage to low-income Los Angeles County residents. L.A. Care is the nation's largest publicly operated health plan. Serving more than 1.8 million members, our mission is to ensure our members get the right care at the right place at the right time. For more history and information on L.A. Care, please visit **www.lacare.org**.

L.A. Care's Delegated Model

L.A. Care delegates certain authorization and claims processing to some of its contracted Participating Provider Groups (PPGs) and Management Services Organizations (MSOs). Delegation is when an entity gives another entity the authority to carry out a function that it would otherwise perform, such as operating within the parameters agreed upon between the health plan and PPG/MSO.

The National Committee on Quality Assurance (NCQA) holds L.A. Care to the following requirements:

- Delegation Agreement - A mutual agreement between L.A. Care and its PPG/MSO outlining specific delegated functions that meet NCQA standards.
- Oversight and Monitoring – L.A. Care must oversee the delegates to ensure that the delegate is properly performing all delegated functions.

For more information on NQCA standards and functions, please visit their website at **http://www.ncqa.org/AboutNCQA.aspx**.

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care which emphasize primary and preventive care. Managed care plans like L.A. Care, have been proven to be a cost-effective use of health care resources that improve health care access and assure quality of care.

In order to determine who is responsible for paying a claim, please contact the members assigned PPG/MSO or reference your PPG/MSO contract for more information.

Timely Filing Deadline

L.A. Care cannot impose a timeframe for receipt of an 'initial claim' submission less than 90 days for contracted providers or 180 days for non-contracted providers after the date of service for timely filing for a new claim.

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 form for facility services. L.A. Care accepts EDI submissions, please reference **http://www.lacare.org/providers/provider-resources/provider-forms**.

Claims Adjudication

Each claim is subject to a comprehensive series of quality checks called "edits" and "audits." Quality checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit and audit checks include verification of:

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

Provider Portal Claims Verification

- The L.A. Care Provider Portal is the preferred method for contracted providers to check claims status. Please see information on how to access the L.A. Care Provider Portal in the Provider Portal section of this handbook.
- The secondary method to check claims status is by calling 1-866-LA-CARE6.

Balanced Billing

Balance billing L.A. Care members is prohibited by law. Contracted providers cannot collect reimbursement from a L.A. Care member or persons acting on behalf of a member for any services provided, except to collect any authorized share of cost.

Provider Disputes

When the claim is the responsibility of the PPG/MSO, a provider dispute can be filed in writing with the PPG/MSO. Contact the PPG/MSO for more information on how to file a claims dispute. If the provider is dissatisfied with the resolution of the initial dispute filed with the PPG/MSO, a second level dispute may be filed with L.A. Care's Claims Provider Disputes unit. A copy of the PPG/MSO denial or Notice of Decision letter must fully describe the dispute and the PPGs/MSOs decision. The second level dispute must include a description of timelines as well as information to support the description of the dispute along with the claim.

Provider disputes must be submitted to:
L.A. Care Health Plan
Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

Authorizations

In order to determine who is responsible for authorization of services, please contact the members' assigned PPG/MSO or reference your contract with the PPG/MSO for more information.

Professional authorizations and payment of claims for those services are usually the responsibility of the PPG. For all other services, PPGs/MSOs and L.A. Care have a contractual document that defines which entity is responsible for a service (e.g., Division of Financial Responsibility and a Delegation Agreement). For additional information on what services are paid for by the PPG or L.A. Care, please call your PPG/MSO.

You can access the *Delegation Matrix* tool to identify which PPG is at risk for authorizing services by visiting **http://www.lacare.org/sites/default/files/Provider%20Authorization%20and%20Billing%20Guidance%2006%2017%2015.pdf**

A copy of L.A. Care's Authorization Request Form is available at: **http://www.lacare.org/sites/default/files/PL0022c_Updated_Auth_Req_Form_10%2001%202015_FINAL.pdf**

Services That Do Not Require Prior Authorization

- Emergency Services, whether in or out of L.A. County but within the continental USA (except for care provided outside of the United States which is subject to retrospective review)
- Emergency Care provided in Canada or Mexico is covered
- Urgent care, whether in or out of network
- Mental health care and substance use treatment
- Routine Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams
  - This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care
- Family planning services, including: counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases, includes: testing, counseling, treatment and prevention
- Emergency medical transportation

Services That May Require Prior Authorization

Note: As the Prior Authorization process may vary between PPGs/MSOs, verify with your contracted PPG/MSO that these services are correct.

- Non-emergency out of area care (outside of L.A. County)
- Out of network care, services not provided by a contracted network doctor
- Inpatient admissions, post-stabilization/non-emergency/elective
- Inpatient admission to skilled nursing facility or nursing home
- Outpatient hospital services/surgery
- Outpatient, non-hospital , such as surgeries or sleep studies
- Outpatient diagnostic services, minimally invasive or invasive such as CT Scans, MRIs, colonoscopy, endoscopy, flexible sigmoidoscopy, and cardiac catheterization

- Durable Medical Equipment, standard or customized; rented or purchased
- Medical Supplies
- Prosthetics and Orthotics
- Home Health Care, including: nurse aide, therapies, and social worker
- Hospice
- Transportation (excluding emergency medical transportation)
- Experimental or Investigation Services
- Cancer Clinical Trials

