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SECTION I: INTRODUCTION

Welcome

We would like to welcome you to Care1st Health Plan. As a provider you play a very important role in the delivery of healthcare services to our Members.

The Care1st Health Plan Provider Manual is intended to be used for the provision of covered services to Care1st Health Plan Members. This manual contains policies, procedures, and general reference information including minimum standards of care, which are required of Care1st Health Plan providers.

As a Care1st Health Plan provider, we hope this information will help you better understand how Care1st Health Plan operates. Should you or a staff Member have questions about information contained in this manual or additional information about Care1st Health Plan, please feel free to contact our Provider Network Operations Department or your Provider Network Administrator in Care1st Provider Relations.

We look forward to working with you and your staff to provide quality managed healthcare service to Care1st Health Plan Members.

Care1st Health Plan

Care1st Health Plan (Care1st) acts as a “gatekeeper” for its Member’s healthcare needs, providing managed health care services to our Members. Care1st is responsible for monitoring the coordination and delivery of the health care our Members receive through follow-up care, pre-authorization approval of referred services, ordering of therapy, consultation, pharmaceutical services, and admission to hospitals.

Medi-Cal

Medi-Cal in California (known as Medicaid in other states) is administered by the State Department of Health Services (SDHS). It was established in 1965 to provide the necessary medical services for those eligible individuals whose income and resources were insufficient to provide for their health care. In California, the Medi-Cal program falls under the provisions of Title 22 of the California Code of Regulations. Since 1998, significant portions of the Medi-Cal population have been enrolled into managed care organizations on a mandatory basis.

In most counties, Medi-Cal is operated through a Two-Plan Model consisting of a commercial plan and a "local initiative". In L.A. County, the commercial plan is Health Net (which includes Universal Health Care and Molina Health Plan) and the local initiative is L.A. Care Health Plan (L.A. Care). L. A. Care has entered into an agreement with Care1st and four other Plan Partners to provide Medi-Cal Managed Care services to beneficiaries of Los Angeles County under the Two-Plan Model. San Diego County operates through Geographic Managed Care (GMC), a California Medi-Cal managed care model designed for Medi-Cal beneficiaries in clearly defined geographical areas of the State, to provide health care services to Medi-Cal enrollees in these specific counties.
Regulatory Agencies

Care1st is subject to government regulations at local, state, and federal levels including the following:
- The Centers for Medicare and Medicaid Services (CMS) - Administers the regulations under which a Prepaid Health Plan operates as a Federally Qualified Health Maintenance Organization.
- The California Department of Managed Health Care (DMHC) - Establishes many requirements in the areas of financial reporting, required services, and continuity of care. It administers the Knox-Keene Act and the Knox-Mills Health Plan Act.
- The California Department of Health Care Services (DHCS) - Establishes requirements part of the Medi-Cal managed Case program. The Plan’s Medi-Cal contracts with L.A. Care Health Plan make it subject to these regulations.

This manual is intended for providers of Care1st Medi-Cal Plans. Specific information on benefits, eligibility, enrollment, and co-payments are outlined within this manual.

SECTION 2: MISSION STATEMENT

Mission

Care1st Health Plan will be a provider-oriented organization that will strive to continuously improve the quality of services rendered to its Members.

Vision

Care1st Health Plan will be a leader in innovation utilizing advanced technology to achieve excellence in customer satisfaction for our Members, providers, and employees.

Values

Care1st Health Plan is committed to basic moral and ethical values driven by integrity, honesty, and respect for all.

SECTION 3: BENEFITS

3.1: Medi-Cal Managed Care

Listed in “Benefits Supplement”

SECTION 4: MEMBER RIGHTS & RESPONSIBILITIES

4.1: Member Rights & Responsibilities

PURPOSE:

To clearly outline Care1st Health Plan’s commitment to providing quality health care to its Members and to communicate to Members, Providers, and Staff the Member’s Right and Responsibilities.
POLICY:

A. It is Care1st Health Plan’s policy to provide quality health care to its Members. To assure Members of this commitment, Care1st has established these Member Rights and Responsibilities.

B. Care1st Health Plan requires its Providers to understand and abide by these Member Rights and Responsibilities when providing services to our Members. Providers are informed of Member Rights through the Provider Manual and Provider News Letters.

C. Care1st Health Plan informs each Member of these Rights and Responsibilities in Member’s Evidence of Coverage, which is distributed upon enrollment and annually thereafter.

MEMBER RIGHTS AND RESPONSIBILITIES

What are your health care rights?

You have the right to know.
- To know your rights and responsibilities.
- To know about our services, doctors, and specialists and be informed when your doctor is no longer contracted with Care1st Health Plan.
- To know about all our other caregivers.
- To be able to see your medical records. You have to follow the State and Federal laws that apply.
- To have an honest talk with your doctor about all treatment options for your condition, regardless of cost or benefit coverage.

You have the right to be treated well.
- To always be treated with respect.
- To have your privacy kept safe by everyone in our health plan.
- To know that we keep all your information private.

You have the right to be in charge of your health care.
- To choose your primary care doctor.
- To say no to care from your primary care doctor or other caregivers.
- To be able to make choices about your health care.
- To make a living will (also called an advance directive).
- To voice complaints or appeals about Care1st or the care it provides including the right to file a grievance if you do not receive services in the language you request.

You have the right to get a range of services.
- To get family planning services.
- To get preventative health care services.
- To get minor consent services.
- To be treated for sexually transmitted diseases (STDs).
- To get emergency care outside of our network.
- To get health care from a Federally Qualified Health Center (FQHC).
- To get health care at an Indian Health Center.
- To get a second opinion.
- To get interpreter services at no cost. This includes services for the hearing-impaired.
- To get informing information materials in alternative formats and large size print upon request.

You have the right to suggest changes to our health plan.
- To tell us what you don’t like about our health plan.
- To tell us what you don’t like about the health care you get.
- To question our decisions about your health care.
- To tell us what you don’t like about our rights and responsibilities policy.
- To ask the Department of Social Services for a Fair Hearing.
- To ask the Department of Managed Health Care for an Independent Medical Review.
- To choose to leave our health plan.

What are your responsibilities as a health care Member?

We hope you will work with your doctors as partners in your health care.
- Make an appointment with your doctor within 120 days of becoming a new Member for an initial health assessment.
- Tell your doctors what they need to know to treat you.
- Learn as much as you can about your health.
- Follow the treatment plans you and your doctors agree to.
- Follow what the doctor tells you to do to take good care of yourself.
- Do the things that keep you from getting sick.
- Bring your ID card with you when you visit your doctor.
- Treat your doctors and other caregivers with respect.
- Use the emergency room for emergencies only. Your doctor will provide most of the medical care that you need.
- Report health care fraud.

We want you to understand your health plan.
- Know and follow the rules of your health plan.
- Know that laws guide our health plan and the services you get.
- Know that we can’t treat you different because of, age, sex, race, national origin, culture, language needs, sexual orientation, and/or health.

SECTION 5: ENROLLMENT

5.1: Eligibility

Eligible Members must reside within the Care1st approved service area and meet the requirements for Medi-Cal benefits. The State’s Automated Eligibility Verification System (AEVS) is the ultimate determination of eligibility, while L.A. Care provides ultimate determination of plan partner assignment. Eligibility may change at any time so providers are reminded to check Member eligibility at the time of each visit.

5.2: Member Enrollment

The Health Care Options (HCO) Program, under the California Department of Health Services (DHS), is responsible for the process of Member enrollment and disenrollment into and out of one of the two (2) plans contracted in L.A. County. The contracted plans are the local initiative plan, L.A. Care Health Plan (L.A. Care), and the commercial plan, Health Net in partner with
Molina and Universal Care. A Member can choose his/her plan by completing a Health Care Options (HCO) plan selection form. If selected, L.A. Care is responsible for assigning Members into one of the five plan partners including Care1st Health Plan. The five plan partners are Care1st Health Plan, Community Health Plan, Kaiser Permanente, Blue Cross of California, and LA Care Health Plan.

5.3: Member Health Plan Selection

Medi-Cal beneficiaries in mandatory aid codes will be sent an enrollment package by HCO. The enrollment package will contain information on the local initiative plan and the commercial plan, as well as provider directories for each. Medi-Cal beneficiaries who receive an enrollment package have 30 days to select a plan and a primary care physician. The enrollment package will also contain a toll-free telephone number for HCO.

To enroll for Membership in L.A. Care/Care1st Health Plan, a Medi-Cal recipient must complete a Medi-Cal Benefit Choice form (HCO form) which is available through Care1st Health Plan, Health Care Options, or any Welfare Office. Members may call Care1st Member Services to obtain an HCO form at (800) 605-2556 or (TTY 711). To join Care1st, the Member must request L.A. Care/Care1st on the HCO Form - section “Plan”. They must also note the requested PCP license number - the PCP number followed by the letter “F”. Forms must be mailed by the Member directly to HCO. PROVIDERS ARE NOT ALLOWED TO HAVE BLANK HCO FORMS IN THEIR OFFICES. The provider may assist a Member when a Member comes to the provider’s office and asks for assistance in completing the HCO form that they have received.

Individuals in mandatory aid codes who do not select a plan will be defaulted into either of the two plans using a special assignment algorithm. If a Member defaults to L.A. Care, they will be assigned by HCO to one of the five plan partners. Recipients in voluntary aid codes may choose to be enrolled in a managed care health plan like Care1st if they so desire.

HCO is also responsible for disenrolling Members from Medi-Cal managed care when their Medi-Cal eligibility is lost or when an exemption request is submitted and accepted. L.A. Care/Care1st Health Plan is not responsible for any issue regarding Medi-Cal eligibility.

5.4: Coverage

Member coverage will begin at 12:01 a.m. on the first day of the calendar month for which the beneficiary's name is added to the approved list of Members furnished by L.A. Care to Care1st Health Plan. All eligibility determination issues must be referred to the Member’s County Department of Public Social Services (DPSS) eligibility worker.

5.5: Newborn Coverage

Coverage of the newborn begins at birth. The newborn is covered under the mother's Medi-Cal by Care1st for the month of birth and the month following as long as the mother's Medi-Cal eligibility remains active. The newborn is covered under the mother's Medi-Cal capitation payment to Care1st and its providers. In order to retain coverage for a newborn, parents must first apply for a social security number (SSN) for the newborn. After receiving a receipt for the SSN, the mother must apply for Medi-Cal coverage for the newborn or the newborn will lose coverage after their initial eligibility expires.
5.6: Change of Primary Care Physician

5.6.1: Member Initiated Change

Members may request a primary care physician (PCP) change during any given month. A Member may request a PCP transfer by calling Member Services. Each eligible Member in a family may select a different PCP.

All transfer requests received by Member Services by the 15th of the month will be effective on the first of that same month if the Member has not utilized any medical services. If services were rendered the transfer will not take place until the first of the following month. PCP transfers requested or received after the 15th of the month will be effective on the first of the following month that the request was made.

Note: All exceptions to this policy must be pre-authorized by the Member Services Manager/Supervisor/Lead or Director prior to approving/processing the transfer request. Each retroactive transfer request is reviewed and approved on an individual per case basis pending circumstances involved, access, and urgency of care. Prior to any change, inquiries will be made to assure there was no prior utilization of services during the month.

When the PCP change is processed and completed, a new ID card will be generated and sent to the Member. All PCP changes are processed by the Enrollment Unit and are noted in the Care1st Customer Service and Inquiry Module database by Member Services for future reference.

5.6.2: Primary Care Physician Initiated Change

Occasional circumstances may arise in which a PCP wishes to transfer an assigned Member to another PCP. In such cases, the PCP must submit a written transfer request to Care1st for approval to send a Member Notification Letter. The PCP must note the reason for the transfer request and provide written documentation to support the removal of a Member from their panel.

Upon receipt of a transfer request form, the Care1st Chief Medical Officer will evaluate the information presented and make a determination. The following are not acceptable grounds for a provider to seek the transfer of a Member:

- The medical condition of a Member
- Amount, variety, or cost of covered services required by a Member
- Demographic and cultural characteristics of a Member

Care1st will ensure that there is no Member discrimination for the above or any other reasons.

If the transfer request is approved, the provider will be asked to send an approved notification letter to the Member giving the Member 30 days to change their PCP. Care1st will contact and reassign the Member according to their choice considering geographic location, linguistic congruity, and other variables.
5.7: Eligibility List

Each Care1st Participating Provider Group “PPG” and directly contracted primary care physician is given an Eligibility Roster of all its assigned Members. The roster will be distributed by the 10th of each month and will contain the information listed below. *Providers participating with Care1st through a delegated PPG will receive eligibility within the format and timeframe established by the PPG.*

1. Month of Eligibility
2. Provider Name and Address, Provider Number
3. Member’s Subscriber Number
4. Member’s Last Name
5. Member’s First Name
6. Date of Birth
7. Age
8. Social Security Number (new Members only)
9. Member’s Address (new Members only)
10. Member’s Telephone number (new Members only)
11. PPG Effective Date.
12. Member’s Medi-Cal Aid Code
13. Sex
14. Special Remarks

5.8: Eligibility Verification

Member eligibility should be verified from the Eligibility Roster at each visit. Should you have any questions about a Member’s eligibility, please call Care1st Member Services.

**Eligibility Status (Class) Codes**

- 01 = Eligible Member - Capitation paid
- 05 = Member on Hold Status - No Capitation Paid (Call Member Services for possible hold release)
- 59 = Member on Hold - Pending termination
- 09 = Member Disenrolled - No Capitation paid
- 00 = Member Voluntarily Disenrolled - No Capitation paid
- 99 = Disenrolled Member - No Capitation paid
- Dep = Dependent Child - Covered under mother’s cap for month of birth and following month

5.9: Identification Cards

Care1st will furnish each new Member with materials within the first seven (7) days of enrollment including:

- A welcome letter
- A Member Identification Card with the 24-hour emergency numbers for their primary care physician (PCP)
- A L.A. Care/Care1st Member Handbook (Evidence of Coverage)
- A Care1st provider directory listing the days and hours of operation, address and telephone numbers for primary care physicians, hospitals, Optometrists, pharmacies, skilled nursing facilities, and urgent care centers.
- A reminder card requesting the Member call and make their first (120-day health assessment) appointment.
- A fraud postcard containing phone numbers to report fraud.
The Member Identification Card is for identification purposes only, and does not guarantee eligibility for Care1st or L.A. Care providers. You should always refer to your Eligibility Roster for current eligibility information, or call Care1st Member Services for eligibility verification.

In addition to the Care1st identification card, the Member will continue to use his/her Medi-Cal benefit information card (BIC) to receive services that may not be covered by Care1st or L.A. Care such as mental health services and glasses.

5.10: Disenrollment

Disenrollment refers to the termination of a Member’s enrollment in L.A. Care and/or Care1st. It does not refer to a Member transferring from one primary care physician to another. Members may disenroll from Care1st and/or L.A. Care at their own discretion.

Under certain circumstances it may be mandatory to disenroll a Member from Medi-Cal Managed Care. Circumstances include a loss of Medi-Cal eligibility, relocation outside of Los Angeles County, or a change of aid code to a managed care ineligible code. Certain medical conditions, such as the need for major organ transplantation, result in mandatory disenrollment as well. For cases in which a disenrolled Member reverts to fee-for-service Medi-Cal, the former Member could feasibly continue to receive care from the same provider(s) on a fee-for-service basis. The disenrollment request will be processed by HCO and not through Care1st or L.A. Care’s grievance process. Members are to send completed disenrollment forms directly to HCO.

5.11: Plan Initiated Disenrollment

Plan initiated request for disenrollment must be based on documentation validating that there has been a breakdown in the relationship between Care1st and the Member, or between the provider and the patient.

Request for disenrollment resulting from a breakdown in the provider/patient relationship must include documentation of any one of the following circumstances:

1. The Member is verbally or physically abusive to the provider, administrative staff or other Members.
2. The Member fails to follow prescribed treatment, or repeatedly fails to keep scheduled appointments.
3. The Member repeatedly uses providers not affiliated with Care1st for non-emergency services without prior authorization.
4. The Member persists in conduct that interferes with the effective rendition of health care.
5. The Member allows someone else to use their Care1st Identification Card.

Reasonable efforts should be made to:
1. Counsel or modify the Member’s behavior.
2. Provide the Member the opportunity to develop an acceptable provider/patient relationship with another provider with the PMG.

These efforts must be documented and indicate that counseling has been unsuccessful if in fact that is the case. This will begin the Member’s involuntary disenrollment process, which must also go through the grievance process.
5.12: Transportation

Non-emergency transportation is provided as a courtesy for all Members who have no alternative means of transportation to assure access to providers. It is provided at the discretion of Care1st Health Plan. All Members requesting transportation must be eligible with Care1st for the month that the transportation is requested. It is typically provided within a five-mile radius from the Member’s primary residence and is offered to and from the provider’s office only. Arrangements must be made by the provider’s office at least 24 hours prior to the appointment by calling Care1st Member Services at: (877) 433-2178 (TTY 711).

5.13: Translation Services/California Relay Services

Care1st Members are culturally and linguistically diverse, representing many different countries and ethnic groups. Providers may access telephonic interpreters for all languages by calling Care1st Member Services. This service is available 24 hours a day, seven (7) days a week. Assistance for the hearing impaired can be accessed telephonically through the California Relay Service.

Face-to-face interpretive services are also available for Care1st Members, including the hearing impaired, by calling Care1st Member Services at (800) 605-2556 (TTY 711) no less than 5 – 7 days in advance.

SECTION 6: GRIEVANCES AND APPEALS

6.1: Member Grievances

PURPOSE
Care1st has established a system for Members to communicate problems and concerns regarding their health care and to receive an immediate response through the Plan's grievance system. This is outlined in the Member Grievance Policy and Procedure Manual, which may be obtained from Care1st. There are 2 categories of Grievances:

- Quality of Care – Allegations of substandard care that could impact clinical outcomes.
- Quality of Service – Allegations that service did not meet standards.

PROCEDURE
Members are encouraged to speak with their Medical Group/PCP regarding any questions or concerns they may have. Members may also communicate their concerns directly to Care1st Member Services by telephone at (800)605-2556 (TTY (800)735- 2929), in writing by completing a Member Grievance Form (See Appendix 3) by e-mail, or in person.

Grievances can be filed by telephone, in writing, or in person. Care1st will acknowledge receipt of all written formal grievances within five (5) business days. Care1st will resolve grievances within 30 days and provide a resolution letter to the Member. Providers and PPG’s are required to provide Medical Records, Authorizations or responses within 7 calendar days of the request in order to resolve the grievance within the regulatory timelines.
If the resolution of the grievance is not acceptable to the Member or if a grievance has remained unresolved for more than 30 days, he/she has the right to contact the California Department of Managed Health Care (DMHC) for assistance. The DMHC is responsible for regulating health care service plans. If a Member has a grievance against Care1st, he/she should first use the Care1st grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the Member. Members may also be eligible for an Independent Medical Review (IMR) to provide an impartial review of medical decisions made by a health plan. The purpose of an IMR is to determine the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. If a Member is not satisfied with a Care1st decision or the grievance process, or needs assistance with a grievance, he/she may contact the DMHC at (888) HMO-2219 (TTY (877) 688-9891) or access its website at http://www.hmohelp.ca.gov. Instructions, complaint forms, and IMR application forms are available online through the DMHC website at http://www.hmohelp.ca.gov.

Medi-Cal Members also have the right to request a State Fair Hearing within 90 days of the incident. For more information about State Fair Hearing requests, Members may call the California Department of Social Services (DSS) at (800) 952-5253 (TTY (800) 952-8349). The Ombudsman Office of the California Department of Health Services (DHS) is also available to Medi-Cal beneficiaries for help with grievances at (888) 452-8609.

Grievances concerning quality of care issues are reported immediately to the Quality Management (QM) Department. The QM Department logs the grievance, gathers medical records/information concerning the grievance, and reviews the case for quality of care. All quality related grievances are reviewed by the Medical Director. All grievances are tracked by type/category and by provider, and are reviewed regularly by the QM Committee for potential quality of care issues. Care1st is primarily responsible for establishing and administering grievance procedures. However, the PPG/Medical Group and/or the PMG/PCP must participate with Care1st by providing assistance and information. Grievance forms shall be made available to Members at each PMG/PCP site. Additionally, providers are given the opportunity to review all Member concerns and respond to the issues identified.

Letters of resolution on all levels of the dispute process will include detailed instructions about the Ombudsman program, the option of filing a State Fair Hearing Request with the California Department of Health Services (DHS), and/or filing an appeal with the State Department of Managed Health Care (DMHC).

**Expedit**ed **Grievance**

The Member may request an expedited grievance when the Member disagrees with the decision not to expedite an appeal. In this situation, they can complain with the health plan’s refusal to expedite an appeal as the Member feels that the appeal meets criteria to be expedited.
6.2: Member Appeals Requests

The definition of an Appeal is: The Request for Reconsideration which follows a denial or unfavorable Coverage/Initial Determination.

The two types of Appeals are:

1. Benefit Appeals – Involving care the plan specifically excludes from coverage (i.e. circumcision, cosmetic surgery etc.).

2. Medical Necessity – Covered Services that are necessary and appropriate for the treatment of a Member’s illness or injury according to professionally recognized standards of practice.

Appeals can be:

Pre Service - Prior to the Member receiving the requested item or service.

Post Service – The service has been rendered and there is a dispute about non-coverage of a claim.

An appeal can be:

Standard - Resolved in 30 calendar days.

Expedited - When the Member’s life, health or ability to attain, maintain or regain maximum function is at risk.

Each Appeal begins the process anew (Denovo) to establish the story including:

1. The Member’s perception
2. The summary of the issue
3. The Authorization Request
4. The denial notice
5. The evidence including Medical Records, clinical notes, submissions by Member or provider
6. A summary of the State Rules, Regulations and Laws
7. Summary of the Plan Language (EOC), Medical Policies, Manuals

The staff involved in preparing and reviewing an appeal may not have been involved in the initial adverse decision/denial, or a subordinate/directly supervised by such person. In addition, for appeals involving clinical issues, the health care practitioner must have appropriate training and experience in the field of medicine involved in the medical judgment that requested the service.

6.2.1: Expedited Appeal

A provider or Member may file an expedited appeal to a determination and ask to have it processed expeditiously. This type of appeal is generally used in a continued stay or continued treatment situation, and when indicated based on the critical clinical condition of the Member. The following circumstances may, but are not limited to, constitute an expedited appeal:

- The Member has been issued a denial for service and:
- The Member is scheduled for ongoing services or admission to a hospital within 72 hours
- The Member suffers from a terminal illness
- The Attending Physician indicates in writing the Member’s health will suffer adverse consequence from the denial decision
1. All requests for expedited appeals will be triaged by licensed personnel to determine whether the appeal meets expedited criteria.

2. Documentation will be collected and presented to a Medical Director so that the case can be resolved and closed to the Member within 72 hours.

**Medi-Cal Member Appeals are handled as grievances as DHS does not differentiate between Appeals and Grievances. All levels of grievances handled within Care1st Health Plan will be resolved within 30 days. (See Section 6.1).**

### 6.3: Independent Medical Review

The independent medical review (IMR) process is an expansion of the appeal process for health plan enrollees. Independent reviews are conducted through the Department of Managed Health Care (DMHC) by an accredited impartial independent review organization to perform the medical review of a Plan/PPG/ Medical Group’s decision to deny, modify or delay health care services, based in whole or in part on a finding that the disputed services are not medically necessary.

The enrollee may request the IMR within six (6) months of any qualifying periods or events. The enrollee shall pay no application or processing fee of any kind.

Upon notice of the Plan from the department that an enrollee has applied for an IMR, the Plan and the Plan’s contracted provider shall provide to the IMR organization all of the following documents within 24 hours if expedited or 48 hours if standard:

A copy of the Members medical records that is relevant to the following:

1. The Member’s medical condition.
2. The healthcare services being provided by the Plan and its contracted provider for the condition.
3. The disputed health care services requested by the enrollee for the condition.

**Independent Medical Review for Experimental/Investigational Procedures**

The IMR also includes therapies, which have been denied by the Plan as experimental or investigational. Experimental/investigational procedures or treatments are a limitation to the Health Plan’s evidence of coverage. These IMR requests do not have to first go through the Care1st Health Plan Appeal process.

**Members That Qualify to Request the Experimental & Investigational Review Process**

The external independent review process applies to those Care1st Members that meet all of the following criteria:

1. The Member has a life threatening or seriously debilitating condition. "**Life threatening**" is defined as either or both of the following:
   a. Diseases or conditions where likelihood of death is high unless the course of the disease is interrupted.
   b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

   "**Seriously debilitating**" is defined as diseases or conditions that cause major irreversible morbidity, i.e. there is an imminent and serious threat to the health of the Member including severe pain, the potential loss of limb, or major bodily function.
2. The Member’s physician certifies that the Member has a condition, as defined in Criteria 1 (above), for which standard therapies have not been effective in improving the condition of the Member, or for which standard therapies would not be medically appropriate for the Member, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to Criteria 3 (below); and

3. Either (a) the Member’s physician, who is under contract with or employed by Care1st, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the Member than any available standard therapies; or (b) the Member, or Member’s physician who is a licensed board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Member’s condition, has requested a therapy that, based on two (2) documents which meet the definition of “medical and scientific evidence” as defined by Health and Safety Code 1370.4 subsection d, is more likely to be more beneficial for the Member than any available standard therapy; and

4. The Member has been denied coverage by Care1st for a drug, device, procedure, or other therapy recommended or requested.

5. The specific drug, device, procedure or other therapy recommended would be a covered service, except for a Care1st determination that the therapy is experimental or investigational.

Criteria Determining Experimental/Investigational Status
In making a determination that any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply is “experimental or investigational” by the Plan, the Plan shall refer to evidence from the national medical community, which may include one or more of the following sources:

1. Evidence from national medical organizations, such as the National Centers of Health Service Research.
2. Peer-reviewed medical and scientific literature.
3. Publications from organizations, such as the American Medical Association (AMA).
4. Professionals, specialists, and experts.
5. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment.
6. An expert physician panel selected by one of two organizations, the Managed Care Ombudsman Program of the Medical Care Management Corporation or the Department of Managed Health Care.

6.4: Provider Disputes – Claims Processing

Purpose:
To establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with H & S §1371.37.38.9.

6.4.1: Provider Questions, Concerns and Disputes

Providers can communicate questions and issues to the Care1st Provider Network Operations (PNO) Department or Provider Dispute Department by telephone, in writing, or in person. Many of these issues can be addressed very quickly following a brief investigation. Issues that cannot be resolved within one day or involve quality of care issues will be addressed as a dispute. Examples of disputes are issues relating to noncompliant Members, non-payment or underpayment of claims by Medical Groups/PPGs. All disputes entered in the provider dispute database will be investigated and a response will be provided in writing. They will be acknowledged within 15 working days and a resolution letter will be sent within 45 working days.
6.4.2: Reconsiderations

A provider will have the ability to furnish the Care1st Provider Dispute Department with any additional information or documentation that may have a bearing on the initial determination of a request for authorization that has been previously denied, deferred, and/or modified.

PROCEDURE FOR RECONSIDERATION:

1. A provider requesting reconsideration may call, fax, or submit in writing any additional information to the Care1st Health Plan UM Department to support the original authorization request. The Fax number to the UM Department is: (323) 889-6214.
2. A reconsideration request will occur within one (1) business day upon receipt of the provider telephone call, written or faxed request.
3. The additional information will be reviewed by the Chief Medical Officer (CMO) of Care1st or his/her designated physician reviewer.
4. If the CMO or designated physician reviewer reverses the original determination based on additional information provided by the provider, an approval letter will be sent to the Provider and the Member.

If reconsideration does not resolve a difference of opinion, the provider may then submit an appeal and/or grievance in writing to the Provider Dispute Department.

6.4.3: Provider Disputes Policy and Procedure

Providers may submit a written dispute to the Care1st Provider Dispute Department. Disputes may pertain to issues such as authorization or denial of a service; non-payment or underpayment of a claim; or disputes with our delegated entities. All written, formal disputes will be responded to in writing. Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within fifteen working days of receiving the written dispute.