Hospital and Ancillary Provider Network

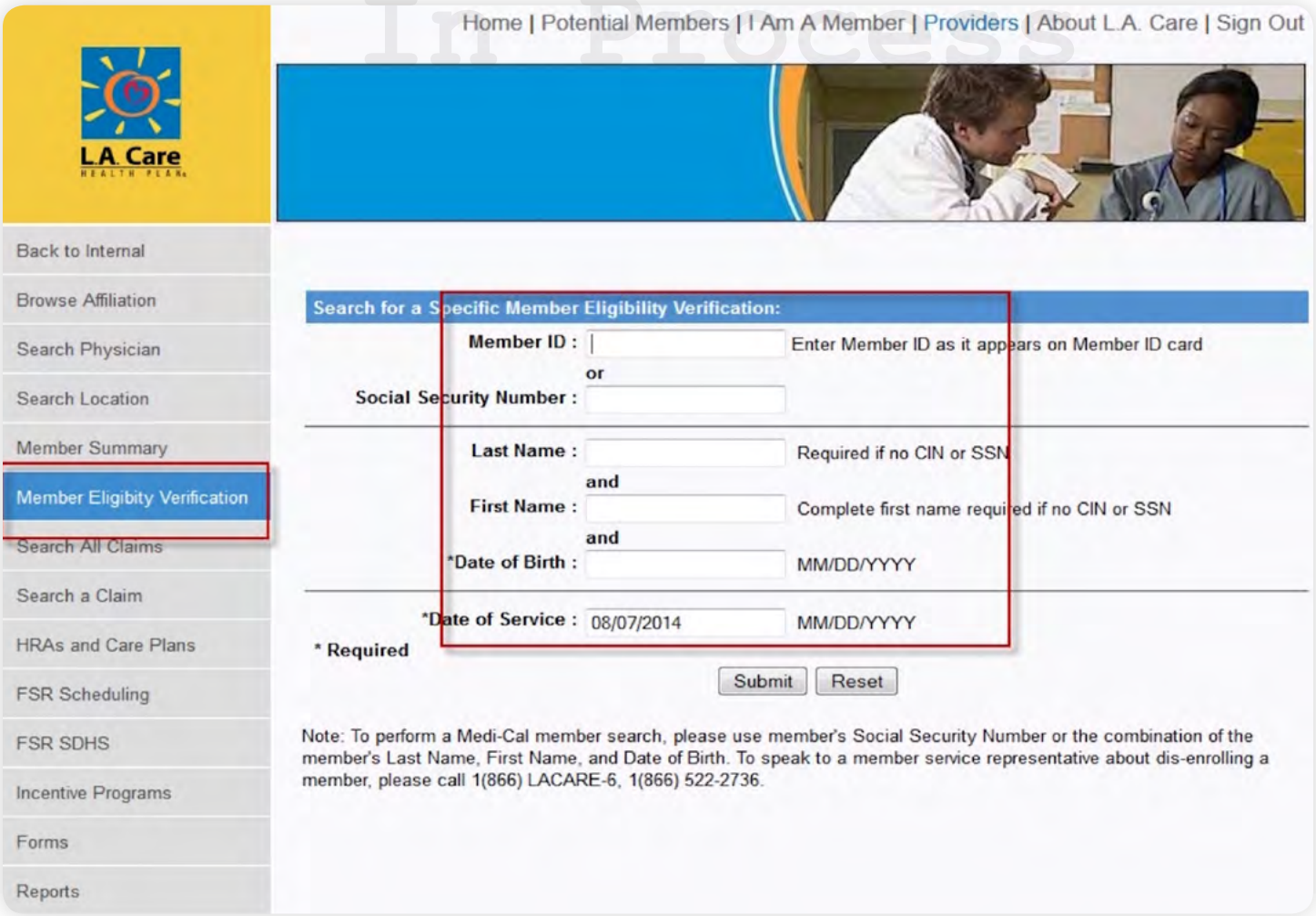
L.A. Care maintains a network of contracted hospitals and ancillary providers. Please contact your PPG/MSO for the most recent list to be utilized for services provided to L.A. Care Direct members.

Checking Member Eligibility

A. Log on to the Provider Portal then select "Member Eligibility Verification."

B. Please fill out all fields with as much information as possible to get the best results. Click "submit" when finished. See Figure 1.

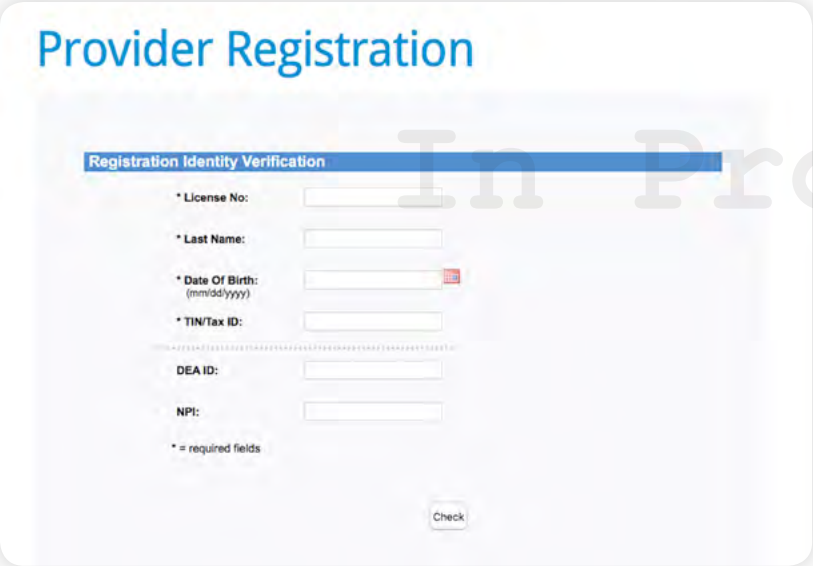
Figure 1.