All provider disputes must be submitted in writing. If a provider attempts to file a provider dispute via telephone, Care1st staff will instruct the provider to submit the provider dispute to Care1st in writing.

A provider can submit a provider dispute in writing to Care1st by mail, e-mail or fax. All provider disputes are forwarded to the appropriate department for processing.

6.4.4: First Level Appeal

A provider may appeal a denial decision made by Care1st Health Plan or one of its PPG’s. Care1st will refer clinical provider appeals and other appropriate cases for clinical review.

When the appeal is referred for clinical review:

1. All parties concerned shall be notified that a referral has been made for a clinical review within 15 working days and a final determination will be made within 45 working days from the date that Care1st Health Plan received the dispute.
2. The clinical reviewer shall evaluate the medical records and submit his/her findings and recommendations to the Physician Reviewers for approval.
The Care1st Health Plan Provider Dispute Department shall send a written letter of resolution outlining its conclusions with background information within 45 working days of receipt of the appeal. Language in the letter will include the next appeal steps the provider can take with the dispute. Care1st shall retain all documentation related to the clinical review for a minimum of (5) five years.

6.5.5: Second Level Appeal

After completing a first level appeal, for L.A. County Medi-Cal only, the provider may submit a second level appeal. A second level appeal must be filed within 30 calendar days of receipt of the Care 1st letter of resolution. It can also be used when Care1st has failed to act within the deadlines set forth above.

Medi-Cal providers seeking a second level appeal, disputes can be filed with Care1st or L.A. Care. If it is sent to Care1st Health Plan, the Provider Dispute Unit will forward the request to L.A. Care with all material and documentation utilized in the First Level Appeal upon request. If a provider appeals directly to L.A. Care, the provider shall submit the following items to L.A. Care:

1. A letter requesting a review of the first level appeal.
2. A copy of the letter sent to Care1st requesting a first-level appeal.
3. A copy of the original documents submitted to Care1st.
4. A copy of the first level appeal - denial response letter if the second level of appeal is based on a denial.
5. A copy of any other correspondence between Care1st and the provider that documents timely submission and the validity of the appeal.

L.A. Care shall acknowledge the Second Level Appeal request by the provider within 15 working days of its receipt. L.A. Care shall review the written documents submitted in the provider’s appeal, and if necessary, request additional information and/or hold an informal meeting with the parties involved. L.A. Care shall send a written letter of resolution outlining its reasons and conclusions, if appropriate, to the provider and the Plan within 45 working days of receipt of the appeal from the provider.

6.5: Attachments

Member Grievance Form & Instructions (See Appendices 3)
SECTION 7: UTILIZATION MANAGEMENT

7.1: Utilization Management Program

Mission Statement

The Care1st Utilization Management (UM) Department is committed to providing healthcare that is medically excellent, ethically driven, and delivered in a Member-centered environment. It recognizes the positive relationship between health education, a culture of wellness, and an emphasis on prevention and the cost effective delivery of care.

Purpose

The purpose of the UM Program is to ensure consistent delivery of the highest quality health care and to optimize Member outcomes. This is accomplished through the establishment of fully integrated multidisciplinary healthcare networks and coordination of all clinical and administrative services under the provisions of the Care1st UM Program.

Goals

- Consistently apply UM standards, guidelines, and policy/procedures in the evaluation of medical care and services on a prospective, concurrent, and retrospective basis.
- Provide access to quality healthcare services delivered in the most appropriate and cost effective setting.
- Facilitate and ensure continuity of care for Care1st Members within and outside of the Care1st Health Plan provider network.

7.1.1: Physician, Member, and Provider Responsibilities

All Members shall select and are assigned to a Primary Care Physician (PCP). The PCP coordinates the entire spectrum of care for assigned Members. This includes direct provision of all primary healthcare services, including preventive health services.

Additional activities and responsibilities include:
- Provide appropriate and cost-effective care consistent with the Care1st UM Program, its protocols, standards, and guidelines.
- Submit complete and timely claims/encounters to Care1st for processing. Information generated from this data will be shared with provider participants at the discretion of the UM Committee. Care1st shall have access at reasonable times and upon reasonable demand to the participating physicians’ books, medical records, and papers (consultation reports, x-rays, test results, charts, operative reports, etc.).
- Refer Members within the Care1st contracted network to the fullest and most reasonable extent possible. (Out-of-network referrals require prior approval).
- Assist in the evaluation of medical appropriateness of care provided to their Members or of care provided by other networks or non-network physicians, either on an individual basis or as part of the UM Committee.
7.1.2: Organization of Health Care Delivery Services

Health care services are provided through a combination of direct contracts, a full and shared risk network model, structured to provide a continuum of care. Contracted network providers include, but are not limited to, PCPs, specialty physicians, community and tertiary hospitals, skilled nursing facilities, home health agencies, pharmacies, laboratories, durable medical equipment providers, and others.

Non-emergent care other than self-referable, direct-access care requires by the Care1st UM Department or by the delegated financially responsible entity. Whenever medically appropriate, services will be arranged with network providers. This does not preclude the use of non-network providers when medically appropriate, as defined in other areas of this document.

7.1.3 Medical Services Structure Membership

The Medical Services Committee is chaired by the Care1st Chief Medical Officer (CMO). Membership is assigned and includes PCPs and a representative sample of specialty care physicians. The term of Membership is one (1) year with reappointment by the Committee and approval by the Board of Directors. There is no limit on the number of consecutive terms that assigned physicians may serve.

Meetings
The Medical Services Committee meets on a quarterly basis and is responsible for the following:

- Reviewing and discussing administrative information presented to the Members.
- Reviewing Utilization Management statistics.
- Receiving, reviewing, evaluating and making recommendations regarding UM activities.
- Reviewing proposed Member treatment plans that require input beyond the expertise of the CMO with specialty advisors.
- Coordinating educational opportunities for physicians regarding UM procedures and processes.

Confidentiality
All committee Members and participants, including medical staff, participating providers, consultants, and others will maintain the standards of ethics and confidentiality regarding both Member information and proprietary information.

Reports
The following reports are reviewed by the UM Committee and the Board of Directors:

- Total hospital bed days per 1000
- Total number of referrals by specialty
- Total number of referrals approved, deferred, and denied
- Turnaround time studies
- Appeals
- E.R. Utilization
- CCS Cases
- Pharmacy Utilization
7.1.4: UM Review Process for Appropriateness of Care

Procedures are utilized for the review process. Benefit algorithms have been developed to allow particular referrals to be automatically authorized by the UM coordinators. This process can reduce the number of referrals not requiring clinical expertise for determination. Referrals that involve medical information and criteria go to the Case Managers or physician reviewers. A physician will conduct a review for medical appropriateness on any denial. When necessary, the CMO will consult with physicians from the appropriate specialty areas of medicine and surgery, who are certified by the applicable American Board of Medical Specialists, for any medical decision that requires this level of expertise. A list of these physician consultants is also available to the CMO for second opinions, reconsiderations and appeal requests.

All PPG’s contracted with Care1st may only utilize Care1st approved criteria as listed below. PPG’s must first use Medi-Cal Guidelines for medical necessity determination and only use the others when Medi-Cal Guidelines are not available. The following is a complete list of the Care1st approved guidelines or sources that may be utilized for issuing approvals, denials or modifications. PPG/MSO Internal Policy or guidelines should not be used for any medical necessity determination on a Care1st member, all benefit denials should either reference a Medi-Cal source or the Care1st Explanation of Coverage (EOC).

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Medical necessity is determined by the review of medical information provided by the requesting physician, hospital medical records, and physician to physician communication. The review is done prospectively, concurrently and retrospectively.

Reviewer Availability
The Chief Medical Officer (CMO) is available to discuss any UM decision. Practitioners can call him at (800) 468-9935 from 9 A.M – 6 P.M Monday – Friday.

7.1.5: Review Criteria

The UM Department uses nationally developed and accepted review criteria, i.e. Milliman Care Guidelines, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, Comprehensive Perinatal Service Program Guidelines, and Title 22. A review of criterion is updated on an ongoing basis. Nationally recognized criteria sets will be renewed at least every two (2) years. The criteria sets alone cannot ensure consistent UM decision making across the organization. Additionally, Care1st Health Plan recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan’s delivery system.
The UM review criteria is available for disclosure to providers, Members, and the public upon request either in writing or by contacting Care1st UM Department at (800) 468-9935.

The Care1st UM Program consists of the following functions and activities. Each is individually explained in specific policy and procedure:

- Specialty Care Referral Management
- Ancillary Provider Care Referral Management
- Outpatient and Ambulatory Services Review
- Elective Admission Review
- Assistant Surgeon Review
- Referral Turn Around Time Frames
- Authorization Validity
- Emergency Services Utilization Review
- Urgent/Emergent Admission Review
- Concurrent Utilization Review
- Discharge Planning
- Second Opinions
- Out-of-Network Referral Management
- Postpartum Health Mother and Baby Program
- Retrospective Utilization Review
- Family Planning Services
- Self-Referable Services
- Standing Referral/Extended
- Direct OB-GYN Access Program
- Sterilizations
- Sensitive Minors
- Sexually Transmitted Disease Services
- Evaluation and Review of Experimental and Investigational Therapies
- Reconstructive Surgery
- Denials
- Reconsideration
- Grievance and Appeal Process
- Expedited Appeals Review
- Pharmacy and Medication Utilization Review
- Organ Transplants
- Vision Care
- Various Linked Programs
- WIC Program Services
- Medi-Cal Waiver Program Services
- CHDP
- California Children’s Services
- Medical Mental Health
- Healthy Families Mental Health
- Healthy Families Seriously Emotionally Disturbed (S.E.D.)
- Drug and Alcohol
- Hospice
- T.B.
- E.P.S.D.T.
- C.P.S.P.
7.2: Complex Case Management Program

MISSION STATEMENT

To work collaboratively with healthcare providers across a full spectrum of healthcare settings by focusing on the attainment of optimal health outcomes through the identification and management of high-risk enrollees with catastrophic illnesses, complex diagnoses, and or selected disease related conditions.

PURPOSE

The Care1st Case Management Program is developed as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs. This purpose is implemented through communication and use of available resources to promote quality, and cost effective outcomes. The Care1st Case Management Program is developed to specifically address the needs of the Member with high cost, high volume, and high-risk health care experiences. The Case Management Program is established to specifically identify eligible candidates that may benefit from the program by diagnostic/symptomatic categorization at initial points of service, with a focus on early identification of risk factors, and conducting a needs assessment. The goal is to identify and intervene early to affect the best outcome for the catastrophically impacted, chronically ill, injured, or high chronically ill, injured, or high-risk OB Members.

7.2.1 The Role of the Case Manager

Case Managers will work with PCPs to evaluate a Member for the program, and assess the Member's condition and social situation for a needs determination. An eligibility benefits determination will be made and compared with the Member's needs. A comprehensive program will then be developed to identify benefit and community resource utilization. Members will be referred to Complex Case Management in the community from various sources, via pre-certification, during hospitalization, while receiving ancillary services or claims.

Once accepted into the Case Management Program, the Case Manager will develop a plan of care. Appropriate referrals will be made to community resources. The Case Manager will monitor and evaluate the case, and revise the plan as appropriate until its conclusion. A case will be closed for the following but not limited to:

- No longer meets medical necessity for the benefit
- Terminates from the plan
- Expires
- Refuses further case management services

7.2.2 Case Management in the Ambulatory Setting

A Case Management Program referral may be received from several sources including:

- Referral Coordinator
- Member Services
- Quality Assurance
- PCP office setting
- Family telephone call with request for Case Management
- Referral from Claims Department
- Referral from Pharmacy Department

Information will be collected about the Member and the case including: demographic information (name, birth-date, most recent address and telephone number, nearest relative with a telephone number, significant person/caretaker); social history (employment, education and training, life style, religious concerns which may impact any case management plan, in-home family structure, residing in a facility, receiving day care or in-home supportive services); and clinical information (should consist of a history and recent clinical information that is related to the diagnoses being evaluated for case management). This information may be obtained by/from many sources, including:

- PCP office nurse or other staff. (A request for medical information may be sent to the PCP office staff that may fax or send the information for the case management record.) If the information is needed on an emergent basis, the information may be obtained over the telephone. Use the request for information letter, if appropriate.
- Current service provider(s) (Occupational/Physical/Speech Therapy, Home Health, surgery, etc.). These providers often have complete records.
- The Member and/or their responsible party/caretaker.
- Specialist(s) involved in the case.

A case management problem can be identified from a variety of sources such as diagnoses and contracted benefit. For example:

- Fractured wrist with surgical repair = suture/wound care, dressings or not, equipment needs, caregiver with instruction, PT/OT needs
- Depression = mental health care
- Fractured leg with cast = PT, crutch, transportation
- Abdominal wound = home health, dressings, and teaching/caregiver
- Absorption/digestive problems = nasogastric/gastrostomy tube and related supplies, liquid nutritional product, instructions to caregiver, monitoring by physician, (Gastroenterologist vs. PCP)
- Major musculoskeletal abnormalities = durable medical equipment and supplies, OT/PT/Speech, caretaker issues/respite, educational needs, incontinent supplies, ADL adaptations
- High-risk OB with symptoms = fetal monitoring, complete bed rest at home, IV therapy

A case management problem can also be one of the following social/clinical issues, which will impact the ability of the Member to overcome the current problem:

- Inadequate parent knowledge
- Parent illness
- Lives alone, or only adult in the household while enduring illness
- Lack of transportation
- Refusal of service
- Treatment recommended is contrary to client belief system
- Mental illness/substance or chemical addiction
- Violent home
- Homeless, living in a shelter or residential treatment center

A benefit evaluation will measure which resource can best provide for the needs of the client:

- CCS
- WIC
- Regional Center
- Alcohol and substance abuse program
- Mental Health
- HIV/AIDS programs
- Waiver program
- Dental services
- Genetically Handicapped Disability Program
- Vision care
- Home Health
- Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP), Early Intervention/Early Start/Developmental Disabilities Services (EI/EI/DDS)
- Contractual benefits of Care1st Health Plan including: Organ transplant evaluation

The Case Management Database is to be maintained by following these steps:

1. Write out the case management interventions that are planned, including the number or length of the service to be authorized.
2. Review the plan with the designated Health Plan physician, Medical Group physician, appropriate treating physicians, caregivers, and providers of service.
   a. Fax completed authorizations to physician(s) for signature and return to Case Management.
   b. Identify contact persons for each person, and request regular written progress reports.
3. Send an Introduction to Case Management Letter to the Member and/or his or her family.

7.2.3: Case Management in the Inpatient Setting

Inpatient Case Managers are licensed nurses and are responsible for the daily utilization review of acute hospital, skilled nursing, psychiatric, and rehabilitation inpatient stays. They interface with the in-house physicians and the Chief Medical Officer to assure continuity of care in the most appropriate setting. Immediately upon notification of admission they begin the process of case assessment and the coordination of discharge planning with the focus of medical necessity. Additional functions are as followed:

- Monitor, document, and report pertinent clinical criteria as established per UM Policy and Procedures to Medical Director and other designated sources.
- Identify and report to quality management referral indicators and submit data for ongoing studies.
- Interface daily with hospital employed discharge planners, Case Managers, and social workers to collaborate and coordinate all identified Members’ needs to promote the most expeditious return of his/her optimal level of function prior to hospitalization.
- Coordinate all services for discharge in timely manner and with contracted providers.

7.3: Primary Care Physician (PCP) Scope of Care

The list below includes, but is not limited to, services considered PCP functions. A PCP’s scope of care is dependent on the level of training the physician has received, the limitations of scope of practice, and uniformity with State and Federal rules and regulations. (These guidelines are based on routine uncomplicated cases that are ordinarily seen by a PCP).

OFFICE/CLINIC:

Allergy:
- Allergy history
- Treat seasonal allergies, hives and chronic rhinitis
- Environmental counseling
- Minor insect bites/stings
- Asthma, (chronic/acute) active with or without co-existing infection
- Peak flow monitoring

Cardiology:
- Perform and interpret electrocardiograms
- Evaluate chest pain, murmurs, palpitations
- Evaluate and treat coronary risk factors, including smoking, hyperlipidemia, diabetes, HTN, lifestyle
- Evaluate and treat CHF, stable angina, non-life-threatening arrhythmias
- Evaluate syncope (cardiac and non-cardiac)
- Provide education and prophylaxis against rheumatic fever or bacterial endocarditis when appropriate

Dermatology:
- Treat acne (acute and recurrent)
- Treat warts with topical suspensions, electrocautery, liquid nitrogen
- Diagnose and treat common rashes including: Contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, seborrheic dermatitis and tinea versicolor
- Identify suspicious moles
- Screen for basal or squamous cell carcinomas
- Diagnose and treat common hair and nail problems and dermal injuries
- Common hair problems including: fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects
- Common nail problems including: trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails
- Dermal injuries including: minor burns, lacerations, and treatment of bites and stings
- Counsel Members regarding removal of cosmetic (non-covered) lesions
- Diagnose and treat irritated seborrheic keratosis
- Treat irritated skin tags < 5
- Manage mild stasis ulcers
- Treat actinic keratosis excluding face with liquid nitrogen or Efudex

Endocrinology:
- Diabetic management and education including Type I and Type II patient
- Member education
- Supervision of Home Blood Glucose Monitoring Testing (coordinate telephonically with Member or via home health nurse)
- Diagnose and treat thyroid disorders including multi-nodular goiter
- Identify and treat hyperlipidemia
- Obesity management, diet instruction, exercise instruction
- Provide Member education and treatment for osteoporosis

Gastroenterology:
- Diagnose and treat lower abdominal pain
- Diagnose and treat acute diarrhea
- Treat protracted vomiting
- Occult blood testing
- Diagnose and treat heartburn, upper abdominal pain, pancreatitis, hiatal hernia, acid peptic disease, reflux
- Diagnose and treat functional bowel syndrome
- Diagnose and treat chronic jaundice under SCP recommendations
- Diagnose and treat chronic ascites under SCP recommendations
- Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids
- Manage stable inflammatory bowel disease under SCP recommendations
- Diagnose and treat uncomplicated hepatitis
- Diagnostic endoscopy
- Screen for colon cancer according to recommended schedule

General Surgery:
- Evaluate and follow small breast lumps
- Order screening mammogram according to approved schedule
- Local minor surgery for hemorrhoids
- Incision and drainage of simple soft tissue infections
- Suture removal
- Evaluate hernias (incisional, inguinal, femoral, ventral)
- Diagnose symptomatic gallbladder disease

Gynecology:
- Perform routine pelvic exams, PAP smears, birth control, and breast exam.
- Diagnose and treat vaginitis sexually transmitted diseases including pelvic inflammatory disease
- Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes
- Diagnose and treat abnormal vaginal bleeding (excluding post-menopausal bleeding)
- Manage stable endometriosis with analgesics and NSAIDs
- Manage premenstrual syndrome with non-steroidal anti-inflammatory agents, diuretics and other symptomatic treatment
- Diagnose pelvic masses and fibroids
- Manage post-menopausal syndrome
- Provide counseling and manage estrogen replacement therapy

Hematology:
- Initial differential diagnosis of anemia
- Treat iron deficiency, B12 and folic acid deficiency
- Recognize anemia of chronic disease
- Evaluation and treatment of stable Sickle Cell Disease

Infectious Disease:
- Common infectious diseases (respiratory, gastro-intestinal, dermatological, venereal, urological, gynecological)
- Initial evaluation for HIV positive
- Viral disorders
- Tuberculosis treatment and prophylaxis

Nephrology:
- Evaluate renal failure
- Evaluate proteinuria
- Evaluate and treat common electrolyte and acid-base abnormalities

Neurology:
- Diagnose and treat psycho-physiological diseases; headaches, low back pain, myofascial pain syndromes, neuropathies and radiculopathies
- Diagnose and treat tension and migraine headaches
- Treat syncope (cardiac and non-cardiac)
- Treat uncomplicated seizure disorders after SPC neurological evaluation
- Manage degenerative neurological disorders with respect to general medical care
- Treat stroke and TIA Members
- Manage dementia, and stable Parkinson’s disease

**Ophthalmology:**
- Perform thorough ophthalmologic history including symptoms and subjective visual acuity
- Perform common eye related services including: distant/near testing, gross visual field testing by confrontation, alternate cover testing, direct funduscopy without dilation, extraocular muscle function evaluation, red reflex testing in pediatric Member
- Diagnose and treat common eye conditions including: viral, bacterial and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctival hemorrhage, dacryocystitis, and sty
- Removal of simple superficial corneal foreign bodies (i.e. eyelash)

**Orthopedics:**
- Treat cervical, thoracic and lumbar back pain
- Treat sprains, strains, pulled muscles, overuse syndromes
- Treat inflammatory conditions
- Conservative treatment of chronic knee problems
- Manage chronic pain problems

**Otolaryngology:**
- Treat tonsillitis and streptococcal infections
- Perform throat cultures
- Evaluate and treat oropharyngeal infections: Stomatitis, Herpes simplex
- Treat acute otitis media and otitis external
- Treat serous effusion
- Evaluate tympanograms/audiograms
- Treat acute and chronic sinusitis
- Treat allergic or vasomotor rhinitis
- Remove ear wax, ear irrigations
- Diagnose and treat acute parotitis and acute salivary gland infections
- Evaluate neck masses
- Evaluate and treat epistaxis

**Podiatry:**
- Basic diabetic foot care and counseling
- Initial management of ingrown toenail, to include soaking, trimming and antibiotic treatment
- Diagnose and treat common foot problems: corns/calluses, bunions

**Pulmonology:**
- Diagnose and treat asthma, acute bronchitis, pneumonia
- Diagnose and treat chronic bronchitis
- Diagnose and treat chronic obstructive pulmonary disease and emphysema
- Manage home aerosol medications and oxygen
- Work up possible tuberculosis or fungal infections
- Promote smoking cessation

**Rheumatology:**
- Diagnose and treat non-articular musculoskeletal problems: Overuse syndromes,
- Manage osteoarthritis.
- Diagnose gout, pseudo-gout
- Diagnose and treat mild rheumatoid arthritis
- Diagnose and treat inflammatory arthritic diseases
- Diagnose and treat uncomplicated collagen diseases
- Diagnose and treat degenerative joint disease

Urology/Nephrology:
- Diagnose and treat initial and recurrent urinary tract infections including pyelonephritis
- Provide long term chemoprophylaxis for recurrent UTI
- Diagnose and treat urethritis
- Evaluate and treat hematospermia
- Evaluate hematuria
- Evaluate incontinence
- Diagnose and treat epididymitis and prostatitis
- Differentiate scrotal or peritesticular masses from testicular masses
- Evaluate prostatism and prostatic nodules
- Initiate evaluation of urinary stones
- Evaluate and manage impotence
- Evaluate and manage BPH

Vascular:
- Evaluate and treat varicose veins
- Evaluate peripheral vascular disease
- Evaluate carotid bruits
- Diagnose transient ischemic attacks
- Manage intermittent claudication
- Diagnose abdominal aortic/thoracic aneurysm

If the PCP wishes to refer the Member to a specialist, **prior authorization** must be obtained from the delegated PPG or Care 1st Health Plan if the provider is directly contracted *(with the exception of self-referable services as outlined in the self-referable section under Utilization Management)*.

7.4: Authorization & Review Process

7.4.1: Authorization Time Frames

Inpatient and outpatient referral requests for Care1st Members that are received from primary care and specialty care physicians will be processed according to classified status within the following designated time frames.

**Emergency Post-Stabilization Services** - Within **30 minutes** of verbal request.

**Emergency care**: Requires no prior authorization.

**Urgent** - Within **72 hours** from the time they are received in the UM Department.
Urgent referrals received by telephone will be directed to a Case Manager or to the CMO when mandated, in order to make an immediate decision. The provider will be instructed to follow-up with a faxed copy of the request at a later time.

Urgent referrals are immediately forwarded for processing. The requesting provider's office will be contacted telephonically at the time of the determination informing them of the authorization decision for the requested service. Providers and Members will be sent written confirmation of the determination within two (2) calendar days.
### Utilization Management Timeliness Standards
**(Medi-Cal Managed Care - California)**

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification (Notification May Be Oral and/or Electronic)</th>
<th>Written/Electronic Notification of Denial and Modification to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine (Non-urgent) Pre-Service</strong></td>
<td>Within 5 working days of receipt of all information reasonably necessary to render a decision.</td>
<td>Practitioner: Within 24 hours of the decision.</td>
<td>Practitioner: Within 2 working days of making the decision.</td>
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<td></td>
<td>Member: None Specified.</td>
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<td>Member: Within 2 working days of making the decision.</td>
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<tr>
<td><strong>Routine (Non-urgent) Pre-Service</strong></td>
<td>Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request.</td>
<td>Practitioner: Within 24 hours of making the decision.</td>
<td>Practitioner: Within 2 working days of making the decision.</td>
</tr>
<tr>
<td>– Extension Needed</td>
<td>- The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member’s provider requests an extension, or the Health Plan/Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member’s interest.</td>
<td>Member: None Specified.</td>
<td>Member: Within 2 working days of making the decision.</td>
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<td>- Notify Member and practitioner of decision to defer, in writing, within 5 working days of receipt of request &amp; provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.</td>
<td></td>
<td>Member: Within 2 working days of making the decision.</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification (Notification May Be Oral and/or Electronic)</td>
<td>Written/Electronic Notification of Denial and Modification to Practitioner and Member</td>
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<td>Practitioner: Within 24 hours of making the decision. Member: None Specified.</td>
<td>Practitioner: Within 2 working days of making the decision. Member: None Specified.</td>
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<tr>
<td>Additional information received</td>
<td>If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.</td>
<td>Practitioner: Within 24 hours of making the decision. Member: None Specified.</td>
<td>Practitioner: Within 2 working days of making the decision. Member: None Specified.</td>
</tr>
<tr>
<td>Additional information incomplete or not received</td>
<td>If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the Member notice of denial.</td>
<td>Practitioner: Within 24 hours of making the decision. Member: None Specified.</td>
<td>Practitioner: Within 2 working days of making the decision. Member: None Specified.</td>
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<tr>
<th>Expedited Authorization (Pre-Service)</th>
<th>Within 72 hours of receipt of the request.</th>
<th>Practitioner: Within 24 hours of making the decision. Member: None Specified.</th>
<th>Practitioner: Within 2 working days of making the decision. Member: None Specified.</th>
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<tbody>
<tr>
<td>Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.</td>
<td>- All necessary information received at time of initial request.</td>
<td>Practitioner: Within 24 hours of making the decision. Member: None Specified.</td>
<td>Practitioner: Within 2 working days of making the decision. Member: None Specified.</td>
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- None Specified.
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<tr>
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<th>Decision</th>
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<th>Written/Electronic Notification of Denial and Modification to Practitioner and Member</th>
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<tbody>
<tr>
<td>Expedited Authorization (Pre-Service) - Extension</td>
<td>• Requests where provider indicates or the Provider Group / Health Plan</td>
<td>Practitioner: Within 24 hours of making the decision.</td>
<td>Practitioner: Within 2 working days of making the decision.</td>
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<td>determines that the standard timeframes could seriously jeopardize the</td>
<td>Member: None specified.</td>
<td>Member: Within 2 working days of making the decision.</td>
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<td>the Member’s life or health or ability to attain, maintain or regain</td>
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<td>maximum function.</td>
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<td>• Additional clinical information required.</td>
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<td>- Note: The time limit may be extended by up to 14 calendar days if the</td>
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<td>Member requests an extension, or if the Provider Group / Health Plan</td>
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<td>can provide justification upon request by the State for the need for</td>
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<td>additional information and how it is in the Member’s interest.</td>
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<td>Additional information received</td>
<td>Practitioner: Within 24 hours of making the decision.</td>
<td>Practitioner: Within 2 working days of making the decision.</td>
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<td>• If requested information is received, decision must be made within 1</td>
<td>Member: None specified.</td>
<td>Member: Within 2 working days of making the decision.</td>
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<td>working day of receipt of information.</td>
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<td>Additional information incomplete or not received</td>
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<td>• Any decision delayed beyond the time limits is considered a denial and</td>
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<td>must be processed immediately as such.</td>
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### Additional Information
- Within 24 hours of making the decision.
- None specified.
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<tr>
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<tbody>
<tr>
<td>Concurrent review of treatment regimen already in place— (i.e., inpatient, ongoing/ambulatory services).</td>
<td>Within 5 working days or less, consistent with urgency of Member’s medical condition. <strong>NOTE:</strong> When the enrollee’s condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee’s life or health or could jeopardize the enrollee’s ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee’s condition, not to exceed 72 hours after the plan’s receipt of the information reasonably necessary and requested by the plan to make the determination. <strong>CA H&amp;SC 1367.01 (h)(3)</strong></td>
<td>Practitioner: Within 24 hours of making the decision. Member: None Specified.</td>
<td>Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.</td>
</tr>
<tr>
<td>Concurrent review of treatment regimen already in place— (i.e., inpatient, ongoing/ambulatory services). <strong>OPTIONAL:</strong> Health Plans that are NCQA accredited for Medi-Cal may chose to adhere to the more stringent NCQA standard for concurrent review as outlined.</td>
<td>Within 24 hours of receipt of the request.</td>
<td>Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).</td>
<td>Member &amp; Practitioner: Within 24 hours of receipt of the request. <strong>Note:</strong> If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification.</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification (Notification May Be Oral and/or Electronic)</td>
<td>Written/Electronic Notification of Denial and Modification to Practitioner and Member</td>
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<tr>
<td>Post-Service/ Retrospective Review - All necessary information received at time of request (decision and notification is required within 30 calendar days from request).</td>
<td>Within 30 calendar days from receipt or request.</td>
<td>Member &amp; Practitioner: None specified.</td>
<td>Member &amp; Practitioner: Within 30 calendar days of receipt of the request.</td>
</tr>
<tr>
<td>Post-Service - Extension Needed  - Additional clinical information required.</td>
<td>Additional clinical information required (AKA: deferral).  - Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request.  Additional information received  - If requested information is received, decision must be made within 30 calendar days of receipt of information  Example: Total of X + 30 where X = number of days it takes to receive requested information. Additional information incomplete or not received  - If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information.</td>
<td>Member &amp; Practitioner: None specified.</td>
<td>Member &amp; Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination.</td>
</tr>
<tr>
<td>Hospice - Inpatient Care</td>
<td>Within 24 hours of receipt of request.</td>
<td>Practitioner: Within 24 hours of making the decision. Member: None Specified.</td>
<td>Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision.</td>
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</table>
7.4.2: Authorization Validity

Authorizations are generally approved for 90 days with a disclaimer stating that authorizations are valid only if the Member is eligible on the actual date of service. Due to the fact that Member eligibility is on a month-to-month basis, Care1st providers must verify Member eligibility prior to delivery of non-emergency services. Eligibility can be verified for most Members 24 hours a day, seven (7) days a week by calling Care1st Member Services at (800) 605-2556 (TTY (800) 735-2929). Providers are responsible for re-verifying eligibility and obtaining an updated authorization once it has expired.