Provider Portal: Registering a New Provider
All contracted physicians and specialist may self-register at
http://www.lacare.org/providers/provider-sign-in/provider-registration.

All information marked with an asterisk is required in order for your request to be processed. See Figure 2.

Figure 2.



All other medical and administrative staff have to submit a request for registration for the Provider Portal. This request can be submitted via email to providerrelations@lacare.org or by phone at 1-213-694-1250 x 4719. The required information that needs to be specified is listed below:

- Name of organization (as listed in the contract)
- Organization address
- Full name of person(s) that need access
- Job title
- Phone number
- Email address
- Purpose/reason why access is needed

Please note all Provider Portal registration requests will be processed within 3 - 5 business days.

Once you receive access to the Provider Portal you will be notified via email to confirm your registration. You will have 24 hours to activate your account with the link provided to you by email. If you do not activate your account within the 24-hour period you will have to contact the Provider Relations department at PPO@lacare.org or by phone at 1-213-694-1250 x5200 to receive a new activation email for your account.

Seniors and Persons with Disabilities

Under federal and state law, medical care providers must provide individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services accessible and,
- Effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.

Physical Access

Providers must make their facilities, as well as their medical equipment and exam rooms accessible. The law requires the development and maintenance of accessible paths of travel to elevators, ramps, doors that open easily, reachable light switches, accessible bathrooms, accessible parking and signage that can assist individuals who are blind or have low vision.

Additionally, health care providers must provide accessible equipment, such as exam tables, diagnostic equipment and the use of a lift or trained staff who can ensure equal access to medical testing.

Reasonable Modifications

The Americans with Disabilities Act (ADA) provides protection from discrimination for people with all types of disabilities, including people with physical, cognitive, communication and mental health disabilities. Health care providers must make reasonable modifications in policies, practices and procedures when necessary to avoid discrimination on the basis of disability, unless the provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.

Examples of reasonable modifications health care providers may need to make for individuals with disabilities are:

- Spend additional time explaining individualized member care plans to ensure understanding
- Scheduling an appointment to accommodate a member with an anxiety disorder who has difficulty waiting in a crowded waiting room
- Allowing members to be accompanied by service dogs

Note: A health care provider cannot require individuals who are visually impaired or hard of hearing to bring someone with them to interpret or facilitate communication. Health care providers cannot charge members for providing any form of interpreter services.

Procedures for Providing Accommodations

Health care providers must:

- Ensure that individuals are informed of their right to request accommodations
- Provide individuals with information about the process for requesting accommodations
- Provide individuals with information about filing complaints about accommodations with L.A. Care if the provider is in the L.A. Care network, and filing complaints with other entities that oversee disability access laws in the health care context.

Health Assessments and Provider Toolkits

Initial Health Assessments

Primary Care Providers (PCP) are responsible for conducting a health assessment screening. All new members must have an initial health assessment (IHA) within:

- Medi-Cal members - 120 calendar days from the date of enrollment with L.A. Care. L.A. Care does not mandate utilization of a standardized form for the IHA. L.A Care does require the documentation of specific elements of the assessment. L.A. Care does provide samples of Well Child Assessment forms. A full description of the IHA process is available in the L.A. Care Provider Manual. Copies of the assessment forms are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Staying Healthy Assessments

For Medi-Cal enrollees, L.A. Care requires the completion of the Staying Healthy Assessments to be administered during the IHA and periodically thereafter as the patient enters a new age category. Forms are located at: **http://www.lacare.org/providers/provider-resources/staying-healthy-forms**.

Provider Toolkits

L.A Care maintains accessible toolkits and resources to assist providers in managing the care of our members. Currently toolkits include:

- Appropriate Use of Antibiotics
- Asthma
- Cardiovascular Care
- Childhood and Adolescent Wellness Flyers
- Chlamydia
- COPD
- Diabetes and Cardiovascular Care
- Obesity Toolkit for Adult and Children
- Pre/Post Bariatric Surgery Toolkit
- Perinatal Care
- Tobacco Control and Cessation
- Better Communication, Better Care: A Provider Toolkit for Serving Diverse Populations
- Behavior Health Provider Toolkit
- Behavioral Health Toolkit for PCPs
- Depression Provider Toolkit

The medical and mental health toolkits are available at **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

The CHDP program provides health assessments for the early detection and prevention of disease and disabilities for low-income children and youth.

CHDP health assessments screenings should consist of the following:

- health history
- physical examination
- developmental assessment
- nutritional assessment
- dental assessment
- vision and hearing tests
- a tuberculin test
- laboratory tests
- immunizations
- health education/anticipatory guidance
- referrals for any needed diagnosis and treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

PCPs are required to follow-up with the components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided. EPSDT services include all services covered by Medi-Cal. A beneficiary under the age of 21 may receive additional medically necessary services.

EPSDT Screening Services

Screening services provided at intervals that meet standards of medical and dental practice, and at such other medically necessary intervals to determine the existence of physical or mental illnesses or conditions. Screening services must at a minimum include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development)
- a comprehensive physical exam
- appropriate immunizations
- laboratory tests (including blood lead level taking into account age and risk factors)
- health education (including anticipatory guidance)

EPSDT Diagnostic Services

EPSDT covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.

ESPDT Treatment Services

Mental Health and Substance Use Services:

- Treatment for mental health and substance use issues and conditions is available under a number of Medi-Cal service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist.

Medically Necessary Personal Care Services

- Are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility, or institution for mental disease, that are:

  (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State), otherwise authorized for the individual in accordance with a service plan approved by the State

  (B) provided by an individual who is qualified to provide such services and is not a member of the individual's family

  (C) furnished in a home or in another location

Oral Health and Dental Services:

- Dental care needed for relief of pain, infection and maintenance of dental health (provided as early an age as necessary).
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.
- Medi-Cal Dental Care and Treatment Services are a carved out benefit for Medi-Cal members through the Medi-Cal Denti-Cal Program. Primary Care Providers are expected to perform dental screenings on all Medi-Cal members as part of the IHA, periodic, and other preventive health care visits and provide referrals to the Medi-Cal Denti-Cal Program for treatment. For children, Denti-Cal uses the periodicity schedule recommended by American Academy of Pediatric Dentistry (AAPD). Also some Dental benefits for adults 21 and older have been recently restored. To find a dentist, Medi-Cal members should be advised to call Denti-Cal at 1-800-322-6384 or visit **http://www.denti-cal.ca.gov**.

Vision and Hearing Services

- EPSDT requires that vision services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.
- Glasses to replace those that are lost, broken, or stolen also must be covered.
- Medi-Cal vision benefits are covered by L.A. Care.
- L.A. Care has contracted with Vision Service Plan (VSP) to coordinate Medi-Cal vision care and lenses.
- To find out more about eye exams or vision care coverage for Medi-Cal members, call VSP at 1-800-877-7195 [TTY/TDD 1-800-428-4833].
- To find out more about eye exams or vision care coverage, you can also call L.A. Care Member Services at the toll free number 1-888-839-9909 [TTY/TDD 1-866-522-2731].

- EPSDT requires that hearing services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Vaccines for Children (VFC)

The Vaccines for Children Program, established by an act of Congress in 1993, helps families by providing free vaccines to doctors who serve eligible children 0 through 18 years of age. The VFC program is administered at the national level by the United States Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers are able to order vaccine through their state VFC program and receive routine vaccines at no cost. This allows routine immunizations to eligible children without high out-of-pocket costs.

Appropriate documentation shall be entered in the member's medical record. It should indicate all attempts to provide immunizations. A receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statements by the member (if an emancipated minor) or the parent(s), or guardian of the member, shall be entered in the member's medical record. Please contact your PPG or MSO for further details.

The Vaccines for Children (VFC) Program is managed by the California Department of Public Health, Immunization Branch. A full description of the program and potential conditions is located at:

- **https://www.cdph.ca.gov/programs/immunize/Pages/HealthProfessionals.aspx**
- **http://eziz.org/vfc/overview/**

California Children Services (CCS)

CCS is a statewide program that treats children under the age of 21 with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Providers are required to refer children with certain physical limitations and chronic health conditions or diseases to a CCS paneled provider or CCS Specialty Care Center for care. A full description of the program and potential CCS conditions is located at:

- **http://publichealth.lacounty.gov/cms**
- **http://www.lacare.org/providers/provider-resources/provider-faqs/ccs**

Services for the Developmentally Disabled

The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment that begins before an individual reaches adulthood. These disabilities include mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation or requiring similar treatment.

For an individual to be assessed in California as having a developmental disability, the disability must begin before the individual's 18th birthday, be expected to continue indefinitely and present a substantial disability. For additional information, please visit the L.A. Care website at: **http://www.lacare.org/dds-0**

Early Intervention/Early Start

A child with or at risk of developmental delay or disability can receive an "Early Start" in the State of California. Teams of service coordinators, health care providers, early intervention specialists, therapists, and parent resource specialists can evaluate and assess an infant or toddler. They can also provide appropriate early intervention services to children eligible for California Early Start. For more information, please refer to the section below; "Primary Care Responsibilities for Care Coordination with Linked and Carved out Services."

Eligibility Criteria

Infants and toddlers from birth to 36 months may be eligible for Early Intervention services through documented evaluation and assessment if they meet one of the criteria listed below:

- Have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing
- Have established risk conditions of known etiology, with a high probability resulting in delayed development
- Are at high risk of having a substantial developmental disability due to a combination of risk factors

For additional information on Early Intervention and Early Start, please see L.A. Care's website at: **http://www.lacare.org/dds-0**

Primary Care Responsibilities for Care Coordination with Linked and Carved out Services

PCPs are responsible for Coordination of Care for Linked and Carved out Services (i.e. CCS, DDS, Regional Centers, etc.).

Care Managers at L.A. Care or the PPG/MSO are available to assist members, who may need or who are receiving services from out of plan providers and/or programs. This service is available to ensure coordinated service delivery and effective joint case management. The coordination of care and services remains the responsibility of each member's PCP. PPG's and the member's PCP will monitor the following:

- Member referral to and/or utilization of special programs and services
- Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- Routine medical care, including providing the necessary preventive medical care and services
- Provision of Initial Health Assessments including the Staying Healthy Assessment (SHA)

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

Out-of-Plan Case Management and Coordination of Care for Linked and Carved out Services

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

Medical Record Documentation

L.A. Care requires physician offices to maintain a certain level of medical record documentation. L.A. Care will assess records using the DHCS Medical Record Review Guidelines during the Facility Site Review process. A copy of the guidelines are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Behavioral Health

Beacon Health Options is L.A. Care's delegated vendor for non-specialty mental health services. All services listed below are provided to our members:

- Individual, and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication and treatment
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation
- For non-specialty mental health services, please contact:
  - Beacon Health Options
  - Phone Line: 1-877-344-2850

County Specialty Mental Health

There are no changes to County Specialty Mental Health services provided by Los Angeles County Department of Mental Health (DMH) or Substance Use Disorder Treatment by the Department of Public Health (DPH).