7.4.3: Specialty Referrals

PCPs are responsible for providing all routine health care services, including preventive care, to their enrolled Members. However, Care1st recognizes that many times Members may require care that must be rendered by qualified specialists.

When, in the opinion of the PCP a Member referral to a specialist is indicated, a request shall be submitted to the Member’s assigned PPG’s UM Department for review and authorization. Treatment requests for Members assigned to Care1st Direct are to be faxed to the Care1st UM Department.

The following information must be provided in order to process the pre-authorization request:
- Working diagnosis
- PCP evaluation to date
- Treatments performed to date
- Clinical justification for the referral request
- Any other relevant medical history

Urgent requests may be received via fax or telephone. If a request is received via telephone, it is to be followed by a fax.

The PCP’s office shall maintain a log indicating the Member information, date of request, type of specialist, clinical reason for referral and the authorization number.

The specialist is required to send a completed consultation report to the PCP. After review of the consultation results and recommendations, the PCP may request additional treatment authorization if clinically indicated.

Contracted specialists also have the option to request additional treatment/care directly from the UM Department, providing the specialist forward the consultation/follow up care and treatment results to the Member’s PCP to be added as part of the Member’s medical record.
7.4.4: Ancillary Referrals

PCPs are responsible for providing total coordination of all routine healthcare services, including use of ancillary services, for their enrolled Members. Therefore, all requests for Member referrals for ancillary services are submitted to the UM Department for review and authorization, with the exception of routine diagnostic laboratory tests through Quest Diagnostics and/or those required under the Quality Management preventive care requirements. Ancillary services are defined as those medical services provided by non-physician or mid-level professionals (i.e., PA’s, NP’s, etc.). This includes, but is not limited to, home care; physical, occupational, and speech therapies; diagnostic laboratory; x-ray; infusion services; and services provided by hospital-based outpatient departments, excluding ambulatory surgery, emergency room, and/or urgent care.

Ancillary services may be requested by a practitioner other than the Member’s assigned PCP only if the requesting party is a participating physician to whom the Member has a current authorization by the UM Department for consultation and treatment.

7.4.5: Outpatient Services

Ambulatory services and outpatient surgery procedures require authorization by the UM Department. Providers can be held financially at risk for non-emergent services performed at their facilities without prior authorization. Services must be provided by the Member’s PCP or the designated physician that has been given authorization by the UM Department for consultation and treatment. In the event that the service cannot be provided in network, an authorization will be conditionally approved by the Plan. Further information regarding out of network providers is covered subsequently in the manual.

The clinical staff will use clinically sound, medically appropriate criteria sets to evaluate necessity for outpatient and inpatient surgery. The ability to perform a surgery on an outpatient basis merely indicates that post-operative care does not require over night stay in an acute care hospital. A facility authorization for routine outpatient surgery can be obtained through the Care1st UM Department.

PPGs are required to submit the approved PPG authorization requests to the UM Department prior to scheduling the procedures, with the exception of full risk PPG.

If an outpatient surgery of an acute hospital based ambulatory procedure is performed on an urgent/emergent basis, authorization will be obtained in the same manner as any urgent/emergent service.

When the authorization number is given, the caller will be advised that the number is for outpatient surgery only and that if the Member requires an inpatient admission status the Care1st UM Department must be notified.

When the Care1st UM Department is notified that a scheduled outpatient surgery has been converted to an inpatient status, a Case Manager will immediately implement the admission and concurrent review procedures.
7.4.6: Elective Admission Requests

All elective inpatient admissions require an authorization by the Care1st UM Department. Requests for elective inpatient admissions must be obtained from either the Member’s PCP or from another physician/provider to whom the Member has current authorization from the UM Department for consultation and treatment. A request for an elective admission will be communicated to the Care1st UM Department by fax or telephone, as indicated by the urgency/timeliness of the request. Whenever possible, these requests should be made no less than five (5) business days prior to projected elective inpatient confinement.

If there is sufficient clinical information to determine that admission criteria are satisfied, the admission will be authorized. The Plan uses MCG Guidelines. Pre-determined lengths of stays are not assigned. Consideration has been given to the fact that each case may have different circumstances and that the recommended LOS serves as a guideline only.

Plan Notification: All contracted per-diem hospitals are responsible for notifying the Care1st UM Department of the inpatient admission by faxing the hospital admission sheets within 24 hours of admission, except for weekends and holidays.

7.5: Emergency Services & Admission Review

7.5.1 Emergency Services

“Emergency medical condition” is defined as a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain, such that a reasonable person would expect that the absence of immediate medical attention could result in (1) placing the Member’s health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Emergency Care
Care1st Members are entitled to access emergency care without prior authorization. However, Care1st requires that when an enrollee is stabilized, but requires additional medically-necessary health care services, providers must notify Care1st prior to, or at least during, the time of rendering these services. Care1st wishes to assess the appropriateness of care and assure that this care is rendered in the proper venue.

Life Threatening or Disabling Emergency
Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be delegated to a non-direct care giver at the emergency department (ED) to be done either concurrently with the provision of care or soon after as possible.

Business Hours
Care1st UM Department is available via telephone from 9:00a.m. to 6:00p.m., Monday thru Friday. In a 911 situation, if a Member is transported to an ED, the ED physician shall contact the Member’s PCP (printed on the Member’s enrollment card) as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care. If the PCP intends to refer the Member to an ED, the PCP must call the ED to authorize the treatment. The physician’s name, date, and time of the authorization will be documented in the ED medical record. If the Member seeks treatment at an ED without prior approval from the PCP, the ED will triage the Member and call the PCP for approval to treat the Member. It is the responsibility of the PCP to grant the authorization for treatment under these circumstances.
Medical Screening Exam
Hospital emergency departments under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all Members presented to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Care1st will cover emergency services necessary to screen and stabilize Members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

After Business Hours
After regular Care1st business hours, Member eligibility is obtained and notification is made by calling the 800 number on the Member ID card. The 800 number connects to a 24-hour multilingual information service, which is available to Members as well as to providers. For information other than eligibility requests, the call service will cross connect the caller to a Care1st On-Call nurse Case Manager. THIS IS NOT A MEDICAL ADVICE SERVICE. This service is for informational purposes and to coordinate Member care. In the event that a Member calls for advice relating to a clinical condition that they are experiencing and believe based on their perception that it is urgent/emergent, the Member will be advised to go to the nearest emergency room or to call 911.

The following are some of the key services that the on-call Case Managers will provide:
- Issue urgent/emergent treatment authorization numbers to providers.
- Act as a liaison to PCPs, specialists, and other providers to ensure timely access and the coordination of follow-up care for the Member’s post emergency care.
- Facilitate Member transfers from emergency departments to contracted hospitals or California Children Services (CCS) paneled facilities when applicable.
- Arrange facility transfer ambulance transport services.
- Assist Members with non-emergent transportation services for weekend appointments when needed.
- Provide network resource information to Members and providers.
- Assist in pharmacy issues.

Link Care1st contracted physicians to ED physicians when necessary.

For additional support the on-call nurse has access to the covering physician, or an alternate covering physician, to assist in physician related issues.

Upon receipt for a request for authorization from an emergency provider, a decision will be rendered by Care1st within 30 minutes, or the request will be deemed as approved. If assistance is necessary for directing or obtaining authorization for care after the immediate emergency is stabilized, the on-call nurse will assist as the liaison to PCPs, specialists, and all other providers to ensure timely access and the effective coordination of all medically necessary care for the Member.

7.5.2: Urgent/Emergent Admissions

Prior authorization is not required for emergency admissions (see Emergency Services for definition of “emergency”). However, authorization should be attempted for urgent admissions. If the admitting physician is not the Member’s PCP, the PCP should be contacted prior to admission when possible.
PCP Notification
The Member's PCP is to be contacted, if at all possible, prior to urgent/emergent hospital admission to discuss medical appropriateness and routing of the admission. Upon contact, the PCP will discuss the Member's case with the ED physician. If the case meets admission criteria, the PCP will authorize the admission under his/her care or opt to call in another physician of his/her choice. If the Member is in a non-contracted hospital, the PCP at that time may determine if the Member is medically stable for transfer to a contracted facility.

Plan Notification
All contracted per-diem hospitals are responsible to notify inpatient admissions to the Care1st UM Department by faxing the hospital admission (face) sheets within 24 hours of admission, except for weekends and holidays. Upon receipt of the hospital admission sheet, the UM Department will record a tracking number on the hospital admission sheet and fax it back to the hospital.

If no admission notification is received from the hospital by the next business day (with exception of weekends and holidays), the authorization for admission and continued stay will then be based on the concurrent and/or retrospective review procedures.

7.5.3: Concurrent Review

Care1st provides for continual reassessment of all acute inpatient care. Other levels of care, such as partial day hospitalization or skilled nursing care may also require concurrent review at the discretion of Care1st. Review may be performed on-site or may be done telephonically. Authorization for payment of inpatient services is generally on a per diem basis. The authorization is given for the admission day and from then on, on a day to day basis contingent that the inpatient care day has been determined to satisfy criteria for that level of care for that day. This would include the professional services delivered to the inpatient on that day. Any exceptions to this (i.e., procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment.

The date of the first concurrent review will generally occur on the second hospital day. The benefit of this process is to identify further discharge planning needs the Member may have due to unforeseen complications and or circumstances.

Clinical information may be obtained from the admitting physician, the hospital chart, or the hospital Utilization Review (UR) Nurse. The Case Manager will compare the clinical presentation to pre-established criteria (MCG Guidelines). If the criteria are satisfied, an appropriate number of days will be authorized for that stay. If the Member remains an inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized for elective admissions are variable and are based on the medical necessity for each day of the Member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the Case Managers and the CMO.
7.5.4: Discharge Planning

The purpose of discharge planning is to identify, evaluate and coordinate the discharge planning needs of Care1st Members when hospitalized. Discharge planning will begin on the day of admission for unscheduled inpatient stays. The review process will include chart review, data collection, and review of the care plan by the attending physician and other Members of the healthcare team. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process.

The goal of the discharge planning process is to follow the Members through the continuum of levels of care until the Member is returned to his/her previous living condition prior to hospitalization, when possible. This approach is performed to ensure continuity of care and optimum outcomes for Care1st Members.

Multiple factors are taken into consideration to effectively evaluate the Member's clinical and psychosocial status for discharge needs. This includes the active problem, clinical findings, the Member’s past medical history and social circumstances, and the treatment plan.

If the PCP was not the Attending Physician of the Member while hospitalized, all efforts will be made to notify him/her of any arrangements made for the Member.

This may be done by one of the following mechanisms:
- Dictated hospital summary note from the Attending Physician.
- Phone call from the Attending Physician.
- Phone call from the Care1st UM Case Manager.
- Inpatient Hospital Notification Form faxed by the Case Manager.

7.5.5: Retrospective Review

Care1st reserves the right to perform a retrospective review of care provided to a Member for any reason. There may also be times during the process of concurrent review (especially telephonic) that the Case Manager did not receive sufficient information based on criteria (MCG Guidelines). When this occurs the case will be pended for a full medical record review by the CMO.

All retrospective review referrals are to be turned around within 30 working days of obtaining all necessary information. Notification of retrospective-review denials will be in writing to the Member and the provider.

When a retrospective UM review indicates that there has been an inappropriate provision of care, the case will be referred to the Quality Management Department for further investigative review and follow-up.

7.6: Authorization Denials, Deferrals, & Modifications

A denial, deferral, and/or modification of a treatment authorization request may occur so that more information can be obtained or recommendations of alternative care may be made during the authorization process. Other than the Member is not eligible, only physicians will make denial of service determinations. The signature of the Chief Medical Officer (CMO) or the reviewing physician is required on the denied referral request authorization form.
At the request of the Primary Care Physician (PCP), providing physician, Member or Member representative, such decisions may be referred for reconsideration or appeal for additional review and determination.

Care1st will send written notification of an authorization request denial, deferral, and/or modification to the Member, the Member’s PCP, and/or Attending Physicians according to the provisions below:

- The PCP and/or the requesting provider will be sent a written or electronic confirmation within two (2) working days of the determination.
- The communication to the provider shall include the name and telephone number of the health care professional responsible. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
- The Member will be sent written confirmation within 48 hours of the determination. For concurrent care within 24 hours of the original notification, electronic or written.
- A disclosure of the specific utilization review criteria/guideline or benefit provision used as a basis for the denial will be sent to the Member and the provider.
- The disclosure shall be accompanied by the following notice: “The guidelines that were used by Care1st Health Plan for your case are used by the Plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need.”
- Criteria/guidelines will be made available upon request to the public, provider, or Member via phone request to the UM Department at (800) 468-9935, via fax to the UM Department at (800) 889-6577, via email at https://www.care1st.com/aboutus/email_ssl.asp or request via mail to UM Department at Care1st Health Plan, 601 Potrero Grande Drive, Monterey Park, CA 91755.

The written notification shall include the following elements:

- The notice to the Member will inform the Member that he/she may file an appeal concerning the determination using the appeal process (as proscribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process.
- How to initiate an expedited appeal at the time they are notified of the denial.
- The Member’s right to, and method for obtaining, a State Fair Hearing.
- The Member’s right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel or other spokesperson.
- The name and address of the entity making the determination.
- The State’s toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Corporation’s toll free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the Member’s satisfaction.

Included within the denial letter to Members and providers are the reasons for the denial determination and, if possible, alternative treatments or care.

No authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reasons including, but not limited to subsequent rescissions, cancellations, or modification of the Member’s contract or when the Plan did not make an accurate determination of the Member’s eligibility.
7.7: Referrals

7.7.1: Second Opinion

The Member, the PCP, or a participating health professional that is treating an enrollee may on occasion request a second opinion prior to surgery to evaluate treatment options, assist with a diagnosis, or validate the need for specific procedures. The CMO will evaluate the medical necessity of an authorization referral request that is submitted formally for a second opinion consultation. An expert panel list is maintained and utilized or second opinion consultation referrals consisting of a board-certified specialist in each area of medicine.

Second opinions when medically necessary will be done by an “appropriately qualified healthcare professional” not previously involved in the Member’s treatment plan.

“Appropriately qualified health care professional” is defined as a Primary Care Physician or specialist acting within his or her scope of practice, and with a clinical background including training and expertise related to the condition associated with the second opinion request.

Second opinion referral requests will be processed within a standard time frame based on the status of the request. When the Member’s condition is such that the Member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function or timeliness that would be detrimental to the Member’s ability to regain maximum function, the second opinion determination shall be rendered as followed:

- **Urgent** - Within 72 hours
- **Routine** - Within 5 working days

Reasons for a second opinion shall include, but not limited to, the following:

- If the Member questions the reasonableness or necessity of a recommended surgical procedure.
- If the Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including (but not limited to) a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

7.7.2: Self-Referable Services (Medi-Cal)

Care1st Medi-Cal Members have freedom of choice in obtaining certain specified services such as family planning, HIV testing, and care for sexually transmitted diseases (STDs). These services are self-referable both in-network and out-of-network. If the Member chooses to self-refer to any willing provider, including out-of-network providers, these services will be covered without pre-authorization.
The following list includes services that, when performed by the PCP, will be covered without prior authorization:

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>Family Planning</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases (STDs) Treatment</td>
</tr>
<tr>
<td>Abortion Services</td>
</tr>
<tr>
<td>Sensitive Services for Minors (12 yrs of age and older if sexually active)</td>
</tr>
<tr>
<td>HIV Testing</td>
</tr>
</tbody>
</table>

Care1st maintains a list of preferred providers for highly specialized tertiary level care. All reasonable attempts will be made to route non-network care to these providers when applicable.

In most cases, payment for self-referable out-of-network services will be limited to the Medi-Cal fee schedule. As necessary, please refer to the State published document (MMCD Letter No. 94-13) on family planning and STDs. A copy of the document will be furnished to Care1st providers upon request.

### 7.7.3: Direct OB/GYN Access

Care1st Members have the option to seek obstetrical and gynecological (OB/GYN) physician visits directly from an obstetrician and gynecologist or directly from a family practice physician providing obstetrical and gynecological services without prior approval from another physician, another provider, or the health care plan on an unlimited basis, as defined under the evidence of coverage in the Member Handbook.

Care1st Health Plan’s policy is to use contracted/participating providers, as well as medical necessity utilization protocols for any OB/GYN services rendered to a Member by a participating physician. The OB/GYN will be required to communicate to the Member’s PCP all pertinent medical information that has occurred from such an encounter in order to maintain the continuity of care for that Member. An outline of the required provisions is as followed:

1. Referrals must be made to Care1st contracted OB/GYN physicians only.
2. Routine and preventive health care services including breast exams, mammograms, and pap tests.
3. Payment for the level of the consultation/follow-up that is indicated on the claim shall be established from the documentation sent along with the claim to substantiate the medical necessity for payment at that level.
4. Any recommended treatments, procedures or surgeries will require prior authorization.
5. Any OB/GYN who is also a PCP will be able to self-refer directly for OB services. Further treatments, procedures, or surgeries will require prior authorization from the Care1st UM Department.
6. Any OB/GYN who is a PCP will provide all GYN services, other than prior authorized surgeries and procedures included under the capitated primary care services payment agreement contract.

### 7.7.4: Independent Medical Review

The independent medical review (IMR) is an expansion of the appeal process; refer to SECTION VI GRIEVANCE and APPEALS, Section 6.3.
7.7.5: Continuity of Care

Care1st will ensure that a Member with an acute or serious chronic condition, high-risk pregnancy or late-term pregnancy can request to remain with a terminated/non-contracted provider until a safe transfer to a Plan provider can be made, and it is consistent with good medical practice.

Definitions

“Continuity of care” Is ensuring that a Member’s care is appropriately managed as the Member moves through the health care delivery system, follow up care is provided, and the Member’s medical records and history follows the Member from provider to provider.

“Delegated” Defers responsibility for the activity as defined by contractual agreement.

“Terminated provider” Is a provider/physician whose contract to provide services to Plan Members is terminated or not renewed by the Plan or one of the Plan’s contracting provider groups.

“Acute condition” Is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

“Serious chronic condition” Is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

1. Persist without full cure or worsens over an extended period of time.
2. Requires ongoing treatment to maintain remission or prevent deterioration.

Procedure

1. Members may file requests with the Plan/PPG for continuity of care when they are SPD members, newly enrolled converting from Medi-Cal Fee for Service via telephone, facsimile, or by mail.
2. Continuity of care considerations will be made in accordance with the urgency of the Member’s condition at the time of such a request.
3. Continuity of care considerations are applicable only to those circumstances when the Member has an acute or chronic condition, or high risk, or late term pregnancy as defined above.
4. The timeframe for Members undergoing continued care with a terminated or non-contracted provider is up to 12 months. This timeframe may be extended in order for the Member’s care to be transferred safely.
5. If the provider was contracted with the Plan/PPG and the contract was terminated, the fee will be based on the contractual agreement prior to the termination.
6. If it is a non-contracted provider and there is no agreement between the Plan and the provider, then the Plan/PPG shall pay the provider similar rates as those paid to similar providers for similar services within a similar geographical region.
7. If the provider does not accept the payment rate, then the Plan/PPG is not obligated to continue care with the provider.
8. The provider shall be bound to the Plan’s contractual requirements for quality assurance, utilization review and credentialing.
9. The Plan will monitor the care provided by requiring the provider to submit ongoing treatment plans, progress notes and other appropriate medical record information.
10. The Plan will coordinate the exchange of the Member’s medical record information from the non-contracted/terminated provider to the Plan provider when the Member’s condition allows for such a transition.

7.7.6: Re-constructive Surgery

Re-constructive surgery, as defined below, is a covered benefit for Care1st Members; however, coverage for cosmetic surgery as defined is excluded.

Definitions

“Reconstructive surgery” is defined as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, tumors, infections, trauma, or disease to do either of the following:

1. Improve function
2. Create a normal appearance, to the extent possible

“Cosmetic surgery” is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

A procedure might be considered either cosmetic or medical depending on the reason for it (e.g. breast reduction surgery for pain).

Requests for reconstructive surgery for Members to correct a condition which has resulted in a functional defect or has resulted from injury or surgery, and has produced a major effect on the Member’s appearance will generally require review by the Chief Medical Officer (CMO) or a physician reviewer.

Submitted documentation of medical necessity should include all of the following:

1. Brief medical history
2. Condition being corrected
3. Date of injury (if applicable)
4. Symptoms
5. Length of time symptoms were present
6. Previous treatment attempted
7. Applicable operative reports
8. Applicable photographs

Physician Reviewer Evaluation
The reviewing physician may forward the case to a Care1st specialty advisor for evaluation and determination.

7.7.7: Standing Referral

Care1st Members that require ongoing extended access to specialty care for chronic, disabling, life threatening or degenerative conditions will qualify for the standing referral policy. The policy applies to those circumstances where the coordination of the specialty care for such a condition has become the principle care for the Member.

A request for a standing referral to a specialist may be initiated by the Member, the PCP, or the Specialty Care Physician (SCP), when the Member has a chronic, disabling, life threatening or degenerative condition requiring extended access for continued treatment and care, and it has been deemed necessary by Care1st Health Plan.
Provisions for Requesting a Standing Referral
1. Request is made by the Member’s PCP, SCP, or the Member.
2. Request is to be made to a Care1st contracted Specialist.
3. Request will be reviewed and agreed to between the PCP and SCP and submitted to the Plan or delegated medical group.

Standing referral requests will include:
1. Member diagnosis
2. Required treatment
3. Requested frequency and time period
4. Relevant medical records

Provisions for Requesting Extended Access to a Specialist
1. Request is made by the Member’s PCP or Specialist.
2. Request is related to a life threatening or degenerative condition, or there are disabling factors involved in the request.
3. Request will be reviewed and agreed to by both the PCP and Specialist, and submitted to the plan or delegated Medical Group.
4. Requesting PCP or Specialist will indicate the health care services the Specialist will be managing and detail those that will be managed by the PCP.

Review and Determination
1. Requests are reviewed by the CMO or medical director designee.
2. Determination will be provided within two (2) business days of receiving all necessary records and information.
3. Communication of the determination to the Member and involved practitioners will be provided within two (2) business days of receiving necessary records and information.
4. Approvals shall include:
a. Number of visits approved.
b. Time period for which the approval will be made.
c. Extension request process.
d. Standard reporting required from the Specialist to the PCP and /or the Plan delegated group physician reviewer.
e. Process for requesting further referrals, if needed.
f. Clause specifying: “… Member eligibility is to be determined at the time services are provided…”

Specialist Communication Guidelines to Primary Care Provider
1. Specialist will provide information to the PCP on the progress and or any significant changes in the Member’s condition.
2. PCP will maintain all communicated information in the Member’s medical record
7.8: Carve-Out Benefits: Public Health, Linked Services and Special Benefit Information

7.8.1: California Children Services (“CCS”)

California Children’s Services (CCS) are carved out of the Care1st Health Plan benefit agreement. The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified providers. The program goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for handicapped children. Identified children with CCS eligible conditions are referred to CCS immediately upon identification.

The Care1st UM Department can serve as a link between Care1st PCPs and the CCS Program. This will be done by appropriately identifying and channeling all potential/applicable referrals to CCS in accordance with the specified program standards.

7.8.2: Child Health and Disability Prevention Program (“CHDP”)

All Members under 21 years of age are to have access to and receive Child Health and Disability Prevention (“CHDP”) Program services in accordance with state and federal requirements for providing preventive services to children.

The provision of CHDP services is accomplished through Care1st providers and/or local health department and school-based programs in accordance with L.A. Care's Memoranda of understanding.

All Members under 21 years of age are to receive an Initial Health Assessment within 120 days of enrollment. An IHA consists of a comprehensive health history and physical examination, and includes an age appropriate health education behavioral assessment.

Comprehensive Health History and Physical Examination

CHDP standards include screening and immunization schedules for specific age groups. The CHDP health screening also includes a comprehensive health history that collects information on the following areas:

<table>
<thead>
<tr>
<th>Social/Cultural</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Illnesses</td>
</tr>
<tr>
<td>Family Health</td>
<td>Accident</td>
</tr>
<tr>
<td>Prenatal, Birth, Neonatal Development</td>
<td>Hospitalizations</td>
</tr>
<tr>
<td>Physical Growth</td>
<td>Immunizations*</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Communicable Diseases</td>
</tr>
</tbody>
</table>

The physical examination must be given while the Member is unclothed. Attention, therefore, should be given to the age of the Member and his/her need for privacy.
The physical examination must include, but is not limited to:

<table>
<thead>
<tr>
<th>Skin</th>
<th>Heart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spine</td>
<td>Hair</td>
</tr>
<tr>
<td>Head</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Eyes (Vision Testing)</td>
<td><em>Genitals (pelvic exam)</em></td>
</tr>
<tr>
<td>Ears (Audiometry)</td>
<td>*Extremities</td>
</tr>
<tr>
<td>Nose, Throat</td>
<td>Palpation of femoral,</td>
</tr>
<tr>
<td>Mouth, Gums,</td>
<td>Dental Screen</td>
</tr>
<tr>
<td>Brachial and radial pulse</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Neck</td>
<td>Height and Weight Chest</td>
</tr>
<tr>
<td>Head Circumference</td>
<td>Lungs</td>
</tr>
</tbody>
</table>

*according to periodicity schedules

Tests are to include the following:
- Lead screening (lead level checks at ages 12 mon, 24 mon, or 72 mon with lead level range above 15 are to be referred to the Los Angeles Lead Program. Follow up lead re-check is to be done after 3 months on lead levels between 10-14 and/or confirmatory re-check to be done within 1-2 months on levels between 15-19)
- Tuberculin tests
- Cholesterol screening
- STD screening
- Lab testing for anemia, diabetes, and/or urinary tract infection
- Testing for Sickle Cell Trait

**Follow-Up on Conditions Identified During CHDP Exams**

Care1st will arrange for any medically necessary services identified through a health assessment (or episodic exam). Treatment for these conditions is to be initiated within 60 days after identified need. (Medical records must contain a just then the Primary Care Physicians will coordinate continued medical care with the CHDP office.