- For Specialty Mental Health services, please contact:
  - L.A. County Department of Mental Health (DMH)
  - Phone Line: 1-855-854-7771
- For Specialty Substance Use Disorder treatment, please contact:
  - L.A. County Department of Public Health (DPH)
  - Phone Line: 1-800-564-6600

L.A. Care's Behavioral Health Department

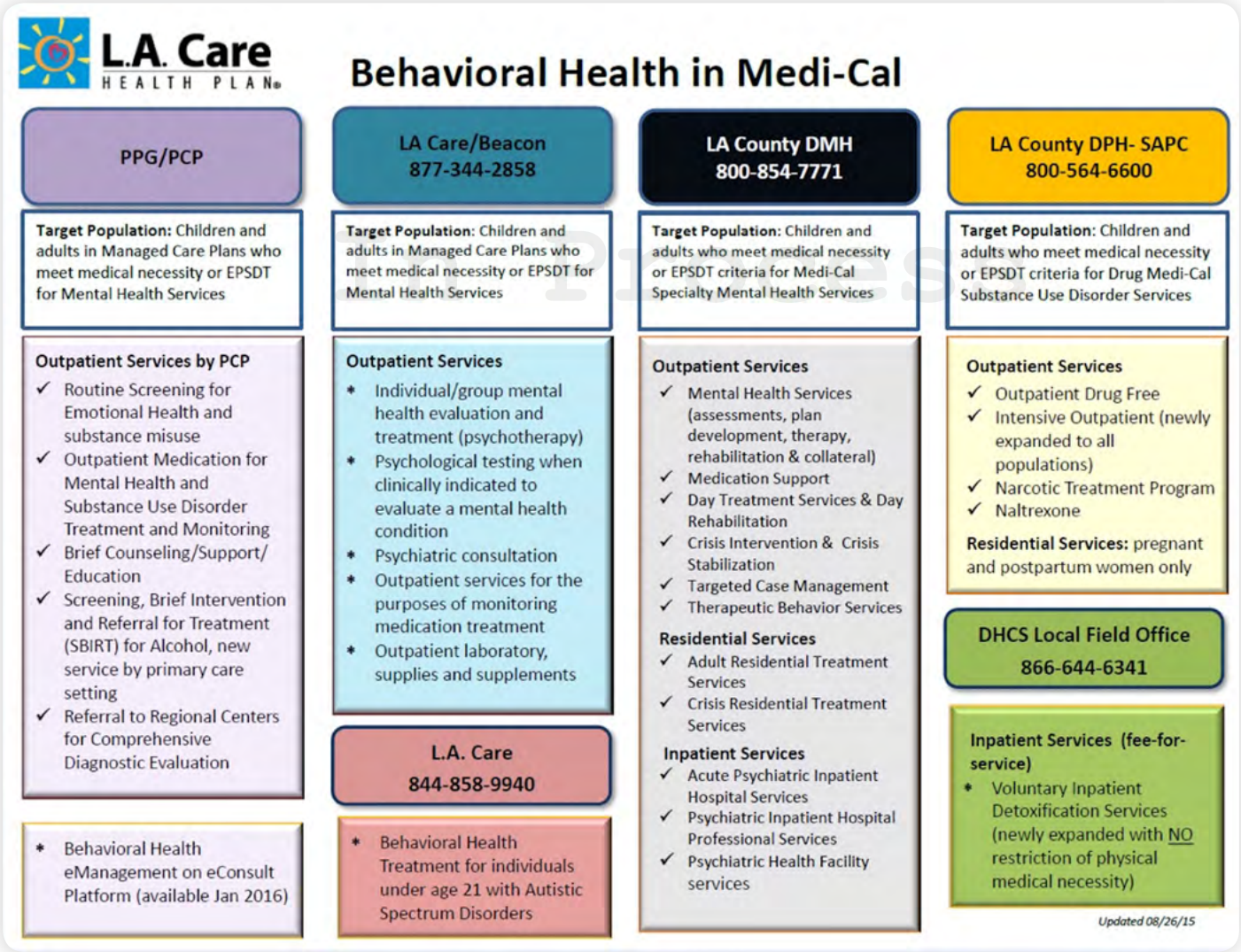
L.A. Care's Behavioral Health Department has licensed behavioral health staff dedicated to supporting you with the services listed below:

- Resolve behavioral health service access issues
- Ensure appropriate clinical transfer in behavioral health system of care
- Assist with service system coordination provided by the Beacon network
- Facilitate Care Coordination between Care Management and PPG Case Managers for behavioral health services
- Educate and train providers and the community
- Support members with behavioral health grievances, appeals and advocacy

This service is available Monday to Friday from 8 a.m. to 5 p.m. You can reach us by phone at 1-844-858-9940 or via email at **behavioralhealth@lacare.org**. Please note that protected health information (PHI) must be sent secured.

The following diagram illustrates services and correlating contact information for L.A. Care's Behavioral Health Medi-Cal program. See figure 3.

Figure 3.



Case Management

L.A. Care has a Case Management department (also known as Care Management) with specially trained staff to help members with complex care needs or members at high risk for adverse outcomes. Examples of members with complex needs may include:

- Serious acute or chronic health condition (trauma, new cancer diagnosis)
- multiple uncontrolled health conditions
- complicated social issues (no social support)

Please refer members with complex needs to L.A. Care through the following ways:

- Complete the Care Management Referral Form which is available on the L.A. Care Provider Portal
- Simply call the Care Management department during regular business hours at: 1-844-200-0104

We will work with our members to develop an Individualized Care Plan (ICP) and provide you with updates to the plan after holding an Interdisciplinary Care Team (ICT) meeting with participants most appropriate to address individualized needs.

Managed Long-Term Services and Supports (MLTSS)

MLTSS is a wide range of services that provide support to seniors and individuals with disabilities so that they can remain living safely at home. Services available to L.A. Care members under MLTSS include:

- **In Home Supportive Services (IHSS):** Provides in home care for seniors and people with disabilities. Eligible members can hire anyone they wish to help them with their daily needs. This includes assistance with home chores, personal care assistance, basic medical needs, getting to provider appointments and providing supervision for people with dementia or other mental impairments.
- **Multipurpose Senior Services Program (MSSP):** Provides intensive care coordination services in the home for seniors age 65 and older. An MSSP nurse and social worker team will provide eligible members with a full assessment of their health and social support needs. Additionally the MSSP team will identify, arrange and provide help with accessing resources, monitor the member's wellbeing, and purchase other needed services that may not be available through L.A. Care or other community based programs.
- **Community Based Adult Services (CBAS):** Provides professional nursing services, physical, occupational and speech therapies, socialization, mental health services, therapeutic activities, social services, nutrition and nutritional counseling for people ages 18 and older. CBAS is a day program formerly known as adult day health care center.
- **Long Term Care (LTC):** Provides continuous skilled nursing care to eligible members with physical or mental conditions in a nursing home. The Medi-Cal LTC nursing facility benefit includes room and board and other medically necessary services.

L.A. Care members receiving MLTSS often have complex needs. They may be diagnosed with multiple chronic conditions (functional and cognitive) or may lack social, educational, and economic support. The MLTSS department can help support your patient's access to needed care by:

- Determining if they are IHSS, CBAS, MSSP and LTC eligible
- Coordinating and navigating IHSS, MSSP and CBAS assessment
- Resolving IHSS, MSSP, CBAS and LTC related issues and navigating the grievance and appeals process
- Applying for IHSS and MSSP services
- Coordinating requests for expedited assessments
- Providing temporary services to fill in coordination of care gaps
- Following up with IHSS, MSSP, CBAS, and LTC services to ensure services are being provided
- Referring to local CBAS centers and MSSP sites
- Accessing community based organizations for non-plan services

To find MLTSS Referral forms, go to the L.A. Care website: **http://www.lacare.org/providers/provider-resources/provider-forms**

MLTSS Contact Information

For Managed Long Term Services and Supports questions:

MLTSS Phone Line: 1-855-427-1223

MLTSS Fax Line: 1-213-438-4877

MLTSS Email: **mltss@lacare.org**

L.A. Care Website: **www.lacare.org**

Federal and State Statutes

Federal Statutes

The Centers for Medicare & Medicaid Services(CMS), is part of the Department of Health and Human Services (DHHS). They administer Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and parts of the Patient Protection and the Affordable Care Act (ACA).

The link below provides access to proposed and existing statutes and regulations relevant to CMS.

https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

State Statutes

The Department of Health Care Services (DHCS) was created and is directly governed by California statutes passed by the California Legislature. These statutes grant DHCS the authority to establish programs and adopt regulations.

The link below provides access to proposed and existing statutes and regulations relevant to the DHCS.

http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx

Access and Availability Standards

L.A. Care requires primary care physicians, behavioral health providers, specialists and ancillary providers to be compliant with access and availability standards. The standards are provided below.

Access to Care Quick Tips

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Primary Care Provider (PCP) Accessibility Standards:			
Routine Primary Care Appointment (Non-Urgent) Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request if no authorization is required ≤ 96 hours if prior authorization is required		
Emergency Care Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	Immediate, 24 hours a day, 7 days per week		
Preventative health examination (Routine)	≤ 10 business days of request		≤ 30 calendar days of request
First Prenatal Visit A periodic health evaluation for a member with no acute medical problem	• ≤ 14 calendar days of request • ≤ 7 calendar days of request for Healthy Kids	≤ 14 calendar days of request	
Staying Healthy Assessment Initial Health Assessment and Individual Health Assessment and Individual Health Education Behavioral Health Assessment (IHEBA)	≤ 120 calendar days from when the member becomes eligible. Members <18 months of age ≤60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less.		≤ 90 calendar days from when the member becomes eligible.
In-Office Waiting Room Time The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.	Within 30 minutes		
Specialty Care Provider (SCP) Accessibility Standards:			
Routine Specialty Care Physician Appointment	≤ 15 Business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	• ≤ 48 hours of request if no authorization is required • ≤ 96 hours if prior authorization is required		
Ancillary Care Accessibility Standards:			
Non-Urgent Ancillary Appointment	≤ 15 business days of request		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

next page >

Access and Availability Standards (continued)