### 7.8.3: Regional Centers

Regional centers provide overall case coordination for eligible consumers and their families to assure access to health, developmental, social, educational and vocational services. Services are provided on a case by case basis, taking into consideration the availability of generic services appropriate to the consumer's needs.

Care1st Health Plan Members who appear to qualify for regional center services will be appropriately identified and referred in accordance with the specifications of the Regional Center Program. This applies to the following:

i. Persons three (3) years of age and older with or suspected to have a developmental disability.
ii. Persons from birth to 36 months who are at risk of developing a developmental disability.
iii. Persons at risk of parenting a child with a developmental disability (genetic).
iv. Individuals with a medical diagnosis which includes:
   - Mental retardation
   - Epilepsy
   - Autism
   - Cerebral Palsy
Other handicapping conditions closely related to mental retardation and requiring treatment similar to that required by persons with mental retardation.

Other applicable factors are that the condition:
- Must manifest prior to age 18
- Is likely to continue indefinitely
- Constitutes a substantial handicap

Factors that do not apply:
- Solely psychiatric disorders
- Solely learning disabilities
- Solely physical in nature (i.e. hearing impairment, vision impairment, orthopedic, etc.)

7.8.4: Early Prevention, Screening, Diagnosis and Treatment

Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services (ESS) are any services a state is permitted to cover under Medicaid law that are medically necessary to correct or ameliorate a defect, physical and mental illness or condition for a Member under the age of 21, if the service or item is not otherwise included in the State’s Medi-Cal Plan.

EPSDT Services
- Case management services
- Cochlear implants
- Home nursing
- Psychology
- Occupational therapy
- Audiology
- Orthodontics
- DME (in certain instances)
- Hearing aids
- Mental health evaluation and services
- Medical nutrition services assessment and therapy
- Pharmacy
- Physical therapy evolution and services
- Pulse oximeters
- Speech therapy

Requested EPSDT services must meet the following medical necessity criteria:
- The services requested meet specific requirements for orthodontic dental services or provision of hearing aids or other hearing services.
- The services requested are to correct or ameliorate a defect, or physical or mental illness, discovered by an EPSDT screening.
- The supplies, items and/or equipment requested are medical in nature.
- The services requested are not solely for the convenience of the Member, the family, the physician or any other provider of service.
- The services requested are not primarily cosmetic in nature or designed to primarily improve the Member’s appearance.
- The services requested are safe and are not experimental and are recognized as an accepted modality of medical practice.
- The services requested, when compared with alternatively acceptable and available modes of treatment, are the most cost effective.
- The services requested are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the medical condition of the Member.
- The service requested improves the overall health outcome as much as, or more than, the established alternatives.
- The predicted beneficial outcome outweighs the potential harmful effects.

As an exception, Care1st Health Plan is not responsible for payment for services provided under CCS, or for case management services provided by a state-conducted referral provider such as a regional center.

### 7.8.5: Women, Infants and Children (“WIC”) Program

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides temporary nutrition, education and assistance for needy women, infants, and children. Supplemental foods are selected to meet specific nutritional needs of pregnant or breastfeeding women and young children by using WIC vouchers. WIC is a free service for Members who meet eligibility requirements.

All WIC eligible Care1st Members who are pregnant, breastfeeding, postpartum, infants and children will be referred to WIC.

#### Screening of Nutritional Needs and WIC Eligibility Identification and Referral

PCPs are to identify pregnant, breastfeeding, or postpartum women, and children under the age of five whom are eligible for WIC supplemental food services.

PCPs are to perform a nutritional assessment and hemoglobin or hematocrit laboratory tests; and assess for a history of frequent illness or a general poor state of health.

In the case of pregnant women, PCPs may refer Members to nutritionists for further assessment.

The PCP or nutritionist is to initiate the referral to WIC, if appropriate. Test results reported on the CPSP assessment tool for OB Members, or on the CHDP Form PM-160 for children, are to be provided to the WIC Program with all referrals.

The PCP must document the WIC referral in the Member’s medical record.

### 7.8.6: Comprehensive Perinatal Services Program (CPSP)

#### Pregnancy and Postpartum Services

Pregnant Members are to be provided comprehensive, multidisciplinary pregnancy and postpartum services with case coordination including obstetrics, risk assessment/reassessments, health education, nutritional services, and psychosocial services in accordance with the standards of the American College of Obstetrics and Gynecology (ACOG), the Comprehensive Perinatal Services Program (CPSP) specifications of Title 22 of the California Code of Regulations, and the provisions set forth below.

#### Case Coordination Elements

Case coordination is the responsibility of the OB physician, although care coordination may be delegated to a team Member who is accountable to the Obstetric Physician.
Components of Case Coordination
Case coordination includes all clinical aspects of care as well as record keeping and communication, as detailed below. Every part of the multidisciplinary system should support personal attention to the Member and interaction with the physician.

- Assessments (obstetrical, nutrition, health education, and psychosocial).
- A written, individualized care plan based on all assessments.
- Appropriate interventions/treatments provided according to the care plan and approved protocols.
- Continuous assessments of the Member’s status and progress relative to care plan interventions, with appropriate revision of care plan when necessary.
- Case conference or other appropriate communication involving all team Members regarding each Member’s care.
- Comprehensive record system where all information relating to Member care is documented and is available to all team Members.
- Record-sharing system or exchange of information among providers especially for referrals, consultations and reporting pregnancy outcome.

Multidisciplinary Conditions/Issues
Common pregnancy and postpartum conditions and issues for multidisciplinary team discussion/action include areas of nutrition (N), psychosocial conditions and services (PS), or health education (HE) such as those listed below.

Pregnancy Conditions/Issues
- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Housing and transportation problems (PS)
- Fear of physicians, hospitals, and medical personnel (HE)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- No previous contact with health care systems (HE)
- Previous receipt of unfriendly health care services (HE)
- Personal and religious beliefs at odds with optimal prenatal care (HE)
- Need for bed rest during pregnancy (PS), (HE)
- Multiple gestation (HE), (PS), (N)

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

Conditions Requiring Medical Referrals
- Diabetes
- Hypertension
- Hepatitis
- HIV Infection
- Genetic Problems
- Epilepsy or Neurological Disorder
- Renal Disease
- Alcohol or Drug Abuse
- Maternal Cardiac Disorders
- Thyroid or Other Endocrine Disorders

Conditions/Issues Requiring Social Work Referrals
- Family Abuse
- Psychiatric Problems
- Chemical Abuse
- Financial Problems
- Insufficient home care resources/capabilities

Related Programs (e.g., CPSP, WIC, CHDP, family planning and dental services)

Providers are to inform Members of pregnancy and prenatal related programs and refer Members to them when appropriate.

7.8.7 Family Planning

Family planning includes the following services:
- Health education and counseling services necessary for Members to make informed choices and understand contraceptive methods.
- Limited history taking and physical examinations. PCPs or OB/GYNs are responsible for the comprehensive history taking and physical examinations.
- Laboratory tests, if medically indicated for the chosen contraceptive method. Pap smears, if not provided per USTF guidelines by PCPs or OB/GYNs.
- Diagnosis and treatment of sexually transmitted diseases, if medically indicated, pursuant to the sexually transmitted diseases section of this manual.
- Screening, testing, and counseling of individuals at-risk for HIV and referral for treatment for HIV-infected Members.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Provision of contraceptive pills, devices, and supplies, as approved by Medi-Cal.

Providers will be required to obtain informed consent for all contraceptive devices.
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

The stipulations below apply to the provision of family planning services:
1. Each physician/provider must be licensed in the state of California and have training/experience in family planning.
2. A Medical Director who meets at least the above qualifications must oversee, if services are provided in a clinic setting, the clinic and all services provided there.
3. Informed consent must be obtained, in writing, from all Members for the provision of all-contraceptive devices and/or procedures. This consent will be filed in the Member’s medical records.
4. In general, OB/GYN, family practice, or internal medicine physicians and nurse practitioners will provide family planning services to Members.
Members may receive care from:
- Their own Care1st PCP or OB/GYN
- A Care1st participating Family Planning provider
- Any out-of-plan Family Planning provider (This is limited to Medi-Cal Members only)

7.8.8: Sensitive Services

“Sensitive services” Means those services that are defined as services related to sexual assault, sub stance or alcohol abuse, pregnancy, family planning, and sexually transmitted diseases for Members 12 years of age and older if sexually active.

Benefit Coverage

Members 12 years of age and older may sign an Authorization for Treatment form for any sensitive services (without parental consent). Parental or guardian consent is required for Members under 12 years of age who seek substance or alcohol abuse treatment services, or for treatment of sexually transmitted diseases.

The Member's PCP should encourage Members to use in-plan services to enhance coordination of care. However, Members may access sensitive services through out-of-network providers without prior authorization.

Family Planning (sensitive) services shall include, but not be limited to:
- Medical treatment and procedures defined as family planning services under current Medi-Cal scope of benefits
- Medical contraceptive services including diagnosis, treatment, supplies, and follow-up
- Informational and education services

In compliance with federal regulations, Care1st Members have free access to confidential family planning services from any family planning provider or agency without obtaining for these services. Access to sensitive services will be timely. Services to treat sexually transmitted diseases or referrals to substance and alcohol treatment are confidential.

Examples of Covered Services:

- Routine pregnancy testing
- Elective therapeutic abortions
- Birth control pills
- “Morning after pill” to avoid pregnancy is approved by the FDA for emergency treatment only (e.g., rape, incest, etc.)
- Depo-Provera as routine birth control
- Norplant, including device, insertion and removal
- Intra-uterine device (IUD) including device, insertion and removal
- Diaphragm
- Contraceptive foam, male and female condoms, cervical caps, sponges, etc.
- Elective tubal ligation
- Elective vasectomy
Office visits for education and instruction for birth control, including symptom-thermal method, billings method, rhythm method; and instruction and education regarding the methods and devices listed above.

- STD screening, testing, diagnosis, education, and referrals for treatment
- HIV screening, testing, diagnosis, education, and referrals for treatment

7.8.9: Sexually Transmitted Disease

Care1st will provide Members with confidential sexually transmitted disease (STD) screening and testing, diagnosis, treatment, follow-up, counseling, education and preventive care. Members should be encouraged to obtain these services from their PCPs. However, Members have the right to receive some services outside of the PCP without prior authorization.

STD Reporting
State law mandates that specified STDs be reported to local health departments. All diagnosed Members that fail to complete treatment must also be reported to the applicable local health department.

7.8.10: Mental Health (Medi-Cal Managed Care)

Inpatient and specialty outpatient mental health services are carved out of the Care1st Medi-Cal benefit agreement. Care1st Members may directly access specialty mental health services through the Department of Mental Health.

Behavioral Health Services Access

There are multiple entry paths for Care1st members to access behavioral health services. Referrals may be requested by primary care physicians (PCPs), specialty providers, County Departments, Community Based Organizations, case managers and member self-referrals. The Care1st contracted MBHO has a toll free 800 number that is available 24/7 for behavioral health service authorization requests. The MBHO number is listed on the member’s ID card. Care1st also has a toll free 800 number that is available 24/7 for general inquiries, member eligibility verification, business hour service authorization requests and after hour service authorization requests. After hour requests are coordinated by cross connecting callers to the afterhours Care1st on call nurses. The nurses have 24 hour access to Care1st physicians for assistance in making any medical necessity determinations that are beyond the nursing scope of practice. The after hour nurse are educated and trained in coordinating behavioral health service referrals as for all levels of mental health treatment to the appropriate provider network for behavioral health care.

Medi-Cal Managed Care Plan Behavioral Health Benefits and Services
It is the responsibility of Care1st Health Plan to provide Medi-Cal Managed Care Plan (MMCP) Behavioral Health Benefits for members defined by the current Diagnostic and Statistical Manual of Mental Disorders DSM resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning.
Role of Primary Care Physicians

The Primary Care Physician is responsible for:

- Initial Health Assessment and IHEBA using an age appropriate DHCS approved assessment tool
- Screening for Mental health Conditions
- Administration of required screening instruments, including but not limited to the “Screening and Brief Intervention, Referral and Treatment” (SBIRT) for substance use conditions
- Referrals for additional assessment and treatment

Primary Care Physicians appropriately provide significant amounts of mental health care that fall within their scope of practice, including the prescribing of psychotherapeutic drugs.

Care1st is responsible for outpatient behavioral health services for members defined by the current DSM resulting in mild to moderate distress or impairment of mental health, emotional, or behavioral functioning provided by Care1st contracted MBHO.

MBHO Behavioral Health Services

Behavioral services will be provided by independent practice level licensed mental health care providers acting within the scope of their license. The services include:

i. Individual/group mental health evaluation and treatment (psychotherapy).
ii. Psychological testing when clinically indicated to evaluate a mental health condition.
iii. Outpatient services for the purpose of monitoring drug therapy.
iv. Psychiatric consultation for medication management.
v. Outpatient laboratory, medications, supplies, and supplements.

7.8.11: Vision

Care1st Health Plan Members are eligible to receive vision care services, including the provision of examinations and eyewear at the same location.

Care1st is contracted with a network of participating ophthalmologists, optometrists, hospital outpatient departments, and organized outpatient clinics strategically throughout Los Angeles County in order to provide enrolled Members with convenient access to vision care services. If the Member belongs to a contracted PPG, the PCP should submit the referral to the PPG. **Providers must use the Prison Industry Authority (PIA) Optical lab for all glass lens prescriptions.**

Participating vision care providers are authorized to submit claims for vision care services and appliances to Care1st, in accordance with Medi-Cal vision care policies and billing instructions.

Members may obtain, as a covered benefit, one pair of corrective lenses every two (2) years. Additional services and lenses are to be provided based on medical necessity.

If the optometrist for any reason feels the Member should be referred to an ophthalmologist or other physician, he/she is to call the Member’s PCP for a telephone referral authorization. This is necessary to ensure the PCP is aware of any potential conditions that may be related to the general health of the Member (such as diabetes).

7.8.12: Dental
PCPs will conduct primary care dental screenings and facilitate appropriate and timely referrals to dental providers. Services delivered by dental providers are carved out of the Care1st Health Plan benefit agreement.

PCPs shall perform an inspection of the teeth and gums for any signs of infection, abnormalities, malocclusion, and inflammation of gums, plaque deposits, caries or missing teeth. If any of the above conditions are observed, PCPs should instruct the Member to make an appointment to see a dentist. Care1st maintains a current list of Medi-Cal dental providers and will be available to assist PCPs in the dental referral process.

As part of the CHPD health assessment, children are to be referred to a Medi-Cal dentist if a dentist has not seen them within the prior six (6) months. Dental screenings of adults are accomplished, at a minimum, as part of the periodic examinations recommended by the United States Preventive Services Task Force (USPSTF) in addition to the course of other encounters. PCPs are encouraged to educate Members about the importance of dental care and to make corrective and preventive referrals.

PCPs are to document screenings and referrals in the Member's medical record.

7.8.13: Organ Transplant

Major organ transplants are excluded services. Members who are approved candidates for a transplant procedure will be disenrolled from the Plan and covered by fee-for-service Medi-Cal. All County Organized Health Systems (COHS) are capitated for major organ transplants for Members aged 21 years or older. For Care1st Members under 21 years of age, the responsibility for provision of and payment for major organ transplant procedures is covered under California Children's Services (CCS).

Care1st’s goal is to achieve early identification of potential transplant candidates, and carefully coordinate services so that Members will have prompt access to the most experienced organ transplantation centers in California. Care1st, in collaboration with its provider network, will identify Members potentially requiring an organ transplant. Once identified, the Member will be referred to a tertiary transplant center to facilitate a work up in order to determine if the candidate is eligible for a transplant.

If the Member is deemed eligible he/she will be disenrolled from the Plan and be enrolled into fee-for-service Medi-Cal.

Approved Fee-For-Service Organ Transplantation
- Bone marrow transplants
- Heart transplants
- Lung and Heart-lung transplants
- Liver transplants
- Liver-kidney combined transplants
- Liver-small bowel combined transplants

Renal and Corneal Transplants
Renal and corneal transplants for Members aged 21 years and older are a covered benefit under Care1st Health Plan. Upon identification of a Member in need of a renal or corneal transplant, Care1st will refer the Member to a DHS licensed and certified hospital with a renal transplant unit. Care1st is responsible for the continuation of all necessary primary care services and the provision of all services related to renal and corneal transplantation including, but not limited to, the evaluation of potential donors and harvesting of the organs from living or cadaver
donors.

Care1st will refer Members under the age of 21 in need of evaluation as potential renal and corneal transplant candidates to the appropriate CCS Program office for referral to an approved CCS transplant center. All related transplant services shall be sent to the local CCS Program office for authorization.

7.8.14: Long Term Care

The managed Medi-Cal skilled nursing facility benefit includes the month of admission and the month thereafter, for a maximum benefit of 60 days. After the 60-day period, the Member is disenrolled back to fee-for-service Medi-Cal. Care1st will ensure that these identified Members are placed in facilities providing the appropriate level of care which is commensurate with their medical needs.

If a Member meets long-term care criteria, Care1st will authorize the admission to a skilled nursing facility, rehabilitation facility, or intermediate-care facility.

If it is anticipated that a Member will require long-term care in the facility for longer than the month of admission and the month thereafter, the Care1st UM Department will begin the process of disenrollment to transfer the Member to fee-for-service Medi-Cal.

7.8.15: Alcohol & Drug

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Misuse of Alcohol

It is the policy of Care1st Health Plan to provide and pay for expanded alcohol screening and brief intervention(s) for members 18 years of age and older that screen positively for risky or hazardous alcohol use or a potential alcohol use disorder.

Primary care site providers shall conduct a pre-screen question to identify potential candidates for alcohol misuse problem(s). The pre-screen process is part of the Staying Healthy Tool. PCPs must offer the Staying Healthy Assessment (SHA) tool within 120 days after a member enrolls with Care1st Health Plan and then every three years thereafter, and with annual reviews of the member’s answers.

Any member identified with possible alcohol use disorders shall be referred to the County Alcohol and Drug Program in the county where the member resides for alcohol misuse treatment.

7.8.16: Tuberculosis

Care1st and its providers will work in close coordination with the local health departments in the treatment and management of Care1st Members with tuberculosis (TB).

All efforts will be made to identify cases of tuberculosis among Members as early as possible, to render infectious cases of TB to non-infectious as rapidly as possible, and to prevent non-infectious cases from becoming infectious. This will be done in accordance with the Los Angeles County Department of Health Services TB Control Program’s developed guidelines and policies for suspected TB cases.

PCPs will serve as the overall Case Managers for the screening and treatment of TB for Care1st Members. Care1st UM Case Managers will participate in a supportive role in coordinating, referring, reporting, contacting and the assessment of needs for any identified
Member that is suspected of having or has TB.

7.8.17: Waiver Program

Waiver Programs provide services in the home for Members who are currently receiving care in acute or skilled nursing facilities. Members meeting criteria for waiver services will be referred to those programs. Care1st will efficiently arrange the Member’s disenrollment and transfer of care to fee-for-service Medi-Cal, thereby enabling the Member to receive care appropriately and safely in a home environment rather than an institution.

Members suitable for the Medi-Cal Waiver Program are:
- Members who have been in a skilled nursing facility (SNF) beyond 30 days without improvement and unable to maintain self-care.
- Members in custodial care.
- Members with an AIDS diagnosis.
- Members with other factors as noted in specific waiver criteria.

7.8.18: Phenylketonuria (PKU)

The treatment and testing of PKU are covered benefits under the Medi-Cal Program. The benefit includes formula and special food products that are medically necessary for the treatment of PKU. The screening of PKU is provided through the Plan’s contracted hospital after birth, but prior to discharge of the newborn.

Metabolic diseases may be a carve-out benefit and may be covered through California Children’s Services (CCS). Infants and children up to the age of 21 years that are identified as having PKU will be referred by the Plan to CCS for case management.

Medically Necessary Enteral Nutrition Products

Plans are required to provide or arrange for all medically necessary covered services, and to ensure that these covered services are provided in an amount no less than what is offered to beneficiaries under Medi-Cal Fee-For-Service. Plans shall develop and implement written policies and procedures for providing medically necessary enteral nutrition products for outpatient Members that minimally meet the new Medi-Cal enteral nutrition benefit policy outlined in the Enteral Nutrition Products sections of the Medi-Cal Part 2 Pharmacy Provider Manual.

Requirements for Medical Authorization of Enteral Nutrition Products

- A prescription by a licensed provider is required;
- Authorization procedures and review for approval of enteral nutrition products shall be supervised by qualified healthcare professionals;
- Decisions and appeals regarding enteral nutrition products shall be performed in a timely manner based on the sensitivity of medical conditions and rendered as:
  
  Emergency requests: in no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment (W&I Code Section 14103.6);
  
  Expedited requests: within three (3) working days for services that a provider or a Plan determines that following the standard timeframe could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function;
Non-emergency requests: within five (5) working days when proposed treatment meets objective medical criteria, and is not contraindicated; and

A regimen already in place: within five (5) working days for review of a currently provided regimen as consistent with urgency of the Member’s medical condition, as required by Health and Safety Code Section 1367.01;

- Any decision on enteral nutrition products that is delayed beyond these time periods is considered approved and must be immediately processed as such;
- Verbal or written notification shall be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by the provider;
- Members shall be notified about denied, deferred, or modified services; and
- Plans shall publicize the appeals procedure for both providers and Members.

Definitions

“Formula” Is defined as an enteral product for use at home.

“Special food products” Is defined as products that are specially formulated to have less than one gram of protein, or used in place of normal food products such as grocery store foods used by the general population.

7.8.19: Cancer Screening

Cancer screening tests are covered benefits under the Medi-Cal Program. Care1st Health Plan follows the standards established by the United States Preventative Services Task Force (USPSTF) as outlined under Section 9.5 of the Provider Manual. In addition, annual cervical screenings includes the conventional Pap test and the option of any cervical cancer screening test approved by the FDA upon the referral of the Member’s health care provider.

7.8.20: Cancer Clinical Trials

Care1st covers routine Member care services that are related to the clinical trial for a Member diagnosed with cancer and accepted into a phase I, phase II, or phase IV clinical trial for cancer. The clinical trial program’s endpoint shall be defined to the test toxicity, and to have a therapeutic intent. The treatment shall be provided in a clinical trial that either (a) involves a drug that is exempt under federal regulations from a new drug application, or (b) is approved by one of the following:

- One of the National Institutes of Health (NIH).
- The Food and Drug Administration (FDA) in the form of an investigation new drug application.
- The United States Department of Defense (DOD).
- The United States Veterans’ Administration (VA).

7.8.21 AIDS Vaccine Coverage

In the event the FDA approves a vaccine for AIDS, it will be covered.

7.8.22 Services Under the End of Life Options Act (ABx2-15) for Medi-Cal Members

End of life services (EOL Services) under this Act, patient consultation by a physician and prescription of aid-in-dying medication, are carved out from Medi-Cal health plans like Care1st.
Medi-Cal Fee-For-Service (FFS) will provide coverage and reimbursement for physicians who provide EOL Services.

Provision of these services by health care providers is voluntary. If you are a physician enrolled in the Medi-Cal FFS program, you may voluntarily provide Care1st Medi-Cal members with EOL Services under the Medi-Cal FFS services, not under your contract with Care1st, and seek payment for EOL consultations from the Medi-Cal FFS program.

You are responsible for documenting an oral request by a Care1st Medi-Cal member for EOL Services whether or not you volunteer to provide these services to the member.

7.9: Delegated UM Reporting Requirements (Participating Provider Group “PPG” Only)

The purpose of UM reports is to provide ongoing monitoring for delegated UM functions and to ensure that services and decisions rendered by the delegated PPG are appropriate and meet DHS, DMHC, and Care 1st standards. All delegated PPGs must report and submit UM information to Care1st as described below (See also Appendix 4: UM IPA Delegation Matrix) on a monthly, quarterly, and annual basis.

**Monthly Reporting Requirements**

Monthly reports are due to Care1st by the 15th of the month following the month in which services were rendered or denials made, and include the following:

1. Authorization Tracking Report – Include authorization #, Member name, requested date, approval date, diagnosis, and requested services
2. Authorization Turn Around Time Report
3. Denials and Modifications – Include all referral and denial/modification information and copies of all denial/modification letters
4. Case Management Log – Include Member name, SSN#, diagnosis, PCP, intervention, and status of the case (open or closed)
5. Second Opinion Tracking Log – Include all authorizations, modifications, and denial information for second opinion requests. The log must include the reason the second opinion was requested
6. Linked Services Logs – Include Member name, PCP name, diagnosis, and intervention
7. HIV/ABR Reporting – Report to include CIN, Medi-Cal number, Care1st ID, PPG, Mo/Yr diagnosed, Mo/Yr billed, date last billed, Aid Code, AEVS Verification number
8. ESRD- Log to include authorization number and category, Member name, DOB and member ID; PCP, ICD9, CPT and description; requesting provider, referred provider and specialty, place of service and quantity; request type and date, decision and decision date
9. Organ Transplant – Log to include Member name, diagnosis, review plan, date case opened and/or closed, monthly updates, and level

**Quarterly Reporting Requirements**

1. UM quarterly reports must be submitted to Care1st 45 days after the end of the quarter (May 15th, August 15th, October 15th, February 15th) The report should include, at a minimum, UM activities, trending of utilization activities for under and over utilization, Member and provider satisfaction activities, and inter-rater reliability activities and improvement.
2. Continuity of Care/Out of Network reports are to be submitted by the 1st of the month
following the end of the quarter (May 1st, August 1st, October 1st, February 1st) – COC
Include Total number of PCP/SCP termed, total number of members requesting
assistance, and total number of members allowed continuing access to provider and
total number of members whose coverage was ended while still needing care. OON
include number of provider OON requests, approved, and in progress, and number
of PPG referrals to OON providers.

**Annual Reporting Requirements**
The following reports must be submitted annually to Care1st by February 15th of each calendar
year:

1. UM Program Description: Reassessment of the UM Program description must be
done on an annual basis by the UM/ QM Committee.
2. UM Work Plan: Submit an outline of planned activities for the coming year, including
timelines, responsible per son(s) and committee(s). The work plan should include
planned audits, follow-up activities and interventions related to the identified problem
areas.
3. UM Program Annual Evaluation: The evaluation should include a description,
trending, analysis and evaluation of the overall effectiveness of the UM Program.

All reports must be submitted to Care1st within the timeframes specified. There must be
separate reports generated for Medi-Cal and Healthy Families Members. Consistent failure to
submit required reports may result in action that includes, but is not limited to, request for a
corrective action plan (CAP), freezing of new Member enrollment, or termination of Care1st
Agreement.
7.10: Managed Long Term Support Services (MLTSS)

Care1st providers may refer a Member to the health plan for consideration to receive MLTSS. Each of these programs is subject to its own eligibility criteria, and a submitted request does not necessarily guarantee approval of service (See Appendix 5: LTSS Referral Form).

MLTSS programs include:

1. **Community Based Adult Services (CBAS)**
   Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, transportation, and other services.

2. **In-Home Supportive Services (IHSS)**
   A program that allows the enrollee to select their provider for in-home care if they cannot safely remain in their home without care giving assistance. To qualify for IHSS, the enrollee must be aged, blind, or disabled and, in most cases, have income equal to or below the current Supplemental Security Income/State Supplementary Program levels.

3. **Multipurpose Senior Service Program (MSSP)**
   A California-specific case management program that provides Home and Community-Based Services (HCBS) to eligible Medi-Cal beneficiaries who are 65 years or older with disabilities as an alternative to nursing facility placement.

4. **Long Term Custodial Care in a Skilled Nursing Facility (SNF) or Sub-acute Facility**
   Facilities that provide long term custodial care for people who cannot live safely at home but do not need to be in a hospital.

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**SECTION 8: ENCOUNTER DATA**

8.1: Encounter Data

**Policy**

PPG and directly contracted providers will submit to Care1st Health Plan complete and accurate encounter data, at least monthly, that meets the standards and time frames established by Care1st Health Plan.

*Providers who are contracted with Care1st through a delegated PPG must submit encounter data to their affiliated PPG in the format and within the timeframes established by the PPG.*

**Compliance Guidelines**

1. **Volume of the data**
   The established encounter volume benchmark for Medi-Cal is 3.5 PMPY

2. **Quality of the data**
   Data acceptance rate shall not be less than 90% of all data submitted

3. **Timeliness of the data**
   Seventy percent (70%) of all encounter data shall be submitted to Care1st within 90 days of the end of the month in which the encounter occurred (date of service)
Directly Contracted Providers

Encounter data must be submitted to Care1st by the 10th of the month following the month in which service was rendered.

Care1st Health Plan  
Attn: Encounter Data  
P.O. Box 4599  
Montebello, CA 90640

8.1.1: Participating Provider Group “PPG”

Encounter data is due within 30 calendar days following the end of the month in which service was rendered. Encounter data must be submitted electronically and is to be submitted by the 10th of each month. If encounter data is not received on the 10th day following the 30 day timeframe, the PPG is considered non-compliant and a penalty may be assessed. Providers who are contracted with Care1st through a delegated PPG must submit encounter data to their affiliated PPG in the format and within the timeframe established by the PPG.

Manual Data Hardcopy Submissions

Encounter data should be submitted electronically in the format required by Care1st. When necessary, manual data submissions must be legible with encounter type clearly marked, and Member and doctor information complete and fully accurate.

1. Manual data should be submitted on one of the following forms:
   PM-160 for all CHDP encounters
   HCFA-1500 / CMS-1500 for all other services
2. Encounter Data should only be submitted to the Claims Department address:

   Care1st Health Plan  
   Attn: Claims  
P.O. Box 4599  
Montebello, CA 90640

8.2: EDI Procedure

1. Delegated PPGs will submit electronic encounter data files in the required format to the Care1st FTP or SFTP site, which can be arranged through the Provider Network Operations and MIS Department. An electronic file must be submitted by the 10th of each month in order to be compliant with Care1st requirements.
2. The Encounter Data Department will process the submission within three (3) business days from the date of receipt, create an error report that indicates the number of records submitted, and the number accepted and rejected. The Encounter Department will upload the error report via the FTP server in the PPG’s designated folder to retrieve and review.
3. PPGs must submit corrections prior to or with their next month’s encounter data submission.
4. All PPGs that do not submit encounter data at least monthly and meet the standards required for volume (where applicable) and quality will be referred to the Provider Network Operation Department for follow-up and possible sanctions.
Electronic Submissions
Electronic data submissions are sent via FTP and each PPG has a designated encounter folder with a private PGP key.

Electronic data must be submitted in **ANSI X12/837 5010 format**.
1. Ansi X12N 837 P or I 5010 format

For additional questions or information, please contact the Encounter Department at (323) 889-6638 extension 3290

8.3: EDI CHDP Services

For CHDP encounter data that are submitted electronically, PPGs are required to submit the original PM-160 form to Care1st. Care1st will make one set of copies of the PM-160s to be sent to L.A. Care and the originals will be sent to the State. To avoid L.A. Care from returning CHDP encounters, ensure that the form is completely filled out and the information provided is valid.

1. **PM-160 form for CHDP Encounters:**
   - Care1st provided PM-160 forms are to be used
   - All forms should be completed in “black” ink only, and require the original provider signature.
   - The 4-carbon copy pages are to be submitted as followed:
     COPY-1: Submit this copy only to Care1st Health Plan (brown copy)
     COPY-2: Submit to Community CHDP Program (yellow copy)
     COPY-3: Health Assessment Provider (patient’s medical file); (white copy)
     COPY-4: To Parent (pink copy)
   - To request PM-160 forms, contact the Care1st Encounter Department at: (323) 889-6638 extension 6290 or fax CHDP_PM-160 Information Only Form Request to (323) 889-5412 (See Appendix 26)

   Additional information is available at [http://www.dhs.ca.gov\pcfh\cms](http://www.dhs.ca.gov\pcfh\cms)

2. **Submit CHDP hardcopy encounter data to the Encounter Data address:**

   Care1st Health Plan
   Attn: Encounter Data
   P.O. Box 4599
   Montebello, CA 90640

SECTION 9: QUALITY IMPROVEMENT

9.1: Quality Improvement Program

**Mission Statement**

The mission of the Care1st Quality Improvement (QI) Department is to provide an effective, system-wide plan and process for monitoring, evaluating and improving quality of care and services to our Members. Care1st is committed to achieving high standards of medical care in a cost effective and efficient manner through an integrated organizational approach.
Purpose

The QI Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care/services, the structures/processes by which they are delivered to Plan Members; to continuously pursue opportunities for improvement and problem resolution.

Goals

- To ensure Members receive the highest quality of care and services.
- To ensure Members have full access to care.
- To monitor and improve Member satisfaction with all aspects of the delivery system and network.
- To utilize a multi-disciplinary approach to assess, monitor and improve Plan policies and procedures.
- To promote physician involvement in quality improvement activities.
- To meet the changing demands of the healthcare industry.
- To promote the benefits of a managed care delivery system.
- To promote preventive health services and disease management.
- To emphasize the unique relationship among the patient, practitioner, provider and health plan.
- To seek out opportunities to improve the quality of care and service provided to our Members.
- To seek out opportunities to improve the quality of services to our practitioners/providers.
- To seek innovative solutions to identified challenges.

Objectives

- To ensure that timely, quality, medically necessary and appropriate care/services that meet professionally recognized standards of practice are available to Members by monitoring the processes/outcomes of care utilizing established and measurable standards. Emphasis will be placed on monitoring preventive services, clinical outcomes, ER usage, bed days, medication usage, access, and complaints/grievances.
- To systematically collect, screen, evaluate information about the quality and appropriateness of clinical care, provide feedback to practitioners/providers about their performance and network-wide performance.
- To maintain a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity, facility site review, and performance.
- To ensure our Members are afforded accessible health care by continually assessing our network of practitioners/providers.
- To design and develop data systems to support QI monitoring and measurement activities.
- To assure compliance with the requirements of accrediting and regulatory agencies including, but not limited to, DMHC, DOC, SDHS, CMS, NCQA and other regulatory agencies.
- To identify, review, monitor and assure resolution of known or suspected quality of care problems, trends that impact the healthcare of our Members, and implement monitoring of corrective actions to prevent recurrence.
- To appropriately oversee QI and credentialing activities of delegated PPGs.
- To ensure that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements.
- To establish and maintain standards for quality of care, accessibility of care, and
service.

- To identify opportunities for improving the quality of patient care and services and to implement monitoring of changes to achieve improvement.
- To establish and conduct focused review studies, with emphasis on preventive services, high-volume practitioners/providers or services and high-risk services.
- To ensure that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
- To measure and improve Member and practitioner/provider satisfaction.

Scope
The scope of the QI Program is comprehensive including activities that have a direct and indirect influence on the quality and outcome of clinical care, services delivered to all Plan Members and delivered to network practitioner/provider. The program addresses issues relevant to the enrolled Member population and practitioner/provider network. Responsibility is assigned to appropriate individuals.

The scope of the QI Program encompasses both quality of care and quality of service. Responsibility for monitoring the scope of care may rest with the Health Plan, delegated PPG or vendor; however, Care1st retains ultimate responsibility for quality.

This QI Program covers all medical products including, but not limited to, Medi-Cal. Behavioral Health is a covered benefit for our Medi-Cal line of business. A formal evaluation of the Quality Improvement Program is performed annually. Our QI standards and procedures are applicable to all Care1st Members.

Evaluation activities may include but not limited to:

- Practitioner/Provider accessibility and availability
- Practitioner/Provider satisfaction
- Clinical practice guidelines
- Under/Over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility site reviews
- Member satisfaction, complaints and grievances
- Timeliness of handling claims
- High risk and high volume services

Functional areas include:
- PQI/Grievances
- Disease Management
- Preventive Services
- Credentialing
- Facility Site Review

Confidentiality & Conflict of Interest
All information related to the quality improvement process is considered confidential. All QI data and information are inclusive of but not limited to minutes, reports, letters, correspondence, and reviews, are housed in a designated, secured area in the QI Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.
All persons attending the Medical Services Committee or its related committee meetings will sign a confidentiality statement, and all Care1st personnel are required to sign a confidentiality agreement upon employment.

No persons shall be involved in the review process of QI issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

9.1.1: Program Structure

Governing Body

The governing body of Care1st is the Board of Directors. The Board of Directors is responsible for the establishment and implementation of the Plan’s QI Program. The Chief Medical Officer reports all quality improvement activities to the Board at least quarterly.

Chief Executive Officer

The Chief Executive Officer has overall organizational responsibility for the QI program; ensures program implementation, function and results; and provides adequate resources and staffing.

The Chief Executive Officer delegates functional responsibility for the QI program to the Chief Medical Officer.

Chief Medical Officer

The Chief Medical Officer (CMO) is a physician who holds a current license to practice medicine with the Medical Board of California. The CMO is the Board of Director’s designee responsible for implementation of QI program activities. The CMO works in conjunction with the Directors of Medical Services, the QI Medical Director, and the QI Directors to develop, implement and evaluate the QI Program. The CMO is chairperson of Medical Services, Credentials/Peer Review, Pharmacy & Therapeutics, QIA Steering, and delegated oversight committees. Responsibilities of the CMO also include but are not limited to:

- Performing statistical analysis relevant to quality improvement functions and goals.
- Developing and/or revising annually the QI Annual Evaluation and Work Plan and presenting for review and approval.
- Developing quarterly QI activity progress reports. QI Improvement policies and procedures.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Medical Services Committee the resolution of quality improvement activities in accordance with the Quality Improvement Program.
- Overseeing compliance required by regulatory agencies.
- Interfacing with all internal departments to ensure compliance to the QI Program and policies and procedures.
- Acting as a liaison with each delegated IPA/PMG and ancillary provider and facility regarding QI issues.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DMHC, SDHS, DHCS CMS, and NCQA.
- Serving as liaison with Regulatory Agencies for QI activities.
- Monitoring and follow up with all applicable QI activities.
- Ensuring that staff collects and monitors data and reports identified trends to the CMO and Medical Services Committee.
- Ensuring that HEDIS and QIP studies are conducted appropriately.
- Overseeing the Facility Site Review Program.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Managing the Credentials process.
- Managing the Practitioner database modification process.
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Interfacing with the Chief Medical Officer for clinical quality of care and service issues.
- Maintaining a comprehensive PQI/QCI database to track pertinent case data that facilitates capturing, tracking and trending of this data.
- Assuring the department adheres to HIPAA compliance standards.
- Overseeing Member clinical grievance case files and the process for the Chief Medical Officer’s action.
- Preparing peer review case files for the Chief Medical Officer’s action.
- Reviewing potential risk management issues and reporting them to the Chief Medical Officer.
- Serving as liaison with DMHC, CMS, SDHCS, DHCS, NCQA and other regulatory agencies for investigation, collaboration and resolution of clinical grievances.
- Developing policies and procedures in conjunction with the Chief Medical Officer.
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
- Preparing PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings.
- Collaborating with Member Services Administrative Grievance Coordinator to identify quality of care issues.
- Overseeing the pre-contractual and annual Due Diligence audit process. Monitoring delegated QI activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Submitting a written report summarizing each pre-contractual or annual review.
- Tracking compliance with reporting requirements and provide reports for Delegated Oversight Committee and Joint Operating Committee meetings.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
- Reporting IPA/PMG findings of non-compliance to the CMO and Delegated Oversight Committee.

**Quality Improvement Director(s)**

**A. Director, Quality Improvement**

The Quality Improvement Director is a Registered Nurse with a current California licensure and oversees the managers in the administrative daily operations of the Quality Improvement Department and is responsible for the execution of Quality Improvement activities listed below. The Quality Improvement Director reports to the Medical Director, Quality Improvement. It is the Director of Quality Improvement’s responsibility to interface with other departments on daily Quality Improvement processes and issues.
Additional responsibilities include but not limited to:

- Assisting in collecting information for quarterly QI activity progress reports.
- Assuring that all staff members are adhering to company standards of conduct.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Ensuring that staff collects and monitors data and report identified trends to the CMO and Medical Services Committee.
- Ensuring appropriate resources and materials are available and ordered to meet the department’s needs.
- Overseeing the Managers in the Reviewing of daily staff time clock logs and ensuring compliance with company standards.
- Assisting in the development of Focused Review Studies.
- Interfacing with the Medical Director, QI and Chief Medical Officer for clinical quality of care and service issues.
- Ensuring the maintenance of the PQI/QCI database to track pertinent case data that facilitates capture, tracking and trending of quality data.
- Overseeing member clinical grievance case files and the process for the Chief Medical Officer and Medical Director.
- Overseeing the preparation of peer review case files for the Chief Medical Officer’s action.
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
- Overseeing the preparation of PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings.
- Overseeing the collaboration with Member Services Administrative Grievance Coordinator to identify quality of care issues.
- Reporting IPA/PMG findings of non-compliance to the Medical Director, QI and CMO.

B. HEDIS and Stars Director, Quality Improvement
The Director of HEDIS & STAR Programs provides support, expertise, and supervision of the entire QI HEDIS team. The primary responsibilities range from oversight of medical record review, data extraction, maintaining data systems, leading the QI HEDIS team, leading the physician/physician office staff as it relates to HEDIS, Risk Assessment and other intervention programs initiated through the Quality Management Department.

Additional responsibilities include but not limited to:

- Provides oversight and support and expertise for interventions initiated by the Quality Management Department and Quality Outreach programs, including medical record abstraction for HEDIS, Outreach Education, Medicare HCC, STAR rating, and Risk Assessment projects.
- Collaborates with HCC Director or vendor to ensure that there is synergy in the physician outreach and the use and abstraction of medical records.
- Management and oversight of QI Outreach team including nurses, coordinators, data entry clerks and physician office staff.
- Effectively leverages available resources (financial, people, time) to accomplish project objectives and contributes to the successful implementation of QI Outreach programs.
- Oversight of the field teams educational and data collection efforts with possible traveling to assigned Physician/IPA office sites.
- Ability to oversee the annual HEDIS Compliance audit including submission and dissemination to HSAG and CMS and other regulatory agencies. Extensive education, validation, and documentation of physician and physician’s office staff regarding HEDIS measures, Medicare HCC Risk adjustment and Risk assessment requirements/compliance guidelines.
- Oversight of the HEDIS data abstraction processes to ensure we adhere to NCQA standards for data abstraction.
- Knowledge and experience with HEDIS Technical Specifications, NCQA Survey and Outcome Measures and be able to write a HEDIS Road Map.
- Must be skilled and knowledgeable with the Minimum Performance Levels (MPL’s).
- Ensures physicians and physician’s office staff meets the HEDIS, Medicare HCC, and Risk assessment requirements by concurrent and ongoing evaluation.
- Teaches nurses and coordinators how to educate physician and physician’s office staff to use various QI Outreach incentive programs.
- Empowers physician/physician’s office staff, promotes physician/physician’s office staff relationships, and ensures client satisfaction.
- Concurrent and ongoing assessment of physician offices’ current practices and streamlining the process as per the QI Outreach implementation project plans.
- Develops new interventions and corrective action plans for physician office sites that fall below the QI Outreach measurement benchmarks.
- Promotes team environment, positive work environment, and quality assurance of QI Outreach team.
- Makes appropriate decisions in the face of ambiguity. Anticipates and resolves barriers while managing multiple priorities.
- Provides support to the CMO and Medical Director, under Quality Improvement to work as part of the Quality Improvement Management Team on projects pertaining to HEDIS. Oversees the PCP and IPA QI report card mailings.
- Attends annual HEDIS and Medicare HCC/Coding certification classes.
- Assists in the annual preparation of the Baseline Assessment Tool and audit process.
- Prepares audit result reports, graphs and presentations.
- Other duties as assigned by the Medical Director, Quality Improvement and as needed to assist the Quality Improvement Department with HEDIS related Accreditation Projects.

C. Other Quality Improvement Staff and Resources
The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Care1st has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staff includes but is not limited to:

- QI Manager of Accreditation and Special Projects
- QI Manager, Facility Site Review
- Credentialing Manager
- QI. Manager, PQI
- Clinical Nurse Supervisor, RN
- Clinical Quality Review RNs
- Data Analysts
- Credentialing Supervisor and Credentialing Coordinators
- HEDIS Clinical Nurse Supervisor
- HEDIS/Quality Outreach Leads & Coordinators

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Facility Site Review RNs and FSR Coordinator
Other supporting administrative staff

Committees

Medical Services Committee

The Medical Services Committee is charged with the development, oversight, guidance and coordination of all Medical Services Department activities, including QI, UM, Health Education and Cultural and Linguistics. The Medical Services Committee monitors provisions of care, identifies problems, recommends corrective action, and guides the education of practitioners/providers to improve health care outcomes and quality of service. The Medical Services Committee is also responsible for QI activities as outlined in the QI Program. Other responsibilities include but not limited to:

- Directing all Quality Improvement activity.
- Recommending policy decisions.
- Reviewing, analyzing and evaluating Quality Improvement activity.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee’s roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
- Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events.
- Reviewing and evaluating reports submitted by the Plan’s counsel.
- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
- Responsibility for evaluating and giving recommendations concerning audit results, Member Satisfaction Surveys, Practitioner Satisfaction Surveys, Access Audits, HEDIS Audits and IQIP Studies.
- Responsibility for evaluating and giving recommendations from monitoring and tracking reports.
- Ensuring follow-up, as appropriate.
**Credentials/Peer Review Committee**

Responsibilities include but not limited to:
- As the peer review body, to review, recommend, take action and monitor the clinical practice activity of the practitioner/provider network and mid-level practitioners.
- As the credentialing body, to review, recommend, approve/deny initial credentialing and recredentialing of the direct-contracted practitioner/provider network.
- Review and approve credentialing policies and procedures and ensure they are carried out.
- Ensure appropriate reports, including 805, NPDB, etc, are made, as required.
- Ensure Fair Hearing procedures are offered and carried out in accordance with approved policies and procedures.

**Delegation**

Responsibility for quality improvement is not delegated to PPGs. Care1st retains sole responsibility for the QI function. PPGs are expected to have their own methods for measuring, managing, and improving the quality of care they provide. Care1st may delegate the credentialing function to those PPGs who have demonstrated their ability to perform this function through a pre-delegation audit. PPGs that have been delegated credentialing will be audited annually by Care1st to ensure compliance with credentialing standards established by Care1st. Care1st retains the right to revoke any delegated function if compliance with standards is not met. (Refer to the delegated oversight program policies and procedures for specifics regarding the delegated oversight process.)

The results of each PPG audit are reviewed with the Care1st CMO and then presented to the Contracts Committee for review and recommendation for delegation status. Recommendations are then reported to the Board of Directors for final review and approval. Audit scores are reported to the delegated oversight committee.

The Care1st Medical Services Department continuously monitors PPG compliance with required submission of all CAPs, reports, audits, studies, and evaluations. All submissions are reviewed for quality, timeliness, and completeness of required information. It is the responsibility of the appropriate Care1st department to monitor the implementation of corrective action plans. Care1st maintains individual PPG files to document all submissions and correspondence and a database to maintain online information with PPG report submission compliance.

Care1st promotes a collaborative, supportive, relationship with its contracted PPGs. The Care1st Medical Services Department works closely with each PPG to facilitate effective delegation oversight.

**9.1.2: Standards of Practice**

The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the QI process are based on professionally recognized standards. Sources for standards include but not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Review of applicable medical literature
- Available medical knowledge
- State and federal requirements
• Standards are used to evaluate quality of care of practitioners/providers
• Standards are incorporated into policies and procedures

Thresholds and targets derived from these standards, norms and accepted for will be:
• Measurable
• Achievable
• Consistent with national/community standards
• Consistent with requirements of regulatory agencies and legal guidelines
• Valuable to the assessment of quality or the potential improvement of quality for our Member population

Standards are communicated to practitioners/providers through the Plan in a systematic manner that may include but not limited to the Care1st Provider Manual, newsletters, and bulletins.

9.1.3: Quality Improvement Process

Care1st utilizes a QI process to identify opportunities to improve both the quality of care and services for all Plan Members. Care1st adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured.

Compliance with standards is measured using a variety of techniques including, but not limited to:
• Quality Screens
• Chronic Care Improvement Plans
• HEDIS
• QIA Studies
• Monitors
• Indicators
• Medical Record Audits
• Facility Site Reviews
• Outcome Measures
• Focused Review Studies
• Member Satisfaction Surveys
• Practitioner/Provider Satisfaction Surveys
• Access To Care Audits

Potential Quality Issues (PQI) and Quality of Care Issues (QCI)

A major component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action plans to address confirmed quality of care issues.

Clinical Complaint and Grievance Process

The Care1st clinical complaint and grievance process provides Members a means by which they can report and seek resolution of concerns regarding practitioners’ or Care1st's ability to provide appropriate health care services, access to care, quality of care, or service issues.
Peer Review

Peer review will be conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner/provider or to review aspects of care, behavior or practice, or deemed inappropriate. The CMO will be responsible for authorizing the referral of cases for peer review. All Peer review consultants (including Members of the Credentials/Peer Review or ad-hoc Peer Review Committees) will be duly licensed professionals in active practice. At least one consultant will be a practitioner/provider with the same or similar specialty training as the practitioner/provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty. The CMO will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand. The QI nurse specialist will prepare all materials for review by the Peer Review Committee and conducts all follow-ups, as required by the Committee.

Quality Improvement Intervention for Systemic Quality of Care Issues

The QI Department will implement opportunities to improve the delivery and quality of care through the design and execution of quality improvement interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple Members, developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to practitioners/providers, Members or staff as appropriate.

- Educating practitioners/providers about clinical standards and practice guidelines.
- Monitoring the receipt of and compliance with standards and guidelines by practitioners/providers.
- Providing feedback to practitioners/providers to inform them of specific findings of QI reviews pertaining to the provider in question.
- Providing health promotion and health education programs to inform Members of ways to improve their health or their use of the health care delivery system.
- Modifying administrative processes to improve quality of care, accessibility and service. These processes may include, but not limited to, customer services, utilization management and case management activities, preventive services and health education.
- Modifying the practitioner/provider network, including adding practitioners/providers to improve accessibility.
- Taking disciplinary action against practitioners/providers.
- Conducting Joint Operations Committee (JOC) meetings with the delegated PPG for the purpose of education and dissemination of new materials, tools and standards.

Quality Studies (HEDIS/QISMC/QIA/Focused Review Studies)

QI Department staff will perform quality studies, as indicated, based on findings from reviews of QCIs, utilization data, pharmacy data, complaints and grievances, satisfaction survey results, medical record audit results, facility site review results and other clinical indicators. In addition, Care1st will participate with collaborative plans and regulatory agencies in state-required HEDIS/QISMC/QIA studies. Studies conducted jointly with regulatory agencies will be in accordance with regulatory agency and state requirements. Quality studies conducted independent of regulatory bodies will be in accordance with Care1st policies and procedures.
**Sentinel Events**

A major component of the QI Program is the use of sentinel events to monitor important aspects of care, accessibility and service.

**Credentialing**

Care1st conducts a credentialing process that is in compliance with all regulatory and oversight requirements.

**9.1.4: Communication of Information**

All QI activities are presented and reviewed by the Medical Services Committee. Communication to the Medical Services Committee may include but not limited to:

- Member grievance statistics and trends
- Sentinel events
- Study outcomes
- Policies and Procedures
- Medical record and facility audit reports and trends
- Delegation audit results
- Satisfaction survey results
- UM referral statistics and trends
- QI Activities
- QI Program, work plan, annual evaluation and quarterly reports
- Regulatory and legislative information
- Access & availability studies

Information concerning the QI Program and a progress report are communicated to practitioners/providers and Members in the most appropriate manner including, but not limited to:

- Correspondence with the practitioners/providers showing individual results and a comparison to the group
- Newsletter articles
- Fax updates
- Practitioner/Provider Manual updates

The QI Program description is made available to all practitioners and Members. Members and practitioners/providers are notified of the availability of the QI Program through the Member Handbook, Provider Manual, and website, respectively.

**QI Program and Policies & Procedures**

The QI Program and its policies and procedures are reviewed annually and revised, as needed, to meet good medical practices; the needs of the Plan, its Members and practitioners/providers; the changing demands of the healthcare industry, and regulatory requirements. The program and its policies and procedures are reviewed by the CMO then submitted to the Medical Services Committee and Board of Directors for review and approval.
Annual Work Plan

The QI work plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement. The work plan is developed annually outlining QI activities for the year, and includes all activities not completed during the previous year, unless identified in the annual evaluation as issues that are no longer relevant or feasible to pursue. The work plan is reviewed by the CMO and the QI Medical Director then submitted quarterly to the Medical Services Committee and Board of Directors for evaluation, review and comment of the QI activities.

Annual Program Evaluation

Quality improvement activities, as defined by the QI work plan, will be evaluated annually to measure the Plan’s performance for the year and to assist in revising the QI program and preparing the following year’s work plan. The evaluation is reviewed by the CMO and the QI Medical Director and submitted to the Medical Services Committee and Board of Directors for review and approval.

Interdepartmental Relationships

Utilization Management Department
The UM and QI Departments are part of the Medical Services Department. The UM Department frequently identifies potential risk management, quality of care issues, and health education needs through case management, inpatient review, utilization review, referrals, etc.

Member Services Department
When a Care1st Member Services representative identifies a potential quality of care issue from a Member call, it is forwarded to the QI Department for investigation and resolution. Member Services records all incoming calls by specific codes for tracking, trending and reporting.

Provider Relations/Contracting Department
The Provider Relations/Contracting Department assists the QI Department in obtaining QI information from and disseminating information to practitioners. In addition, the Provider Relations/Contracting Department:
- Serves as a liaison between the QI Department and practitioners/providers to facilitate education and compliance with approved Care1st standards.
- Schedules Joint Operating Committee meetings.
- Serves as a liaison with delegated Medical Groups/PPG.
- Assists the QI Department with practitioners/providers who do not comply with requests from the QI Department.
- Ensures contracted ancillary practitioners/providers and facilities meet regulatory and accreditation requirements.

Health Education Department
The Health Education Department and QI Department work together on projects related to practitioner/provider and Member education. The Health Education Department is part of the UM Department. Educational opportunities identified through complaints, grievances, quality of care issues, facility site review audits, focused review studies, etc., are forwarded to the Health Education Department. The QI Department also works with the Health Education Department on preventive service guidelines, 120-day initial health assessments and Staying Healthy Assessment compliance.
**Credentialing Department**

The Credentialing Department is part of the QI Department. Quality improvement information is provided to the Credentialing Department for inclusion in the credentialing/recredentialing process. The QI Department provides the Credentialing Department with facility site review, medical record audit scores and any sanction activity related to those reviews and with identified QCIs, as appropriate. The QI AVP works with the Credentialing Department to take peer review cases, as directed by the CMO, to the Peer Review Committee for review and action.

### 9.2: Policies & Procedures

#### 9.2.1: Confidentiality of Quality Improvement Information

**Policy**

All QI activities designed to monitor or improve medical care shall remain confidential. All information related to the QI process is considered confidential. All QI data and information including, but not limited to, minutes, reports, letters, correspondence, and reviews are housed in a secured area in the QI Department. All aspects of a quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the Medical Services Committee and any of its subcommittees.

Confidentiality shall be maintained in accordance with all applicable laws and regulations and standards of practice.

**Procedure**

1. All Member-identified information is kept confidential by all employees, consultants and caregivers, except to the extent needed to accomplish appropriate coordination and continuity of care among medical, nursing, ancillary and other team Members who may need to exchange information for provision of care.