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Behavioral Health Care Accessibility Standards:			
Routine Appointment (includes non-physician behavioral health providers)	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request		
Life Threatening Emergency	Immediately		
Non-Life Threatening Emergency	≤ 6 hours of request		
Emergency Services	Immediate, 24 hours a day, 7 days per week		
After Hours Care Standards:			
After Hours Care Physicians (PCP, Behavioral Health Provider and Specialists, or covering physician) are required by contract to provide 24 hours a day, 7 days per week coverage to members. Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to member, upon request within 30 minutes. *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.	• Automated systems must provide emergency 911 instructions; and • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician within 30 minutes If process does not enable the caller to contact the PCP, Behavioral Health Provider, Specialist or covering practitioner directly, the "live" party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.		
Call Return Time (Practitioner's Office) The maximum length of time for PCP, Behavioral Health Provider, Specialist offices, covering practitioner or triage/screening clinician to return a call after hours.	≤ 30 minutes *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.		
Practitioner Telephone Responsiveness:			
Speed of Telephone Answer (Practitioner's Office) The maximum length of time for practitioner office staff to answer the phone.	≤ 30 seconds		
Member Services Department Call Service Standards:			
Speed of Telephone Answer • The maximum length of time for Member Services Department staff to answer the telephone. • Call Abandonment Rate	• 90% of calls ≤ 30 seconds • NTE 5% in a calendar month		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

1-866-LACARE6 (1-866-522-2736)
www.lacare.org

V. 10/5/2015

Members Rights and Responsibilities

L.A. Care Members have the right to the following:

- **Respectful and courteous treatment:** Members have the right to be treated with respect, dignity and courtesy by their provider and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.
- **Privacy and confidentiality:** Members have the right to have their medical records kept confidential. Provider offices must implement and maintain procedures that protect against disclosure of confidential patient information to unauthorized persons. Members also have the right to receive a copy of and request corrections to their medical records. Physicians must abide by California State minor consent laws. Members have the right to be counseled on their rights to confidentiality and members consent is required prior to the release of confidential information, unless such consent is not required.
- **Choice and involvement in their care:** Members have the right to receive information about their health plan, services, and providers. Members have the right to choose their Primary Care Provider (PCP) from L.A. Care's provider directory. Members also have the right to obtain appointments within access standards. Members have the right to talk with their provider about any care provided or recommended. Members have the right to discuss all treatment options, and participate in making decisions about their care. Members have the right to a second opinion. Members have the right to speak candidly to their provider about appropriate or medically necessary treatment options for their condition. Members have the right to deny treatment. Members have the right to decide in advance how they want to be cared for in case of a life-threatening illness or injury. Members also have the right to assist with the formulation of their advanced directives. Written policies and procedures respecting advanced directives shall be developed in accordance.
- **Voice concerns:** Members have the right to grieve about L.A. Care and/or its affiliated providers. They also have the right to receive care without fear of losing their benefits. L.A. Care will help members with the grievance process. If members don't agree with a decision, they have the right to appeal. Members have the right to disenroll from their health plan whenever they want. As a Medi-Cal member, they have the right to request a State Fair Hearing, including information on the circumstances under which an expedited fair hearing is possible.
- **Service outside of L.A. Care's provider network:** Members have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of their health plan's network. Members also have access to Federally Qualified Health Centers and Indian Health Services Facilities.
- **Service and information:** Members have the right to request an interpreter at no charge and not use a family member or a friend to translate for them. Members have the right to access the Member Handbook and other information in another language or format, including; braille, large size print, and audio format upon request.
- **Know their rights:** Members have the right to receive information about their rights and responsibilities. Members have the right to make recommendations about their rights and responsibilities. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

As a member of L.A. Care members have the responsibility to:

- **Act courteously and respectfully:** Members are responsible for treating providers and staff with courtesy and respect. Members are responsible for being on time for their visits or calling your office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information:** Members are responsible for giving correct information and as much information as they can to all of their providers and L.A. Care. Members are responsible for getting regular check-ups and telling their provider about health problems before they become serious.
- **Members should follow their provider's advice and take part in their care:** Members are responsible for talking about their health care needs with their provider, developing and agreeing on goals, doing their best to understand their health problems following the treatment plans and instructions you both agree on.
- **Use the Emergency Room only in an emergency:** Members are responsible for using the emergency room in case of an emergency or as directed by their provider.
- **Report wrong doing:** Members are responsible for reporting health care fraud or wrong doing to L.A. Care. Members can do this without giving their name by calling the L.A. Care Fraud and Abuse Hotline toll-free at 1-800-400-4889.

To access the L.A. Care Member Rights section on the website go to **http://www.lacare.org/members/member-protection/member-rights**.

Cultural and Linguistic Services

L.A. Care provides an array of cultural and linguistic services and resources to assist you in delivering effective patient-centered care. The following is a quick guide to help you and your staff understand the state and federal regulatory requirements that guide cultural and linguistic services to ensure compliance.

Bilingual Staff

Effective communication though qualified interpreters improves quality of care, increases member satisfaction and minimizes the risk of liability and malpractice lawsuits. L.A. Care offers no cost qualified interpreting services to you and your members in an effort to discourage the use of bilingual staff as interpreters. If a member of your staff is bilingual and utilizes the second language to interact with members, it is important they are qualified and proficient in English and the other language with proper training and education.

Please maintain the following documentation for your qualified bilingual staff:

- Certification for medical interpreters
- Number of years of service employed as an interpreter (e.g. resume)
- Certificate of completion interpreter training program
- Bilingual skills self-assessment

Bilingual Language Skills Self-Assessment Tool

The self-assessment tool is a resource to assist you in identifying language skills and resources existing in your office. It can be used to document bilingual skills of your staff before the professional assessment. The self-assessment tool is included in Section 1 of "What you need to know" in the Provider Toolkit. The assessment should be conducted annually for office staff and every three years for physicians.