2. Member protected health information (PHI) can only be reviewed by QI personnel that are involved in the actual investigation of the issues. This includes the CMO, QI Medical Director, QI Director, QI Manager, QI nurse specialist and the QI administrative assistant. The QI Medical Director is ultimately responsible for assuring the protection of PHI.

3. All Member information is considered PHI and will be de-identified prior to being presented to the committee for review. Member information includes but is not limited to: names, addresses, dates, telephone numbers, fax numbers, e-mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, serial numbers, URLs, internet address, biometric identifiers and photographs.

4. All case files will be protected and kept in a secured, locked area at all times. Office fax machines, printers and copiers used for this information will be kept in a secure location, where only the authorized personnel (see above) will have access.

5. Only the minimum necessary information will be requested for the review and investigation of these issues.

6. Member-identified information may also be shared in the following circumstances:
   a. As consented to as part of a insurance plan and then held in confidence as part of Plan policy.
   b. As required by state and federal agencies and their designees as part of medical
record availability, eligibility information, requests for authorization or referral to their agencies or their designees.

c. De-identified Member issues are discussed within the confidentiality protection of the Medical Services Committee and other peer review bodies. Committee Members and staff shall sign and adhere to a Confidentiality Statement as it relates to the committee’s functions.

7. All Members of the Medical Services, Pharmacy & Therapeutics and Credentials/Peer Review Committees and any subcommittees of those committees will sign a confidentiality statement, which shall remain in effect for a one-year period and will be maintained in the appropriate department.

8. Any employee, consultant or representative in any way involved in the QI process will sign a confidentiality statement upon employment or contract inception.

9.2.2: Clinical Grievances

Policy

The Care1st QI Department will evaluate and review all clinical grievances, involving practitioners/providers, Members and other health professionals, from all sources and make a determination as to whether there is a quality of care issue. The California Department of Managed Healthcare (DMHC) requires Member grievances be resolved to the Member within 30 days. All grievance information is considered protected and confidential in accordance with state and federal regulations.

Procedure

1. A Member grievance may be received by:
   a. Formal written letter, or
   b. Phone call to Care1st’s Member Services, or
   c. The PPG or another department directly from the Member or Member’s family
2. Practitioners/providers, PPGs, and Care1st or regulatory agencies can receive Member grievances.
3. All Member grievances must be reported to the Care1st QI nurse specialist within 24 hours of receipt. All grievances must be reported by PPGs on the monthly grievance log due to Care1st by the 5th of every month.
4. When a regulatory agency receives a grievance, Care1st will assist in the investigation and resolution process as requested.
5. The Member Services Department will send a state-approved acknowledgement letter with all required appeal language to the Member within 5 days of when the grievance is received by Care1st.
6. The QI nurse specialist will be responsible for collecting documents for all Member grievances and providing the documents to the CMO for analysis, resolution and actions.
7. The QI nurse specialist will request additional information and records from the practitioners/providers and PPGs, as needed.
8. Grievances must be resolved to the Member within 30 days from receipt of the grievance and the Member must receive a resolution letter.
9. The Member may appeal the resolution of the review to contracted regulatory agencies or SDHS. The Member may also request mediation, pursuant to the Health & Safety Code, Section 1368.
10. The QI Medical Director and or CMO will assign a severity level to each case. The QI
Department will enter all grievances into the grievance, PQI database for tracking, trending and reporting purposes.

Care1st Chief Medical Officer and or the QI Medical Director Responsibilities relating to the Clinical Grievance Process:

1. The Care1st CMO and or the QI Medical Director is responsible for analyzing and summarizing all clinical complaints and grievances and for applying a severity level to all clinical complaints and grievances.

2. If the CMO and or QI Medical Director determines a quality of care issue exists, one or more of the following actions are taken:
   a. Verbal or written communication will be sent to the practitioner/provider requesting a response to the identified issue(s) by the CMO and or QI Medical Director within a thirty-day timeframe.
   b. A severity level will be assigned if the necessary information and documentation is complete.
   c. A corrective action plan will be assigned, as warranted. The concerns will be clearly stated in writing to the practitioner/provider, with specific instructions on a corrective action plan, including timeframes, as applicable.
   d. The CMO and or the QI Medical Director may elect to send the case to a third party review for confidential consultative expertise.
   e. If necessary, the CMO and or the QI Medical Director will present the case to the Peer Review Committee or directly to the Medical Services Committee for recommendations and actions. After final determination, the CMO and or the QI Medical Director will close the case by completing the Case Summary form.

3. If there is no quality of care issue identified, the CMO and or the QI Medical Director will complete the action section and sign the Case Summary form and the case will be closed at that time.

4. When a request is received in writing from a practitioner/provider for reconsideration on a closed case, the CMO and or the QI Medical Director will review the written response and may elect to reevaluate the case based on the additional information. The practitioner/provider will be notified, in writing, by the CMO and or the QI Medical Director that either a) there has been a change in the severity level and/or corrective action plan, or b) the initial determination stands. The QI nurse specialist will modify the grievance and PQI database to reflect any changes as a result of re-evaluation.

9.2.3: Potential Quality of Care and Quality of Care Issues

Policy

Any clinical concern or system-related matter with a potential quality of care issue shall be referred to the QI Department for review, investigation, and resolution. All data will be captured in a database for tracking, trending and necessary intervention by the appropriate department or committee.

Procedure

1. All cases which may be a potential quality of care (PQI) or quality of care issue (QCI) will be forwarded to the QI Department for evaluation and review. PQIs and QCIs may be forwarded by any department or committee including, but not limited to, the following:
- Members
- Member Services Department
- Utilization Management Department
- Provider Relations Department
- Claims Department
- Credentialing Department
- Chief Medical Officer
- QI Staff
- Care1st or its subcommittees
- External Sources:
  a. Regulatory agencies
  b. Practitioner/Provider offices
  c. Medical facilities and hospitals

2. When any of the above become aware of a PQI/QCI issue, the QI nurse specialist will be notified either in person, in writing or via the UM to QI referral databases.

3. The PQI/QCI case will be date stamped upon receipt by the QI nurse specialist.

4. The QI Department will review 100% of all PQI/QCI cases. The QI nurse specialist will review the case and determine based upon clinical and quality improvement knowledge, whether to retain the referral for investigation or to route the referral to the appropriate department for processing.

5. Any of the following descriptions, as perceived by the Member or practitioner/provider, identified by a Care1st department, or referred from an external source, may be considered a PQI/QCI issue and referred to the QI Department:
   a. Member Services – Any Member issue, concern, or allegation involving clinical practice or judgment.
   b. Utilization Management – Any systems-related issue such as delays or inconveniences caused by internal processes, delays in planned service at practitioner/provider level, or any sentinel event.
   c. Provider Relations – Any systems issues caused by internal processes at the practitioner/provider level, or any contractual issues involving clinical practice and judgment.
   d. Claims Department – Any PQI/QCI issue identified by the claims staff or from ongoing claims review processes conducted by the QI nurse specialist.
   e. Credentialing Department – Any PQI/QCI issue identified by the credentialing staff or Credentialing Committee.
   f. Provider Grievance – Any PQI/QCI issue identified by a provider, PPG, medical facility, or network vendor.
   g. Quality Improvement Department – Any PQI/QCI issue identified by the QI staff, CMO or any quality improvement committees.

6. The QI nurse specialist will request medical records and a written response from the appropriate source (e.g., clinic, practitioner/provider facility, PPG, ancillary agency) to be submitted within the designated timeframe. Medical records may be mailed, faxed or delivered by courier.
7. If medical records and practitioner/provider responses are not received within the designated timeframe, a second request letter will be sent to the practitioner/provider from the QI Director.

8. If no response is received, a letter will be sent to the practitioner/provider notifying him/her that he/she is in breach of contract and of possible sanctions, including closing his/her panel or termination. The practitioner/provider will be given a five-day turnaround time.

9. If the medical records or practitioner/provider response has not been provided to Care1st by day six, the CMO will notify the practitioner/provider in writing and by telephone that his/her panel is closed and termination is possible due to non-compliance.

10. If no response is received after 5 days, the case will be closed, at the discretion of the Care1st CMO and a severity index and corrective action assigned based on current information available.

11. When all information is obtained and the case review is complete, the QI nurse specialist will complete the Case Summary form and present a summary of all documentation to the CMO for recommendations. The CMO will identify a quality of care (QOC) description code, outcome code, classification code; assign a severity level and corrective action code.

12. On completion of the review, the QI nurse specialist will ensure the following:
   a. The CMO reviews all documentation and determines if there was a quality of care issue.
   b. If no QCI is identified, the case is closed; the Case Review Summary forms are dictated by the CMO signed, dated and the action section completed. The QI nurse specialist will notify the practitioner/provider, medical facility, clinic, ancillary practitioner/provider and/or PPG, as appropriate, of the Level 1 outcome using the standardized letter.
   c. The CMO documents his rationale for action in the action section of the case review summary.
   d. If the CMO determines a quality of care issue exists, one or more of the following actions will be taken by the CMO:
      i. Verbal or written communication to the PPGs requesting additional information for the identified issue(s), if warranted and within the 30 day time frame.
      ii. Assign a severity level, if necessary information or documentation is complete.
      iii. Assign the corrective action as warranted. A letter will be sent clearly stating the concerns, with a specific corrective action plan and timeframes, as applicable.
      iv. Present the case to the Peer Review Committee for action.
      v. Elect to send the case to a third party review for consultative expertise.
      vi. Close the case, after final determination, by completing the Case Review Summary form.

13. For any case remaining open after 30 days, the QI nurse specialist will document the reasons in the database.

14. A practitioner/provider profile report will be forwarded to the Credentialing Department at the time of recredentialing or upon request. Delegated PPGs may
request a practitioner/provider profile for recredentialing; however, the PPG will be provided a copy of all final actions at the time the action is taken.

15. On case closure, the QI nurse specialist will enter final closure information into the complaint and grievance PQI database.

16. Cases forwarded from regulatory agencies will be processed as per the above procedure. After the investigation is complete, the entire case packet will be sent per Fed Ex to the regulatory agency and QI Department for review and possible presentation at the Clinical Grievance subcommittee meeting.

17. All information for each case, including all written correspondence, case summary, and all applicable documentation will be maintained in a case file. Files are maintained for a period of no less than seven (7) years.

18. Any follow-up or monitoring required by the assigned corrective action plan will be tracked by the QI nurse specialist.

19. The CMO will ensure that the assigned corrective action is implemented.

20. When any trend in quality of care issues is identified, the QI nurse specialist will notify the CMO for appropriate action and intervention.

21. When a request is received in writing from a practitioner/provider for reconsideration on a closed case, the following actions will be taken:
   a. The CMO will review the written response and may elect to reevaluate the case based on additional information.
   b. If there is a change in severity level and/or corrective action plan, or the initial determination stands, the practitioner/provider will be notified in writing by the CMO.
   c. The QI nurse specialist will modify the database to reflect any changes as a result of re-evaluation. PQI/QCI trending reports will be presented to the Medical Services Committee at their quarterly meetings. Identified trends and patterns, corrective action follow-up and improvement opportunities are reported and presented to the Medical Services Committee for review and action.

9.2.4:Assigning QI Severity Level

Policy

Upon completion of a case review, for either a Member complaint or grievance or potential quality of care issue (PQI), the Care1st CMO will assign an appropriate severity level. The severity level system is a numerical system. The QI Department tracks and trends all cases with a severity level to identify any trends or issues.

Procedure

1. At the conclusion of a QI case review, the Care1st CMO and/or the QI Medical Director will determine if the care rendered was within acceptable professional standards.

2. After reviewing the case, the CMO and/or the QI Medical Director will assign an appropriate severity level to the case.

3. The QI severity level system is categorized as followed:
   a. **Level 0:** No Quality of Care Issue Case is entered for tracking and trending only
Level 1: **Appropriate** Quality of Care with no adverse effect or outcome.
Level 2: **Borderline** Quality of Care with potential for adverse effect or adverse outcome.
Level 3: **Moderate** Quality of Care with actual adverse effect and potential for adverse outcome.
Level 4: **Serious** Quality of Care Issue with actual adverse effect and adverse outcome.
Level 5: **Significant** Quality of Care Issue with significant adverse effect and significant adverse outcome, including loss of limb or life.

Severity level category guidelines include but not limited to:

**Level 0: No Quality of Care Issue:**
- Non clinical issue for tracking and trending only

**Level 1: Acceptable** Quality of Care Issue:
- Unsubstantiated allegations
- Unavoidable complication
- Known complication
- Unavoidable progression of disease or condition

**Level 2: Borderline** Quality of Care Issue:
- Illegibility
- Incomplete, inappropriate documentation
- Delay or failure in referral
- Attitudes issues
- Miscommunication
- System issue without adverse outcome
- Access related issue without adverse outcome

**Level 3: Moderate** Quality of Care Issue:
- Delay/inappropriate treatment
- Inadequate work-up
- Preventable hospitalization or re-admission
- Delay or failure in referral
- Medication error with adverse outcome
- Delayed/misdiagnosis

**Level 4: Serious** Quality of Care Issue:
- Preventable serious complication
- Preventable death
- Preventable disability
- Practice that results in a serious adverse effect

**Level 5: Significant** Quality of Care Issues
- Loss of life
- Loss of limb

4. If a practitioner/provider has had a previous case(s) with the same or similar circumstances, this may warrant the assigning of a higher severity level and/or additional corrective action requirements, at the discretion of the CMO and/or the QI Medical Director.
5. After the CMO and or the QI Medical Director assigns a severity level and the case is closed per protocol, all information will be entered into the QI database and a case file will be created.

9.2.5: Peer Review

Policy

The Chief Medical Officer (CMO) and or the QI Medical Director at Care1st reviews all quality of care or potential quality of care issues. In the event the CMO and or the QI Medical Director does not hold the expertise or feels the issue is of such a high severity level or needs additional input in any case, he/she may forward the case to the Peer Review Committee.

Care1st will utilize the appropriate specialties/subspecialties for peer review cases. Cases that the CMO determines need additional expertise and review will be sent to an outside review company and will be reviewed by a same specialty board-certified physician.

Procedure

1. The CMO will review and act on all complaint/grievance and PQI cases going to Peer review in accordance with established policies.
2. In the event the CMO decides additional expertise is needed, the case may be sent to an outside consultant or to the Peer Review Committee or Medical Services Committee, depending on the nature and urgency of the case.
3. Patient and practitioner/provider names in all peer review cases reviewed by an outside consultant, Peer Review Committee or Medical Services Committee will be de-identified to maintain patient and practitioner/provider confidentiality.
4. In the event the CMO or peer review body determines a case needs review by a specialty/subspecialty it will be sent to an outside review organization to be reviewed by a board certified provider of the same specialty.
5. The CMO will be responsible for ensuring all actions of the peer review body are carried out and monitored. The CMO will make follow-up reports to the appropriate committee, as necessary.
6. The CMO will review all corrective action plans for completeness and appropriateness. The QI nurse specialist will track all required corrective action plan activities and report to the CMO.
7. In the event a practitioner/provider does not complete the actions required by the peer review body, the CMO will report such to the Peer Review Committee.
8. The QI nurse specialist will maintain case files for all peer review cases.
9.2.6: Sentinel Events

Policy

The UM Department will identify sentinel events and refer cases to the QI Department as a potential quality issue (PQI). Sentinel events will be assessed for quality of care issues and actions will be taken, as appropriate, and reported to the Medical Services Committee to identify opportunities for improvement.

Procedure

1. The list of sentinel events below is approved annually by the Medical Services Committee.
2. When a sentinel event occurs, the UM Department refers the case to the QI nurse specialist as a PQI. The QI nurse specialist processes the PQI in accordance with the PQI and QCI Policy and Procedure.

<table>
<thead>
<tr>
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<th>Event Description</th>
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<tbody>
<tr>
<td>000</td>
<td>Mortality</td>
<td>015</td>
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<td>001</td>
<td>Unexpected Death</td>
<td>016</td>
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<td>002</td>
<td>Asthma Admission</td>
<td>017</td>
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<td>003</td>
<td>Breast Malignancy</td>
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<td>004</td>
<td>Pregnancy Induced Hypertension</td>
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<td>005</td>
<td>Pulmonary Emboli</td>
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<td>006</td>
<td>Diabetic Admission</td>
<td>021</td>
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<td>007</td>
<td>Low Birth Weight Infant</td>
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<td>008</td>
<td>GI Catastrophe</td>
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<td>009</td>
<td>Readmission with 30 days</td>
<td>024</td>
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<td>010</td>
<td>Medical Management Issue</td>
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<td>011</td>
<td>Surgical Management Issue</td>
<td>026</td>
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<td>012</td>
<td>Hypertensive Admission</td>
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<td>013</td>
<td>Cervical Malignancy</td>
<td>028</td>
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<td>014</td>
<td>Delay in Service or Authorization</td>
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</tbody>
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9.2.7: Practitioner/Provider Requests to Terminate Patient-Provider Relationship

Policy

Care1st has a system in place for a practitioner/provider to report a Member’s noncompliant or abusive behavior. Care1st will work with the practitioner/provider to improve the Member’s compliance to their medical treatment plan. Care1st reviews cases for clear documentation of noncompliant behavior or abusive behavior and assists the practitioner/provider in transferring Members to a new practitioner/provider when the behavior has adversely affected the patient-practitioner/provider relationship.

Procedure

1. When a practitioner/provider has a Member that is exhibiting non-compliant behavior it is his/her responsibility to document this behavior in the Member’s medical record.
2. Examples of noncompliant behavior include:
   a. A Member is not adhering to their treatment plan after several attempts by the
      practitioner/provider to change the behavior. Examples of this include:
      - Chronically missing appointments.
      - Not taking medications or adhering to scheduled treatments.
      - Narcotic drug seeking behavior.
      - Inappropriate ER visits.
   b. A Member or family Member of the Member exhibits abusive behavior.
      Examples of abusive behavior include:
      - Use of excessive profanity even after being asked to refrain from the behavior.
      - Threatening behavior towards the practitioner/provider or office staff.
      - Threatening behavior towards other Members or family Members.
      - Constant abusive and disruptive behavior that hinders the practitioner/provider
        and office staff in the care of other Members in the facility.

3. When a Member exhibits non-compliant or abusive behavior, it is the responsibility of
   the practitioner/provider to report it immediately to the Care1st QI nurse specialist.

4. When the practitioner/provider requests the Member be removed from his/her care,
   he/she must submit the request on the required form (See Appendix: 7
   Practitioner/Provider Request to Terminate Patient/Provider Relationship Form). The
   practitioner/provider is required to submit the request along with all necessary
   medical records and documentation of the Member’s behavior.

5. The CMO and or the QI Medical Director will review all requests from
   practitioners/providers to terminate the provider/patient relationship. The CMO and
   or the QI Medical Director will take action and may include any of the following:
   a. Refer the Member’s case information to case management in an attempt to
      change the non-compliant behavior.
   b. Instruct the practitioner/provider that more documentation is needed before a
      determination can be made.
   c. Remove the Member from the practitioner/provider’s care and reassign to
      another provider/practitioner.
   d. Refer the case to peer review for review and action.

6. If it is determined that the Member is to be removed from the practitioner/provider’s
   care, the practitioner/provider will be instructed to send the Member a Care1st
   approved letter explaining the decision.

7. The Care1st Member Services Department will contact the Member to assist them in
   selecting a new practitioner/provider.

8. If it is determined that the Member should not be removed from the
   practitioner/provider’s care, the CMO and or the QI Medical Director will give the
   practitioner/provider guidance to successfully continue the relationship.

9. If the patient-practitioner/provider relationship is not terminated and the non-
   compliant or abusive behavior continues, the practitioner/provider may resubmit the
   request to terminate the relationship.

   9.3: Quality of Care Focused Studies

Policy

The Care1st QI Department develops quality improvement studies based on data collected
through various methods including, but not limited to, encounter data, claims data, complaints
and grievances, potential quality of care issues (PQI), access and availability surveys, and
satisfaction surveys. Care1st participates with regulatory agencies in the state-mandated
Quality Improvement System for Managed Care (QISMC), Health Plan Employer Data and Information Set (HEDIS), and Quality Improvement Activities or Projects (QIAs or QIPs). Studies conducted jointly with regulatory agencies will be in accordance with state requirements. Focused review studies conducted independent of a regulatory agency will be in accordance with the procedures as described herein.

Procedure

1. Focused review studies will include the following design elements:
   - Objective and reason for topic selection
   - Sampling framework and sampling methodology
   - Data collection criteria and analysis methodology
   - Report of data and/or findings
   - Quantitative/Qualitative analysis
   - Barrier analysis
   - Action plans, as appropriate
   - Reassessment, as appropriate

2. The study will be designed to produce accurate, reliable, and meaningful data in accordance with standards of statistical analysis. The study questions will be framed using information from scientific literature, professional organizations, practitioner/provider representatives, regulatory requirements, and outcome-related data. The practice guidelines/quality indicators used in the study will be specified, whenever possible. The variables to be collected and analyzed will be defined and derived from the practice guideline/quality indicators. Data may be collected through a variety of methods including, but not limited to: Member surveys, practitioner/provider surveys, medical record audits, on-site practitioner/provider facility inspections, analysis of encounter/claims data, analysis of prior authorization data, and analysis of Member complaints and grievances.

a. Data may be collected through sampling or may include the entire population that meets the study criteria. The following criteria should be considered in making this decision:
   - The size of the Member population eligible for study
   - The method of data collection (e.g., administrative data, medical record review or hybrid of both)
   - The nature of data to be collected
   - The degree of confidence required for the data

b. The following questions will be used to determine the method for validating the results:
   - How will the raw data collected be verified?
   - What statistical analytical tests will be performed on the data?
   - What adjustments for age, severity of illness, or other variables, which may affect the findings, will be made?
   - What is an acceptable level of performance?
3. The QI Department, in conjunction with the CMO and or the QI Medical Director, will analyze and interpret study results and develop a corrective action plan to address the findings. Results will be compared to recognized, relevant benchmarks, when available. Action plans will include:
   a. Expected outcomes that must be expressed in measurable terms
   b. Specific interventions/actions to be taken to positively impact the problem. Improvement actions/interventions may include but are not limited to the following:
      - Assign Members to case manager for specialized attention
      - Re-engineer organizational processes and structures
      - Provide Members with educational materials or programs
      - Develop Member incentive programs
      - Introduce new technology to streamline operations
      - Develop employee-training programs to improve understanding of health practices of various cultural groups
      - Disseminate practitioner/provider performance data to allow peer measurement
      - Provide educational materials that may be relevant to understanding and treating the population to practitioners/providers
      - Develop clinical practice guidelines through collaboration with SDHS and other collaborative plans
      - Address any practitioner/provider-specific concerns through the peer review process
   c. Implementation schedule
   d. Monitoring plan
   The results, interpretation and action plan will be presented to the Medical Services Committee for review and approval and then forwarded to the Board of Directors.

4. Reports will be made to the Medical Services Committee as required by the action plan.

5. Results will be made available to Members and practitioners/providers through newsletters, bulletin faxes, special mailings, etc., as appropriate.

6. Sources for standards, norms and guidelines pertaining to the measurement of quality of care include, but are not limited to, the following:
   - NCQA standards for quality and utilization management.
   - Other independent credentialing, certification and accreditation organizations, including JCAHO, CMRI, The Quality Commission, AAAHC and URAC.
   - HEDIS Medicare performance standards.
   - Medicare performance standards.
   - Federal Agency guidelines including the Centers for Medicaid and Medicare Services (CMS), Office of Technology Assessment (OTA), Agency for Healthcare Policy and Research (AHCPR), National Institute of Health (NIH), Department of Health and Human Services (DHHS), Center for Disease Control (CDC), and the United States Public Health Services (USPHS).
- United States Preventive Services Task Force (USPSTF) guidelines
- National consensus organization guidelines for clinical practice.
- Child Health and Disability Prevention (CHDP) program guidelines.
- English language peer reviewed medical literature.
- MCG and Robertson Guidelines.
- Pharmacology guidelines extracted from the practice standards of the American Society of Hospital Pharmacists (ASHP) and the PDR.
- Expert opinion.
- HMO standards for access to ambulatory care.
- Interqual Severity of Illness/Intensity of Service (ISSI).
- Commission for Professional Activity Studies (PAS) length of stay norms.

9.4: Practitioner/Provider and Member Satisfaction Surveys

Practitioner/Provider Satisfaction Survey

Care1st will conduct a practitioner/provider satisfaction survey with all contracted PCPs and high volume specialists at least annually. Results will be summarized and reported to the appropriate departments and committees for follow-up and action.

Member Satisfaction Survey

Care1st will conduct a Member Satisfaction Survey at least annually. Results will be summarized and reported to the appropriate departments and committees.

9.5: Clinical Practice Guidelines

Policy

Care1st recognizes that clinical practice guidelines are a useful resource for improving the quality of clinical care and standardizing the level of care given to Members with acute and chronic diseases. Care1st has adopted the guidelines approved by local regulatory agencies as required and develops its own guidelines.

Procedure

1. The Medical Services Committee is responsible for developing, reviewing, and updating clinical practice guidelines that may be used by practitioners/providers. The Medical Services Committee will review and adopt the guidelines developed by local regulatory agencies and collaborative Plans. Guidelines will be reviewed at least every two (2) years.
2. Guidelines are distributed to direct-contracted PCPs and delegated PPGs as they are developed and/or revised through educational sessions, mailings, newsletters and updates to the Provider Manual.

3. Decision-making in UM, Member education, interpretation of covered benefits and other areas to which the clinical practice guidelines apply will be consistent with the guidelines.

9.6: Initial Health Assessment (“IHA”)

Purpose

To ensure and promote timely access to an Initial Health Assessment (IHA) within 120 days of enrollment or 60 days for Members less than 18 months of age. The IHA consists of a comprehensive health history, assessment of health education needs, physical assessment, and specific evaluations, tests immunizations, counseling, follow-up, and treatments.

Policy

As referenced in Title XVII and the United States Preventive Services Task Force (USPSTF), Members are entitled to and should receive timely access to an IHA or, alternatively, should have documentation in their medical record that a comparable assessment has recently been performed. Care1st will:

1. Notify Members of the importance and availability of IHAs through the Member EOC, newsletters, etc.
2. Notify practitioners/providers of the requirement for IHAs through the Provider Manual, newsletters, etc.
3. Monitor compliance
4. Follow-up with the Member and practitioner/provider when an IHA has not been performed within 120 days of enrollment with Care1st

Health Assessment Services Include:

1. Health assessments for Members under 21 years of age must include, at minimum (Pediatric patients should receive CHDP Health Assessments per the CHDP periodicity schedule.):
   - Health and developmental history
   - Age appropriate behavioral assessment
   - Unclothed physical examination, including assessment of physical growth
   - Inspection of ears, nose, mouth, throat, teeth and gums
   - Assessment of nutritional and dental status
   - Hearing and vision screening, as appropriate
   - Immunizations and tuberculosis testing appropriate to age and health history necessary to make status current
   - Lab tests appropriate to age and/or sex, including anemia, diabetes, lead levels, sickle cell trait and urinary tract infections
   - Health education and anticipator guidance appropriate to age and health status

2. Health Assessments for Members 21 years of age and older must include, at minimum:
   - Complete history and physical examination, which includes inspection of ears, nose, mouth, throat, teeth and gums
   - Blood pressure
- Cholesterol
- Clinical breast exam for women over 40 years of age
- Mammogram, within two (2) years for women over 40 years of age and one (1) year for women 50 and above
- Pap smear for women beginning at the age of first sexual intercourse and once every 1-3 years depending on the presence or absence of risk factors and the results of previous pap smear
- PPD
- Health education and anticipatory guidance appropriate to age and health statistics
- Fecal occult blood testing every year after age 50
- Sigmoidoscopy at least once at age 50
- Rectal exam at least once every 5 years after age 50
- Prostate specific antigen (PSA) testing for men annually after age 50
- Exam of testes for men
- Rubella antibody screening for women of childbearing age at least once prior to first pregnancy
- Immunization for tetanus-diphtheria (Td) at least every ten (10) years
- Influenza vaccine every year after age 65

Procedure

1. The Member Handbook, distributed at the time of enrollment, contains both basic information about PCP services and specific information describing the importance of the IHA. It encourages Members to access this service. Members are specifically directed, in their Care1st new Member packet, to contact their PCP’s office to schedule an IHA.
2. Care1st Provider Relations representatives educate contracted practitioners/providers on the 120-day health assessment requirements. Practitioner/Provider bulletins and newsletters are used to reinforce awareness of the compliance and tracking process.
3. Care1st has developed an interactive voice response (IVR) system that notifies Members of the need for and availability of an IHA. Upon receiving updated eligibility lists, PCP offices, in cooperation with Care1st, shall contact new Members, with a minimum of three documented attempts, including at least one telephone call and one mail notification to assess the current need for an IHA and to schedule an appointment, if necessary. If a comprehensive health assessment has recently been performed elsewhere, the PCP shall obtain the appropriate records and document this in the medical record.
4. When a significant health problem, requiring further evaluation or referral, is identified, the PCP will be responsible for scheduling an appointment date for follow-up within 60 days.
5. If a Member refuses an IHA, the refusal must be documented in the medical record.

9.7: Facility Site Review (“FSR”)

Purpose

The facility site review (FSR) is a comprehensive evaluation of your facility, administration and medical records. The following requirements meet Title 22 Regulatory requirements for a facility site review, which are mandatory under Care1st’s contract with the State Department of Health Services (SDHS). Each PCP site will be evaluated every three (3) years by Care1st or its contracted vendor according to the requirements. A complete facility review audit tool is included at the end of this section.

9.7.1: FSR Evaluation Tools
Policy

The Facility Review is a comprehensive evaluation of the Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control related to your physical location. The reviews are conducted by a Certified Site Review Nurse using the attached tools that have been approved by Care1st Medical Director’s

Procedure

1. An FSR will be conducted by Care1st upon receipt of a request from Provider Network Administrators or Credentialing prior to any Primary Care Physician’s site being added to the practitioner/provider network.

2. The FSR Coordinator will process a FSR for all sites within 90 days of receipt of a request for an FSR or their three-year FSR anniversary date.

3. The FSR will be conducted using the most current review Survey tool approved by the Care1st Medical Directors.

4. Practitioners/Providers will be contacted to schedule a mutually agreed upon date and time to conduct the review. If the review is conducted after the expiration date of the current certificate, at the office’s request, there is the possibility of the practitioner’s panel being closed to new members until the review is completed with a passing score and all corrective action plans have been submitted and closed.

5. The Facility Site Review unit will send a confirmation letter along with a pre-review packet that contains sample copies of the tools to be used as well as a set of policies and procedures and forms that your office can use to update the office policies and procedures to meet criteria from the Center for Medicare and Medicaid Services and the California Department of Health Care Services.

6. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough and helpful. If a reviewer cannot answer a question he/she will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.

7. After completing the review, the reviewer will score the facility according to the approved scoring guidelines. Compliance will fall into the following categories:
   - Full Pass 90% and above without deficiencies in critical elements
   - Conditional Pass 80-89%, or 90% and above with deficiencies in Critical elements
   - Not Pass Below 80% 10. A corrective action plan (CAP) is required for all sites that have a deficiency in a critical element, score between 80 and 89% or a score below 80%

8. The Critical Element CAP, if required, is due within 10 business days of the date of the review. The CAP for the rest of the deficiencies will be due 45 days from the date of the review.
9. Care1st staff is available to assist practitioners/providers with the review preparation and CAP completion.

10. New Practitioners/Providers who score below 80% will not be admitted to the network until they have corrected all deficiencies and have another review and receive a passing score. Failure of a new provider to submit a CAP within the timeframes or refuses to have a re-review following submission of the CAP will be deleted as a potential provider and will have to reapply for admission to the network.

11. Practitioners/Providers that score 80 to 89% and do not submit a CAP or CAPS within required time frames will be referred to the Medical Director and Credentialing Committee for further action, which may include termination from the network.

12. Care1st and the practitioners/provider’s delegated PPGs will contact practitioners/providers who do not submit their CAP within the required timeframes to offer assistance.

### 9.7.2: Facility Review Tool Purpose

To set forth minimum requirements for a contracted PCP office’s physical plant,

**Policy**

1. Convenient, adequate parking is available, some of which must be accessible to handicapped persons.

2. The facility is neat, clean, and well organized. Adequate storage space is available so that patient care areas are not unnecessarily cluttered. Electrical wiring is covered and concealed according to building codes. Incandescent bulbs and fluorescent tubes are covered. Floors, walls and ceilings are in good repair. Lighting is adequate.

3. Waiting areas have sufficient floor space and seating capacity to accommodate the typical patient load.
   a. Children and obstetrical patients are separated wherever possible.
   b. Plan and non-plan patients are not differentiated by providing separate waiting areas or entrances.

4. The number of examination and treatment rooms is adequate to accommodate patient needs.

5. There is at least one exam room, which is maintained for patients with contagious or infectious diseases.

6. The number of adult, pediatric and obstetrical examination tables is adequate to meet patient needs.

7. The office hours of operation and emergency telephone number(s) are clearly indicated on signs posted at or near the main entrance. If the office's entry area or parking lot is protected by a gate when the facility is closed, hours of operation and the emergency telephone number(s) are shown on a sign posted on the gate.

8. Policies and procedures for housekeeping must be maintained including specific responsibilities of personnel and a procedure for regularly monitoring completion of specified tasks.

### 9.7.3: Handicap Access

**Purpose**

To assure easy access to medical offices for handicapped plan Members.

**Policy**

The special needs of handicapped Plan Members will be met to provide appropriate access.
Procedures

1. Special parking with adequate signage is provided within a reasonable distance from the facility's main entrance.
2. Wheelchair access to the main entrance is easy via a ramp or absence of stairs or steps.
3. Restroom doors of at least one restroom are wide enough to accommodate wheelchair-bound Members.
4. Adequately secured handrails near toilets are provided in at least one restroom within the facility.
5. Drinking fountains are accessible to wheelchair-bound Members.
6. If public telephones are available within the facility, at least one is appropriately placed for handicapped access.
7. All features for the handicapped are marked by adequate signage.
8. Facility features designed specifically for handicapped access (e.g., specifically designated parking spaces, sign postings directing Members to special restrooms, handrail, etc.) are regularly inspected, and repaired or replaced if necessary.
9. Grievances, complaints and disenrollments mentioning inadequate handicapped access are carefully analyzed to determine areas where improvements can be made. Legitimately needed improvements are made promptly.
10. Use of the handicapped parking space(s) is periodically monitored to assure availability of this space(s) to the handicapped.

9.7.4: Medical Equipment

Purpose

To ensure that each contracted medical office maintains an appropriate set of medical equipment in a good state of repair.

Policy

Practitioner/Provider offices will maintain all medical equipment according to manufacturer recommendations and/or community standards of practice.
Documentation of testing and inspections, including logs and certifications will be maintained in accordance with established policies.

Procedures

1. The following equipment is available within the facility:
   a. Scales
      - Adult Balance Beam
      - Infant
   b. Blood pressure cuffs
      - Standard
      - Extra Large or Thigh
      - Pediatric
c. Stethoscopes
d. Vision eye charts with distance marker based on the type of chart and with adequate lighting:
   - Kindergarten or Symbol
   - Snellen
   - Occluder (disposable or with cleaning solution and procedure posted)
e. Autoclave
f. Otoscopes
g. Ophthalmoscopes
h. Thermometers
i. Refrigerator with an independent freezer section or individual units
   - Temperature is maintained between 36 and 46 degrees F (or 2 and 8 degrees C)
   - Freezer temperature is maintained between 2 and 8 degrees F (or –14 degrees C)
   - Is not used for food storage, if drugs and laboratory specimens are stored in the same refrigerator
   - May be used to store laboratory samples if these samples are kept in separate solid covered section of refrigerator, i.e. the bottom (vegetable) drawer section refrigerator/freezer temperatures for each day of the month. Initials of the inspector(s) are entered for each inspection
j. Proper controls (e.g., foot, knee, elbow, etc.) on surgery sink(s)
k. Audiometer if seeing patients from 3 through 20 years of age
l. Tape measure for head circumference measurement (1/8 inch or 1 mm) if seeing infants
m. Pediatric length measuring device with right angle block
n. Wall measure device with right angle block
o. Exam gloves, gowns and masks. Exam gowns should be available in adult and pediatric sizes
p. Scales are inspected and balanced annually
q. Autoclave spore testing is conducted monthly. Autoclave spore testing reports are maintained in chronological order in a binder or file
r. All medical equipment is calibrated annually:
   - Equipment determined to be unsafe, nonfunctional and beyond repair is promptly replaced.
   - Current inspection/calibration stickers are affixed to equipment and are clearly visible. These stickers include the name of the inspector and the date of last inspection.
   - Physical therapy hydro-equipment, if maintained at the facility, is culture tested and inspected monthly. Testing reports are maintained in chronological order in a binder or file.
   - Staff is properly trained in the use of the audiometer, autoclave and other equipment.
   - Evidence of the age of the equipment inspection/calibration is maintained.
   - Evidence of staff training on use of equipment is maintained in employee personnel records.
9.7.5: Fire & Earthquake Safety

Purpose

To assure PCP offices meet minimum fire and earthquake safety requirements.

Policy

1. The facility is maintained in compliance with all applicable local, state and federal fire and general safety requirements.
2. The facility has a current fire inspection certificate issued within the preceding 12 months indicating that acceptable local standards are met.
3. Exit signs are clearly visible and appropriately located.
4. Emergency evacuation maps are easily readable and appropriately located in hallways and in all exam rooms.
5. The office maintains a written emergency evacuation plan. The plan includes specifications for staff Members with responsibility for evacuating patients and staff, and procedures for notifying fire and/or police departments.
6. Fire extinguishers are regularly inspected (e.g., once every 12 months) and readily accessible to staff.
7. Covered containers are used for regular (non-infectious) waste.

Procedure

1. Fire inspections are scheduled once every 12 months. The office maintains a central file of certificates and correspondence regarding these certificates.
2. Inspections of fire extinguisher(s) are scheduled once every 12 months. The office maintains a central file related to these inspections. Current inspection tags are securely attached to extinguishers.
3. Regular reviews of fire safety features (e.g., exit signs, evacuation maps, etc.) are scheduled.
4. The written emergency evacuation plan is discussed in new employee orientations and is readily accessible to all staff. The plan is regularly reviewed and updated to reflect changes in the physical plan, changes in safety codes, etc.
5. Response to a Fire
   - Sound the alarm either with the pull alarm station or telephone.
   - If using the telephone, give the location and extent of the fire.
   - Warn others near you.
   - Check doors before opening for heat. If hot, do not open.
   - Open doors slowly and be prepared to close doors quickly.
   - Evacuate all patients and other employees who are in immediate danger.
   - If you have time and there is no immediate danger, close all window and doors in the area.
   - Do not use elevators.
   - Above all, remain calm.
6. Earthquake Safety
   - Assign responsible person(s) to coordinate response to an earthquake.
- Move away from windows and glass.
- Take cover under a sturdy desk, table
- After the quake, assess damage and check others around you for injury.
- Provide first aid, if qualified.

Follow instructions to move patients and/or evacuate building.

9.7.6: Emergency equipment and medications

Policy

Each practitioner/provider office shall ensure that it has sufficient supplies and equipment on hand for handling medical emergencies. All clinical staff shall be trained in emergency procedures and the appropriate use of emergency equipment and supplies. Records of this training shall be maintained at the practitioner/provider site.

Procedures

1. Each practitioner/provider office shall maintain an emergency kit which at minimum will contain the following:
   - Benadryl (injectable) and/or oral
   - Spirits of Ammonia
   - Epinephrine (injectable)
   - Ambu Bags - Adult and Pediatric
   - Oxygen Masks/Nasal Cannula, Adult and Pediatric
   - Airways - Adult, Child and Infant
   - Oxygen Tank with a fill gauge and a flow meter tanks in transport carts are encouraged and recommended

2. A written inventory of emergency equipment/supplies must be maintained. It shall be checked and signed off by a designated staff Member at least monthly.

3. Medication must be stored according to manufacturer recommendations.
   - Oral, injectable and inhalation medications will be stored separately and well-marked. i.e. on different shelves
   - Storage unit must lock and be inaccessible to unauthorized personnel.

4. Telephone numbers for emergency services and the local poison control center shall be posted at the front desk area and in the area where emergency supplies are stored.

9.7.7: Infection Control

Purpose

To ensure that bio-hazardous waste is handled and disposed of in accordance with all applicable laws and regulations.
Policy

All practitioner/provider offices are required to have in place policies and procedures to ensure that bio-hazardous waste is handled and disposed of in accordance with all applicable laws and regulations. Staff training related to handling of bio-hazardous waste must be kept on site both current and historical.

Procedure

**Cleaning of exam rooms, equipment and surfaces**
1. Must be done daily using a solution that is EPA Certified to kill HIV, Hepatitis and TB.
2. Written Schedules are available showing frequencies for routine cleaning, the disinfectant used and the responsible personnel.

**Handling & Disposal of Bio-hazardous waste**
1. Bio-hazardous waste must be handled and disposed of in accordance with all applicable laws and regulations of the Department of Environmental Health Services (DEHS) of the County of Los Angeles and any other local health laws and regulations.
2. Bio-hazardous waste must be contained in a manner and location which afford protection from animals, rain and wind and does not provide a breeding place or food source for insects or rodents.
3. Bio-hazardous waste must be separated from other waste at the point of origin in the producing facility, i.e. separate containers for regular waste and bio-hazardous waste.
4. Bio-hazardous waste must be transported to an off-site treatment or disposal facility by a hauler registered as a hazardous waste hauler by the Department of Environmental Health Services (DEHS) of the County of Los Angeles or the provider has a limited hauling quantity exemption that is current and kept on-site.
5. "**Medical waste**" Includes all of the following:
   a. Viral hazardous waste or sharps waste.
   b. Waste which is generated or produced as a result of the diagnosis, treatment or immunization of patients.
6. "**Bio-hazardous waste**" Means any of the following:
   a. Viral hazardous waste or sharps waste.
   b. Waste which is generated or produced as a result of the diagnosis, treatment or immunization of patients.
   c. Laboratory waste, including, but not limited to, all of the following:
      - Human specimen cultures from medical and pathological laboratories.
      - Wastes from the production of bacteria, viruses or the use spores, discarded live and attenuated vaccines and culture dishes. devices used to transfer inoculate and mix cultures.
   d. Waste containing any microbiologic specimens sent to a laboratory for analysis.
   e. Human surgery specimens or tissues removed at surgery, which are suspected by the attending physician and surgeon of being contaminated with infectious agents known to be contagious to humans.
   f. Waste, which at the point of transport from site, at the point of disposal, or thereafter, contains recognizable body fluid products.
g. Containers or equipment containing body fluid products, which are known to be or could possibly be infected with diseases that are communicable to humans.

h. Waste containing discarded materials contaminated with excretion, exudates, or secretions from humans that are required by infection control staff, the attending physician or surgeon or the local health officer to be isolated in order to protect others from communicable diseases.

7. "Sharps waste" Means any device having acute rigid corners, edges, or protrusions capable of cutting or piercing including, but not limited to, the following:
   a. Hypodermic needles, syringes, blades, and needles with attached tubing.
   b. Broken glass items, such as Pasteur pipettes and blood vials.

**Containment and Storage**

**HEALTH AND SAFETY CODE – HSC DIVISION 104. ENVIRONMENTAL HEALTH [106500. - 119405.]** *(Division 104 added by Stats. 1995, Ch. 415, Sec. 6.)*

**PART 14. MEDICAL WASTE [117600. - 118360.]** *(Part 14 added by Stats. 1995, Ch. 415, Sec. 6.)*

**CHAPTER 9. Containment and Storage [118275. - 118320.]** *(Chapter 9 added by Stats. 1995, Ch. 415, Sec. 6.)*

118280

(A) If the person generates 20 or more pounds of bio-hazardous waste per month, the person shall not contain or store bio hazardous or sharps waste above 0° Centigrade (32° Fahrenheit) at any onsite location for more than seven days without obtaining prior written approval of the enforcement agency.

(B) If a person generates less than 20 pounds of bio-hazardous waste per month, the person shall not contain or store bio-hazardous waste above 0° Centigrade (32° Fahrenheit) at any onsite location for more than 30 days.

1. To contain or store medical waste, each Care1st site will ensure the following:
   a. All examination and treatment rooms and laboratory areas have both regular waste cans and bio hazardous waste cans.
   b. All bio-hazardous waste cans must be the step-on variety and contain a red plastic bag liner. The can must be labeled using the International Bio-hazardous Label.
   c. A separate non-breakable, secured (locked) leak-proof container must be used for disposal of sharps (i.e., used syringes or blood drawing equipment) and are not used for the disposal of dressing and similar items.

2. To contain bio-hazardous waste in a bio-hazard bag:
   a. The bags will be tied to prevent leakage or expulsion of contents during all future storage, handling, or transport.
   b. Bio-hazardous waste will be bagged and placed for storage, handling, or transport in a rigid container. The container will be leak resistant, have tight fitting covers, and be kept clean and in good repair.
   c. The container may be of any color and will be labeled with the International bio-hazardous label on the lid and on the sides so as to be visible from any direction.
   d. Place all sharps waste in a sharps container that is leak proof, rigid and puncture resistant or liquid or semi-liquid waste will be discarded using absorbent material and placed in a bio-hazardous bag.
   e. Full sharps containers will be stored in the bio-hazardous storage unit for disposal by the certified waste hauler.

3. Reusable bio-hazardous containers are stored in a secured, locked area that is inaccessible to unauthorized personnel.

4. Broken, cracked or otherwise compromised bio-hazardous containers must be replaced
immediately by the bio-hazardous waste hauler.
5. Care1st facilities will not use a trash chute to transfer medical waste.
6. Medical waste in bags or other disposable containers will not be subject to compaction by any compacting device and will not be placed for storage or transport in a portable or mobile trash compactor.

**Autoclave Procedures**
1. An autoclave must be maintained in good repair for steam sterilization and certified annually or as directed by the manufacturer’s instructions.
2. An autoclave this is not working must be marked and information kept as to when it will be picked up or services.
3. An autoclave this is not being used should be removed from the office laboratory, exam or multipurpose room immediately.
4. Follow the manufacturer instructions for wrapping items and for loading and operating the autoclave.
5. Sterilized equipment is clearly marked with the sterilization date and is sterile until the package is damaged, discolored or used.
6. Expired sterilized equipment must be made inaccessible to practitioners/providers until it has been re-sterilized.
7. A regular schedule of inspections and calibrations is maintained along with monthly spore testing.
8. There is a written procedure to follow if a spore test is positive.

**Cold Sterilization**
1. Cold sterilization is acceptable for reusable surgical instruments and reusable diagnostic equipment. The following minimal steps are required:
   a. Clean items after each use by washing them in a solution of Hot water and a disinfectant soap solution.
   b. Completely submerge the cleaned items in sterilization solution. The item is considered sterile after it has been submerged for the period indicated by the solution manufacturer.
   c. Rinse items in **sterile water immediately** prior to use, wearing sterile gloves, drying with a sterile towel and placing on a covered sterile tray.
2. The containers with sterilization solutions are labeled with the name of the solution and the date of activation and expiration and must be covered at all times.
3. Follow the manufacturer instructions for determining the expiration dates as solutions may vary. Regularly check the containers for evaporation loss of solution and replenish as necessary.

**Infection Control**
1. Hand washing is the easiest and the most important measure to practice in the prevention of the spread of infection. While normal skin contains microorganisms of low virulence as resident flora, the transient flora acquired from other sources can be pathogenic. Hands are frequently implicated in the spread of infections. Hand washing practices have been shown to greatly reduce the spread of pathogenic flora.
2. All health care practitioners/staff will wash their hands:
   a. On arrival at work
   b. Before examining a patient
   c. After examining a patient
   d. Before performing invasive procedures, whether gloves are worn or not
e. Before and after contact with any wound
f. After contact with any source likely to be contaminated by pathogenic microorganisms.

**Protective Clothing**

1. Disposable gloves will be worn when handling all types of body fluids. When the handling of the body fluids is complete, remove the gloves in a manner so that the gloves are turned inside out. Dispose of the gloves in the appropriate red-bag-lined bio-hazardous waste container and wash hands thoroughly.

2. In cases of possible contamination of employee clothing, a disposable gown should be worn. Dispose of the gown in the appropriate red-bag-lined bio-hazardous waste container and wash hands thoroughly.

3. Goggles or face shields and water repellent, disposable gowns must be available to the staff for cases where projectile body fluids could be a possibility. After the procedure is complete, the goggles or shields are to be disposed of as bio-hazardous waste.

**9.8: Medical Records**

**9.8.1: Policy**

The onsite practitioner/provider audit is a comprehensive evaluation of the medical records. Through this process Care1st will identify areas of excellence and deficiencies based on approved criteria. Care1st will provide information, suggestions and recommendations to assist physicians in meeting and exceeding standards. All Primary Care Physicians will have a complete medical record review at each practice location, conducted in conjunction with the facility site review process.

1. If the site, is a group practice the sample of medical records will be inclusive of all practitioners and determined by 1 to 3 Practitioners=10 charts; 4 thru 6 Practitioners=20 charts and 7 or more Practitioners=30 charts. If the facility is used by multiple practitioners that are not part of the same medical group then the facility receives individual medical record reviews for each practitioner and 10 medical records will be reviewed for each practitioner.

2. The medical record review looks at your member records related to Format, Documentation, Continuity/Coordination of Care, Pediatric Preventive Care, Adult Preventive Care and if applicable OB/CPSP Preventive Care. Reviews are completed and Scoring of the medical record review will show The Certified Nurse reviewer will conduct the Medical Record Review in conjunction with the periodic Facility Review utilizing the most current approved Medical Record Review Tool. If this is an initial Medical Record Review it will be a separate on-site review from the Facility Review and only medical records will be reviewed.

3. The FSR Coordinator will arrange an appointment with the individual practitioner/provider office. Care1st personnel are available to assist the practitioner/provider in preparation for the review and forms can be obtained from Care1st or from the Pre-Review packet that was received when the Facility Site Review was scheduled.

4. If the practitioner/provider is unwilling to schedule the medical record audit, the FSR Coordinator will notify the FSR Manager or Supervisor. If arrangements cannot be made to complete this Medical record Review the practitioner panel will be closed to new members and the situation is referred to the QI Medical Director and the Credentialing Committee for further action which may include termination from the Care1st Network.
5. The Review Nurse, will review medical records, using the following rationale: passing or 80% or higher.

6. In order to ensure compliance with Care1st standards, Care1st will conduct follow-up audits of all practitioners/providers who score less than 80% on their initial or routine medical record review.

7. Survey results will be utilized to conduct practitioner/provider education and as a component to the recredentialing process.

9.8.2: Procedure

1. Group Practice 1 thru 3 practitioners=10 records; 4 thru 6 Practitioners=20 records; 7 or more Practitioners=30 records. If more than 1 practice is using the same facility then each independent practitioner will have 10 charts reviewed.

2. The FSR specialist will complete and score the medical record audit using the following ranges: 79% or lower is non-passing score; 80-90 % passing but requires a Corrective Action Plan; 90 thru 100% is an exempted pass and no Corrective action is required but the reviewer will make appropriate recommendations.

3. If a corrective action plan is required the reviewer will complete the corrective action plan at the time of the review and go over the deficiencies and corrective actions with the Practitioner and/or the office manager.

4. The practitioner/provider and/or office manager will sign the 1st CAP Notification Letter as verification of receipt of the completed review tool and Corrective Action Plan if appropriate, and the nurse reviewer will supply a copy to the practitioner/provider/office manager.

5. If the nurse reviewer is unable to conduct an exit review, all information will be mailed to the practitioner/provider.

6. The Provider will have 45 days from the date of the review to complete the corrective action plan and submit it to the Quality Improvement Department/Site Review unit at Care1st Health Plan.

7. The Medical Record Review results will be maintained in the practitioner/provider’s FSR file.

8. The review results are accessed as needed by the Credentialing Department for the practitioner/provider’s credentialing file.

9. When the CAP is received the review nurse will review the entire Corrective Action Plan and based on clinical knowledge and the document content will:
   a. Approve the CAP and place it in the practitioner/provider’s FSR file and have a closure letter sent to the Practitioner.
   b. If it is not approved as submitted, the review nurse will indicate what is missing or inappropriate and the FSR Coordinator will request the missing information from the practitioner’s office.

10. If the practitioner/provider’s CAP is not received within 45 days, the FSR Coordinator will have a 2nd request letter sent to the practitioner giving an additional 10 days to submit the letter.

11. If the practitioner/provider does not furnish the required documentation after the extended deadline, a third request is sent giving an additional 3 days to submit the Corrective Action Plan. If at the end of the 3 days the CAP is not received the situation is referred to the QI Medical Director and the Credentialing Committee for
further action which may include termination from the network.

12. If on-site follow up is required for the corrective action plan the review nurse will indicate this to the FSR coordinator who will schedule a visit in 3 to 6 months as indicated by the review nurse.

13. As a result of the follow-up by the FSR specialist, one of the following actions will be taken:
   a. For practitioners/providers who are compliant with the CAP, the information will be placed in the provider’s FSR file and entered into the QI medical record database.
   b. For practitioners/providers who are non-compliant with their CAP, the information will be forwarded to the Care1st QI Medical Director and the Credentialing Committee for further action.

9.8.3: Guidelines

Policy

A legible, detailed, well organized, confidentially stored, easily retrievable medical record will be maintained for each patient. These records shall be consistent with standard medical and professional practices, meet the standards of oversight organizations including Care1st, regulatory agencies, and the California Department of Health Care Services.

Procedure

1. The medical record is a legal document and should be treated as such.
2. The maintenance of the patient medical record is the responsibility of the individual practitioner/provider’s office. The medical record should be secure and inaccessible to unauthorized persons in order to prevent loss, tampering, and disclosure of information, alteration or destruction of the record.
3. A patient’s medical record should be easily retrievable at the time of the patient’s encounter and for administrative purposes. To accomplish this, there should be a system for tracking the record. Records should be stored in one central location that is inaccessible to unauthorized persons.
4. Inactive medical records must remain accessible for a period of time which meets state and federal requirements (currently five years and to age of majority for minors). Patient medical records may be converted to microfilm or computer disks for long term storage.
5. Medical records must be destroyed in accordance with state and federal requirements. Every practitioner/provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of the information contained therein.
6. Entries must be legible to someone other than the author.
7. All entries must contain author identification. Signatures must include the first initial, full last name, and title. Initials are acceptable if the author can be identified in another manner.
8. Each page in the medical record must contain the patient's name and date of birth (an ID # may also be used).
9. Each chart must bear a label displaying the Member’s name (last name, first name order) and date of birth (an ID # may also be used).
10. Care1st has designed a variety of medical record forms for practitioner/provider use. These forms have been designed specifically to satisfy Care1st and SDHS documentation standards.

11. All reports must be filed in the appropriate section of the record within 72 hours after receipt.

12. All consent forms must be filled out completely, including the date, time and signatures. If the consent is completed by someone other than the patient (i.e., parent of a minor child), the relationship must be noted. Practitioner/Provider staff must witness all consent forms.

13. A chart is first prepared when a Member presents the first time for treatment or the PCP receives reports relating to the individual's treatment elsewhere.

14. If it is necessary to correct a handwritten entry, the person making the correction will line out the incorrect entry and sign and date the deletion. Do Not Use Whiteout or Other Products To Cover the Entry. Do Not Completely Black Out the Incorrect Entry.

15. Each form or other document must be securely placed in the appropriate section of the chart using fasteners. No loose papers or removable self-stick notes are to be in the chart; information on these items must be transferred to a progress sheet or other form.

16. Reports or other documents that are not on a standard size paper must be stapled or taped to an 8 1/2 x 11 sheet and placed in the chart.