- To order the toolkits go to **https://external.lacare.org/HealtheForm/**
- To download the toolkits go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**

Interpreting Services

Qualified interpreting services are essential to communicating effectively with limited English proficient members. L.A. Care's face-to-face and telephonic interpreting services are available to you and your staff at no charge. Interpreting services also include American Sign Language (ASL). The following information describes how to access these services:

- Face-to-face Interpreting Services
  - Call 1-888-839-9909 to request an interpreter for medical appointments.
- Telephonic Interpreting Services
  - Call 1-888-930-3031 to be connected with an interpreter over the phone immediately.
- California Relay Services
  - Call 711 to communicate with the deaf and hard of hearing members over the phone.

Key Things to Remember

- Inform members of the availability of no-cost 24/7 interpreting services including ASL.
- Document the member's preferred language in the medical chart.
- Discourage use of friends, family members and minors as interpreters.
- Document member's request/refusal of interpreting services in the medical chart after no-cost interpreting services are offered to them.

Language Poster

The language poster is an effective way to let your staff and members know about availability of no cost interpreting services and how to access the services from L.A. Care. The poster is translated into 14 languages and should be posted at the key points of contact such as front office and exam rooms.

To order the posters, go to **https://external.lacare.org/HealtheForm/**

Telephonic Interpreting Card

Keep the card available for easy access to no cost telephonic interpreters.

To order the telephonic card, go to **https://external.lacare.org/HealtheForm/**

Cultural and Linguistic Training

The following workshops are a rapid way to learn how to deliver culturally and linguistically appropriate care to diverse member populations. The below instructor-led classroom or Learning Management System (LMS) trainings are available at no cost for your convenience:

- Interpreting Services
- Cultural Competency
- Disability Awareness

To schedule classroom training sessions at your facility, contact **CLStrainings@lacare.org**

To access online LMS, go to **https://lacareuniversity.torchlms.com**

Cultural and Linguistic Provider Toolkit

The provider toolkit is a comprehensive guide to culturally and linguistically appropriate services. It is organized in five sections which contain helpful information and tools that can be reproduced as needed.

- To order the toolkits, go to **https://external.lacare.org/HealtheForm/**.
- To download the toolkits, go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

Online Resource Directory

To refer the members to cultural and linguistic community services, go to **http://www.healthycity.org/**.

Customer Service

The following are suggested best practices. The information consists of useful reminders and tips providers and medical office staff can utilize to enhance a positive customer service experience.

Build rapport with the member

- Address members by their last name if the member's preference of greeting is not clear
- Focus your attention on members when addressing them
- Learn basic words in your member's primary language, like "hello" or "thank you"
- Explain the different roles performed by office staff

Make sure members know your role

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed and how the provider coordinates specialty care
- Have instructions professionally translated and available in the common language(s) spoken by your member panel
- It is not necessary to raise the volume of your voice if the issue is language comprehension and not hearing

Keep members' expectations realistic

- Inform members of delays or extended wait times

Work to build members trust

- Inform members of office procedures, such as when they can expect a call with lab results, how follow-up appointments are scheduled and routine wait times

Determine if the member needs an interpreter for the visit

- Document the member's preferred language in the member chart
- Have an interpreter access plan. Use of interpreters with a medical background is strongly encouraged, rather than family, minors or friends of the member
- Assess your bilingual clinical staff for interpreter abilities

Give members the information they need

- Have health education materials in languages that reflect your membership
- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss

Make sure members know what to do

- Review any follow-up procedures with the member before they leave your office
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests and whether or not a follow-up appointment is necessary

Develop pre-printed simple handouts of frequently used instructions and translate the handouts into the common language(s) spoken by your membership

Styles of Speech

People vary greatly in the length of time between comments and responses. The speed of their speech and their willingness to interrupt may vary.

- Tolerate gaps between questions and answers; impatience can be seen as a sign of disrespect
- Listen to the volume and speed of the member's speech as well as the content. Modify your own speech to more closely match that of the member to make them more comfortable
- Rapid exchanges and even interruptions are a part of some conversational styles
- Do not be offended if a member interrupts you
- Stay aware of your interruption patterns, especially if the member is older than you are

Eye Contact

The way people interpret various types of eye contact is tied to cultural background.

- Look people directly in the eyes to demonstrate communication engagement
- For other cultures, direct eye contact is considered rude or disrespectful. Never force a member to make eye contact with you.
- If a member seems uncomfortable with direct eye contact, try sitting next to them instead of across from them

Body Language

- Follow the member's lead on physical distance and contact
- Stay sensitive to those who do not feel comfortable
- Gestures can have different meanings
- Be conservative in your own use of gestures and body language
- Do not interpret member's feelings or level of pain solely from facial expressions

Gently Guide Member Conversation

English language predisposes us to a direct communication style however, other languages and cultures differ.

- Non English speaking members or individuals from diverse cultural backgrounds may be less likely to ask questions

Facilitate member-centered communication

- Avoid questions that can be answered with "yes" or "no"
- Steer the member back to the topic by asking a question that clearly demonstrates that you are listening
- Some members can tell you more about their health through story telling than by answering direct questions

Thank you for taking this training. Please make sure to sign and attest that you have read and understood this information and provide a copy to your PPG or MSO. If you would like more information, please refer to the L.A. Care Provider Manual. If you have additional questions, please contact your PPG or MSO.

Produced by the L.A. Care Provider Network Operations department.