17. The medical chart is organized in specific sections. A six section format, per the following table, is recommended:

Section 1. Patient Information (Inside the front cover)
1. Patient information sheet. This form should always be on top of all other forms in this section
2. The signed general consent for treatment and all other consent forms (e.g., IUD, sterilization, surgery, etc.) must remain in the chart and should be placed in this section
3. Authorization for release of medical records
4. Letters to and from the patient and/or his or her agent
5. Special cultural and linguistic needs

Section 2. History & Physical/Progress (First divider)
Adult charts:
1. Patient history/data base is/are the top forms in this section.
2. Problem List
3. Medication Flow Sheet
4. Immunization Flow Sheet
5. Hearing/Vision Screen Record
6. History and Physical Forms

Pediatric charts (if applicable):
1. CHDP Health Guidelines
2. Age Specific Assessment Form
3. Problem List Medication Flow Sheet
4. Medication Flow Sheet
5. Immunization Flow Sheet
6. Hearing/Vision Screen Record
7. Growth Charts
8. Lead Screening Questionnaire
9. Nutrition Screening Form
10. Episodic Visit
11. PM-160 Forms (CHDP forms)

Section 3. Laboratory
1. Laboratory reports are to be filed in reverse chronological order with the most current data on the top
2. Reports of a size that will not mount on the form should be taped to a regular piece of paper and filed on a mounting form

Section 4. X-R and EKG
1. File in reverse chronological order filing with EKG results segregated from each other

Section 5. Consult / Referral
1. Referral information such as correspondence directed to an outside agency, physician, health facility, etc. regarding the medical information obtained in his/her particular patient's medical record
2. Copies of Requests for Referral/Consultation forms are filed in this section until the report is received, at which time the report is filed and the request is discarded
3. Copy of medical records from previous medical practitioners/providers
4. Hospital discharge summaries
5. Emergency room records

Section 6. Miscellaneous
1. Complete OB records on inactive OB cases
2. Correspondence with insurance companies or health plans
3. Back to work or back to school forms
4. Any reports, correspondence, forms, etc. that do not belong in another section a) If it becomes necessary to start a new volume, label the new chart "Vol. II of II" and label the old chart "Vol. I of II". The following items should be carried Volume II:
   a. Consent to treatment form
   b. Problem Index
   c. Most recent history and physical form
   d. Pertinent history from previous practitioners/providers
   e. Most recent lab, x-ray, EKG and progress notes

Confidentiality
1. All information contained in the medical record shall remain confidential. This includes medical, personal, social and financial information.
2. Only authorized personnel (i.e., physicians, nurses, social workers, and authorized clerks) may have access to the contents of the medical record.
3. Patient information in the medical record shall only be discussed over the telephone to facilitate patient care and only between qualified medical professional directly involved in the patient's care or health maintenance.
4. Patient information in the medical record shall only be discussed by appropriate personnel and only in a location that assures confidentiality.
5. Disclosure of patient medical records is discretionary in accordance with Sections 56.10 (Section 2) and 56.104 (Section 3) of the California Civil Code. Original patient medical records will not be removed from an office except under court order or under special arrangements with the physician’s office.
6. Patient information in a medical record may only be released under the following conditions:
   a. The attorney or representative of the patient may receive a copy of the authorization from the patient or his/her representative. The patient must present identification when requesting a copy of his/her medical record. Outside health care practitioners/providers; federal, state, county or city agencies; employers; and insurance companies may also receive a copy of the patient record with the patient’s authorization.
   b. Any release in response to a court order or to authorized persons will be reported to the patient in a timely manner.
   c. Member records may be disclosed, with or without patient authorization, to qualified personnel for the purpose of conducting scientific research; however, these records must not identify, directly or indirectly an individual patient in any report of the research or otherwise disclose participant identity in any manner to prevent divulging confidential information.
   d. In accordance with individual provider agreements/contracts, health plan representatives are provided appropriate access to Member medical records for the purpose of quality review.

7. Minors have the right to access confidential services without parental consent; therefore, those medical records and/or information regarding medical treatment specific to those confidential services are not to be released to the parent(s) without the minor’s consent.

8. Patient medical records may be transmitted to a requesting physician or facility via facsimile machines making sure that the transmission is confidentially directed and received. Due to the breakdown of fax paper, faxed materials not received on plain paper faxes must be photocopied prior to inclusion in the patient’s record.

9. Release of information must be documented in the patient’s medical record. The documentation must include:
   a. The date and circumstances under which disclosure was made.
   b. The names and relationships to the patient, if any, of persons or agencies to whom disclosure was made.
   c. The specific information disclosed.

10. The supervisor of medical records assumes full responsibility for the Medical Records Department and all records.

Mental Health Care Records

1. Notwithstanding subdivision (c) of Section 56.10 of the California Civil Code, no practitioner/provider of health care, health care service plan, or contractor may Release medical information to persons or entities authorized by law to receive that information pursuant to subdivision (c) of Section 56.10, if the requested information specifically relates to the patient’s participation in outpatient treatment with a psychotherapist, unless the person or entity requesting the information or an authorized agent of the entity submits a signed request (See Appendix: 6 Sample: Authorization for Disclosure of Patient Healthcare Information Form). For the purpose of this policy, “psychotherapist” means a person who is both a “psychotherapist” as defined in Section 1010 of the Evidence Code and a “practitioner/provider of health care” as defined in subdivision (d) of Section 56.05 of the Civil Code.

2. All requests for release of mental health information will include:
   a. The specific information relating to a patient’s participation in outpatient treatment with a psychotherapist being requested.
b. The specific intended use or uses of the information.
c. The length of time during which the information will be kept before being destroyed or disposed of. (A person or entity may extend that timeframe, provided that the person or entity notifies the practitioner/provider, plan, or contractor of the extension.).
d. A statement that the information will not be used for any purpose other than its intended use.
e. A statement that the person or entity requesting the information will destroy the information and all copies in the person’s or entity’s possession or control will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified in paragraph 2(c) has expired.

3. All notifications of an extension of the timeframe in the original request will include:
   a. The specific reason for the extension
   b. The intended use or uses of the information during the extended time
   c. The expected date of the destruction of the information

4. The person or entity requesting the information will submit a copy of the written request to the patient within 30 days of receipt of the information requested, unless the patient has signed a written waiver in the form of a letter signed and submitted by the patient to the practitioner/provider of health care or health care service plan waiving notification.

5. This policy and procedure does not apply to the disclosure or use of medical information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless the disclosure is otherwise prohibited by law.

6. Nothing in this policy and procedure shall be construed to grant any additional authority to a practitioner/provider of health care, health care service plan, or contractor to disclose information to a person or entity without the patient’s consent.

9.9: Access to Care

9.9.1: Access to Care Standards

Policy

Care1st will ensure that all primary care practitioners/providers are in compliance with approved Access to Care Standards (See Appendix 8). Compliance with these standards is monitored through Member complaints and grievances, PQIs, Member Satisfaction Surveys, medical record reviews, disenrollments, PCP transfers and annual access surveys.

Procedure

1. Primary and specialty care physicians are required to be available to render emergency care to Members 24 hours a day, 7 days a week, either directly or through arrangements for after hours coverage with an appropriately qualified practitioner/provider. Physicians may provide care in their offices or, based on the medical necessity of the case, refer the Member to an urgent or emergency care facility. Care1st has a nurse on call to arrange for care if a practitioner/provider is unavailable. If a Member contacts the Plan about an emergency situation, the Plan will direct the Member to an appropriate urgent or emergency care center for immediate assessment and treatment. After-hours access issues will be referred to QI as a potential quality issue (PQI) and handled in accordance with approved procedures.
2. The Plan’s Access to Care standards provide that no Member be required to travel any unreasonable distance or for any unreasonable period of time in order to receive covered services. For the purposes of these standards, “reasonable” is determined by analysis of the following factors:
   a. The population density of the geographic area traveled.
   b. Typical patterns of traffic congestion throughout the day.
   c. Established travel patterns in the community.
   d. Established patterns of medical practice in the community.
   e. Natural boundaries and geographic barriers to travel.
   f. Any other relevant factors.

To assure appropriate accessibility of services, these standards must be applied on a case-by-case basis. Nevertheless, as a general rule, the Plan has determined that a Member should not be required to travel more than 10 miles or 30 minutes to reach a contracted practitioner/provider.

3. The practitioner/provider contract allows the Plan to monitor accessibility and requires contracted practitioners/providers to abide by standards established for accessibility. The practitioner/provider contract also specifically provides that Members will not be discriminated against with respect to accessibility to care, reasonable accessibility to emergency services, and minimal weekly availability for the provision of health care services.

4. The practitioner/provider contract also mandates participation in the Plan’s quality of care review program. Participation in the quality of care review program requires practitioner/provider cooperation with the assessment of quality of care, accessibility and utilization patterns. The contracted practitioner/provider agrees to take any appropriate remedial action deemed necessary by the Plan.

5. Access & Availability surveys are conducted at least annually using the Access to Care standards as a benchmark. Performance is measured for compliance with the guidelines. Standardized methodology appropriate for this type of survey will be used. All high volume direct contracted PCPs are audited annually by the Plan. High volume will be determined by the CMO. Delegated PPGs are required to conduct an access survey at least annually for all of their PCPs. These results are forwarded to Care1st and reviewed for trends, patterns or quality of care/access issues. Care1st will survey a sample of the delegated practitioners/providers to validate the PPGs’ access survey results.

6. Access & Availability survey results are reviewed by the CMO and the Medical Services Committee and opportunities for improvement are identified. Results and quality activities are reported to the Board of Directors. Results are communicated to practitioner/provider network and to delegated PPGs through JOCs, newsletters, etc.

7. Selected interventions are implemented to improve performance. These may include written counseling and/or written corrective action plans for physicians not complying with the Access to Care standards. Continued non-compliance may result in referral to the Peer Review Committee for action up to and including termination. Interventions may also include global education for practitioners/providers regarding the standards.

8. The effectiveness of the interventions is evaluated or re-measured. Additional telephone or mail surveys may be conducted to further evaluate a particular problem.
9. Access to care is also monitored and tracked through Member satisfaction surveys, Member complaints and grievances, potential quality of care issues, Member requested disenrollments and transfers, emergency room utilization and facility site reviews.

10. PPGs are expected to ensure that each practitioner/provider in their network receives and complies with the attached Access to Care standards.

Medi-Cal Laws requires organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal manage care enrollee must be comparable to those for Medi-Cal fee-for service members.

9.9.2: Monitoring Process

The effectiveness of this policy will be monitored through oversight by regulatory agencies including DMHC, CMS and accrediting entities. Effectiveness will also be measured annually through the annual access to care studies.

9.10: Broken/Failed Appointments

9.10.1: Broken/Failed Appointment Follow-up

Policy

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients who fail to keep scheduled appointments.

The following is a sample "Broken/Failed Appointment" protocol which may be implemented by practitioner/provider offices if no other protocol is currently in place.

Procedure

1. To assure timely and efficient recall of patients who fail to keep scheduled appointments. The primary care practitioner/provider is responsible to:
   a. Determine daily whether and what type of follow-up is necessary.
   b. Document this decision in the patient chart, using a “Broken/Failed Appointment” rubber stamp. An example is provided here:

   BROKEN/FAILED APPOINTMENTS

   BROKEN APPT. DATE: ________________________________
   REVIEW DATE: ________________________________
   FOLLOW-UP REQ: ________________________________
   FOLLOW-UP ASAP: ________________________________
   NEW APPT. DATE: ________________________________
2. At the end of each day the receptionist will determine which patients failed to keep their appointment by:
   a. Checking the appointment schedule and making a list of all failed appointments.
   b. Gathering the pulled charts which were ready for appointments (Charts are pulled the day before scheduled appointments).

3. Use a progress sheet with the latest date or a new progress sheet, and stamp the sheet with the “Broken/Failed Appointment” rubber stamp.

4. Attach the progress sheet to the medical record and forward to the primary care practitioner/provider.

5. The medical assistant (M.A.) or designated individual will review all charts of those patients who missed an appointment and wait for further orders from the practitioner/provider.

6. The practitioner/provider will review the chart to determine the need for patient recall.

7. The practitioner/provider will complete items 2, 3 and 6 as needed, on the Broken/Failed Appointment rubber stamp, using the following guidelines:
   - Item 2 – Write in review data
   - Item 3 – Enter a checkmark if follow-up action is ordered
   - Item 4 – Enter a checkmark if the patient is to return to the clinic as soon as possible
   - Item 6 – Enter signature and title

8. If the patient needs follow-up, the M.A. or designated individual shall try to contact the patient one time by phone. If no results, a recall postcard or letter will be mailed out to the patient’s current address of record. A copy will be filed in the chart.

9. Every attempt to contact the patient, with date and time of each attempt, must be documented in the progress notes. Only the following staff may document patient recall activities in the medical record: M.D., P.A., N.P., R.N., L.V.N., or M.A.

10. The M.A. completes items 1, 5 and 7 as needed on the broken/failed appointment stamp using the following guidelines:
    - Item 1 – Enter the date of the broken appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 6 – Enter date, signature and title of person doing recall activity.

11. The broken/failed appointment will also be documented in the appointment schedule for tracking purposes.

12. The practitioner/provider is responsible for final decisions concerning a broken/failed appointment follow-up. Patients being followed for reportable conditions shall also be reported to the local health authority.

13. The administrator or office manager is responsible for:
   a. Assuring that all clinic personnel are aware of their responsibilities under this procedure.
b. Designating, in conjunction with the Medical Director, the persons responsible for implementing this policy.

c. Periodically monitoring the performance of staff in carrying out their duties.

9.11: Advance Directives

A primary care practitioner/provider is required to educate each Member 18 years or older about advance directives. This must be documented in the medical record. The Member does not need to sign any advance directive but must be informed and educated about what an advance directive entails.

9.12: Clinical Telephone Advice

Policy

1. All telephone calls from patients with problems or medical questions must be documented (by date and time of call and return phone number) and promptly brought to the attention of the doctor.

2. At no time shall office personnel give medical advice without the direct involvement of the practitioner/provider or physician assistant.

3. The doctor must renew all prescriptions.

4. In the event a patient calls with a medical emergency, the patient will be instructed to call 911 immediately.

5. Medical groups that offer or contract with a company to offer telephone medical advice services must ensure that the service meets the requirements of Chapter 15 of Division 2 of the Business and Professionals Code, which include registration and monitoring.

Services which only direct patients to the appropriate setting for care (e.g., hospital or urgent care clinic) or prioritize physician appointments are not considered telephone medical advice services.

Care1st contracts with a certified vendor for after-hours Nurse Advice line.
### 9.13: HEDIS Measurements

**Use of Practitioners/Providers Performance Data**

Practitioners and Providers will allow Care1st Health Plan to use your performance data for quality improvement activities (e.g., HEDIS, clinical performance data).

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| 1. Well Child Care Birth to 15 Months        | Care1st will audit Members who have turned 15 months old during the measurement year. Must have been continuously enrolled with Care1st from 31 days through 15 months. A separate rate will be determined based on the amount of well child visits they have received. | The Member should have six (6) well child visits at 15 months of age. Must have evidence of the following:  
- Health and developmental history  
- Physical examination  
- Health education/anticipatory guidance |
| 2. Well Child Care 3, 4, 5, 6 Years of Age   | Care1st will audit Members that have turned three, four, five or six years old during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year. | The Member must have at least one (1) well child visit during the measurement year. Must have evidence of the following:  
- Health and developmental history  
- Physical examination  
- Health education/anticipatory guidance |
| 3. Well Child Care in Adolescents            | Care1st will audit Members who have turned 12 through 21 years of age during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year. | The Member must have at least one (1) comprehensive well child visit with primary care practitioner/provider during the measurement year. Must have evidence of the following:  
- Health and developmental history  
- Physical examination  
- Health education/anticipatory guidance |
| 4. Immunizations at 2 Years                  | Care1st will audit the immunizations of Members that turn two years old During the measurement year. There must not be more than a one-month gap in enrollment during the 12 months before their second birthday. | The Member must have all the required immunizations as follows:  
- **DPT/DTAP** - at least four before the second birthday.  
- **IPV/OPV** - at least three polio vaccinations before the child’s second birthday.  
- **MMR** - at least one MMR with the date falling between the first and second birthday.  
- **HiB** - at least two H influenza type b immunizations prior to the second birthday.  
- **Hepatitis B** - three hepatitis B vaccinations before the child’s second birthday.  
- **VZV** - at least one chicken pox vaccine between the child’s first and second birthday or documented history of chicken pox. |
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| 5. Initiation of Prenatal Care | Care1st will audit women that have had a live birth during the measurement year who have been enrolled no more than 279 days but at least 43 days prior to delivery. | The Member must have one (1) pre-natal visit within 42 days prior to the end of the first trimester.  
- Must have a basic obstetrical examination that includes fetal heart tone or pelvic examination with measurement of fundus height.  
- Obstetric panel or antibody titers and or ultrasound.  
- Documentation of LMP or EDD with a risk assessment. |
| 6. Prenatal Care in the 1st Trimester | Care1st will audit women who deliver a live birth during the measurement year who were continuously enrolled for 280 days prior to delivery and who had prenatal care visit on or between 176 days to 280 days prior to delivery. | The Member must have a pre-natal visit with in the first trimester of pregnancy, which would be between 176 days to 280 days prior to delivery. The pre-natal visit should include:  
- Obstetrical examination with fetal heart tones or pelvic examination and measurement of fundus height.  
- Obstetric panel, antibody testing and ultrasound.  
- Documentation of LMP or EDD with risk assessment, education and complete obstetrical history. |
| 7. Post-Partum Check-Up       | Care1st will audit women who delivered a live birth during the measurement year who were continuously enrolled 56 days after delivery. | The Member must have a post-partum visit between 21 days and 56 days after delivery. Post-partum visit should include:  
- A pelvic examination  
- Evaluation of weight, blood pressure, breasts and abdomen |
| 8. Chlamydia Screening        | Care1st will audit women age 16 to 26 years of age who are sexually active. Must be continuously enrolled during the measurement year with no more than a one-month gap in enrollment. | The Member must have at least one (1) chlamydia test performed during the measurement year. |
9.14: Credentialing Program

Purpose

To ensure that all network practitioners/providers meet the minimum credentials requirements set forth by Care1st and the regulatory agencies including, but not limited to, the NCQA, DHCS, DMHC, and other regulatory agencies for participation in the network. At least every three (3) years, the practitioners/providers are required to undergo recredentialing to ensure that they are in compliance with these standards.

Scope

The credentialing program applies to all direct-contracted and delegated practitioners, and those who are affiliated with Care1st through their relationship with a contracted PPG. Care1st requires the credentialing of the following independent practitioners: physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), optometrists (OD), and mid-level practitioners/providers (PA, NP, and NMW) employed in these practitioner’s offices and see Care1st Members. Care1st and its delegates may also credential other allied health professionals, such as psychologists (PhD, PsyD), audiologists (AU), registered dietitians (RD), and other practitioners authorized by law to deliver health care services and contracted by Care1st on an independent basis.

Care1st does not credential hospital-based practitioners (i.e. radiologists, anesthesiologists, pathologists, and emergency medicine physicians) who see Care1st Members solely as patients of the hospital.

Objectives

- To ensure that all practitioners/providers, including both direct-contracted and delegated, who are added to the network meet the minimum Care1st requirements.
- Care1st practitioners/providers are evaluated for, but not limited to, education, training, experience, claims history sanction activity, and performance monitoring.
- To ensure that network practitioners/providers maintain current and valid credentials.
- To ensure that network practitioners/providers are compliant with their respective state licensing agency and Medi-Cal programs, and Care1st has a process to ensure that appropriate action is taken when sanction activity is identified.
- To establish and maintain standards for credentialing and to identify opportunities for improving the quality of practitioners/providers in the network.

Credentialing Policies & Procedures

Policies and procedures are reviewed annually and revised, as needed, to meet the needs of Care1st, its practitioners/providers, and the changing requirements of the regulatory agencies. Policies and procedures are reviewed by the Chief Medical Officer and submitted to the Credentials Committee and P&P Committee and Board of Directors for review and approval.
Credentials Committee
The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners/providers contracted with Care1st Health Plan. The CMO serves as chairman of the Credentials Committee, which is comprised of a multi-specialty panel of practitioners/providers in the Care1st network, the QI Director, the Credentialing Manager, and any additional physicians, as needed, for their professional expertise. However, only physicians may vote. A minimum of three (3) voting Members is considered a quorum. The Credentials Committee will meet as often as needed to conduct the business but not less than quarterly.

The responsibilities of the Credentials Committee include but are not limited to:

- Review, recommend, and approve/deny initial credentialing, recredentialing, change of credentials, and inactivation of direct-contracted practitioners/providers for the Care1st network.
- Review and approve credentialing policies and procedures and ensure they are carried out.
- Review and recommend actions for all network practitioners/providers identified with sanction activities from the state licensing agency and Medi-Cal and OIG.
- Ensure appropriate reports, including 805, NPDB, etc. are made, as required; and
- Ensure Fair Hearings are offered and carried out in accordance to the established policies and procedures.

9.14.1 Minimum Credentials Criteria
All practitioners will be credentialed and recredentialed in accordance to the approved policies established by Care1st.

1. All applicants will meet the following minimum credentialing requirements:
   a. Hold and maintain a current and unrestricted State medical or professional license.
   b. Hold a current and valid DEA certificate, if applicable.
   c. Maintain current and valid malpractice insurance in at least a minimum coverage of $1 million per occurrence and $3 million annual aggregate (Optometrists and audiologists are required to have minimum malpractice coverage of $1 million per occurrence and $2 million annual aggregate).
   d. Maintain current hospital privileges in the requested specialty at a Care1st contracted hospital. This requirement may be waived only for PCPs if the physician arranges for another Care1st practitioner/provider to provide hospital coverage at a contracted hospital. This arrangement must be documented in writing by the covering physician and submitted to Care1st. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, pathology, radiology, psychology, and optometry).
   e. Meet minimum training requirements for the requested specialty. The applicant must have no mental or physical conditions that would, with reasonable accommodation, interfere with his/her ability to practice within the scope of the privileges requested.
   f. Be eligible to participate in the Medi-Cal program with no sanctions.
   g. Have no felony convictions.
   h. Be able to provide coverage to Members, either personally or through appropriate physicians 24 hours per day, seven (7) days per week.
i. Agree to abide by Care1st policies and procedures.

j. PCPs are required to have a passing score on the facility site review and medical record review.

2. All applicants will meet the following minimum training requirements: Physicians (MD, DO) must be either:
   - Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards.
   - Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board.
   - A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969, and had been in practice full time since may be “grandfathered” into Family Practice.

a. A practitioner applying for General Practice must sign the Care1st form (See Appendix 9), attesting to practicing primary care medicine for the last five (5) years and indicate completion of at least one year stateside training in primary care medicine (Internal Medicine or Family Practice) or completion of at least one year of specialized training (not in primary care medicine) in United States and provide two letters of recommendation from other primary care physicians.
   - An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine and sign the Care1st Addendum E. OB/GYN’s applying for PCP status may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.
   - For newly established subspecialties, the physician may substitute five (5) years of work experience and be “grandfathered” into the specialty if the fellowship has not been approved.
   - The physician has completed an International Medical Graduate (IMG) training program and has completed a Canadian or British Isles residency program. (The ABMS formally recognizes Canadian and British medical schools and residencies as equivalent to US training but does not recognize Canadian and British Specialty Boards).

b. Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., ABPOPPM and ABPS) or completed a podiatric residency program or doctorate in podiatric medicine.

c. Optometrists (OD) are required to complete a professional degree in optometry.

d. Dentists (DDS, DMD) are required to have completed a professional degree in dentistry.

e. Physician assistants (PA), nurse practitioners (NP), and nurse midwives (NMW) must have successfully completed the academic program required for the requested status. For example, a nurse practitioner must have completed a nurse practitioner academic program.

f. Allied health professionals are required to have successfully completed the professional program required for their requested specialty.

The HIV specialist must meet any one of the following four criteria:

- Credentialed as an “HIV Specialist” by the American Academy of HIV Medicine.
- Board certified in HIV medicine by a Member board of the American Board of Medical Specialties.
- Board certified in Infectious Disease and meets the following qualifications:
  - In the immediately preceding 12 months, has provided continuous and direct medical care to a minimum of 24 patients who are infected with HIV.
  - In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
- Meets the following qualifications:
  - In the immediately preceding 24 months, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV.
  - Has completed any of the following:
    - In the immediately preceding 12 months, has obtained board certification or recertification in infectious disease.
    - In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients.
    - In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
  h. The HIV specialist may utilize the services of a nurse practitioner or physician assistant if:
    - The nurse practitioner or physician assistant is under the supervision of an HIV specialist.
    - The nurse practitioner or physician assistant meets the qualifications specified in subsection g. iii above.
    - The nurse practitioner or physician assistant and the supervising HIV specialist have the capacity to see an additional patient.

The Credentialing Committee may consider other exceptions as it deems necessary and/or appropriate. The Chief Medical Officer may recommend the acceptance of an applicant even if the practitioner/provider does not satisfy minimum criteria if there is a determined need and if there is credible evidence that the practitioner/provider is capable of providing the services requested.

PPGs that are delegated credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non-physician practitioners/providers in accordance with the above Care1st policies and procedures, NCQA guidelines and applicable federal and state laws. Recredentialing is required at least every three (3) years.

Care1st retains ultimate responsibility and authority for all credentialing activities. Care1st will assess and monitor the PPG’s delegated credentialing activities as follows:

1. The Credentialing Department will conduct pre-contractual and annual onsite audits in accordance with the PPG Delegated Oversight Assessment and Scoring Policy and Procedure (QI Policy 1.0.1). The audit will include a review of the PPG’s policies and procedures, Credentialing Committee minutes and the PPG’s credentials files. The standardized audit tool (Appendix C) will be used to conduct the audit. The PPG will be required to submit a credentialing roster, with credentialing and recredentialing dates, at least one (1) week prior to the scheduled audit date. Care1st will use one of the following techniques for the file review:
   a. PPGs who have received a score above 90% in their last two consecutive Care1st annual audits will have their credentialing files reviewed based on the NCQA’s 8/30 Rule. Prior to the audit, the Care1st auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the PPG. The Care1st auditor will review the files in the order indicated on the file list, starting with the first eight (8) initial files. If all eight (8) initial files are compliant with all the required elements, then the remaining 22 reserve initial files will not have to be reviewed. If a required element is noted to be “non-applicable” in a file, then the auditor will review a reserve file for only that element. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files. After completion of the initial file review, the auditor will follow the same procedure for the recredentialing file review.
   b. For PPG’s who scored below 90% in their last two (2) Care1st annual audits, Care1st will continue to review 50 or 5%, whichever is less (with a minimum of ten credentialing and ten recredentialing files). Prior to the audit, the Care1st auditor will provide the PPG with a list of the files to be reviewed.

2. PPG will be required to sign and abide by the credentialing agreement, which is attached to the capitated group agreement.

3. To be delegated and to continue delegation for credentialing, PPGs must meet the minimum standards by scoring at least 80%. The PPG will be required to submit a corrective action plan (CAP) for all deficiencies within 30 days of receiving notice of audit results. After reviewing the CAP, the PPG will be sent a letter noting acceptance of the CAP or any remaining deficiencies. The Credentialing Department will monitor compliance with the CAP, as required.

4. Delegated credentialing status may be removed by Care1st at any time in which the integrity of the credentialing or recredentialing process is deemed to be compromised or inadequate.

5. Care1st retains the right to, based on quality issues, approve new practitioners/providers and sites and to terminate or suspend individual practitioners/providers or sites.
6. Delegated PPGs are required to submit a monthly roster of practitioners/providers approved for recredentialing.

7. The PPG is required to respond to all other Plan requests for information including specific information related to a provider’s training, action related to any sanctions, etc.

8. The PPG is required to submit copies of originals files for selected practitioners/providers at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight.

9.14.3: Credentials Process for Directly Contracted Physicians

1. The Credentials Committee is responsible for making decisions regarding initial credentialing, recredentialing, and changes to credentials, and inactivation of all direct-contracted practitioners/providers.

2. Care1st has adopted the California Participating Physician Application (CPPA), which requires the practitioner to provide information on:
   a. Reasons for inability to perform the essential functions as a provider, with or without accommodation.
   b. Lack of present chemical dependency or substance abuse, including illegal drugs.
   c. History of loss of license and felony convictions.
   d. History of loss or limitations of privileges or disciplinary activities.
   e. Attestation regarding the correctness and completeness of the application.

3. In addition to completing an initial application, the practitioner must provide:
   a. A copy of his/her current professional license to practice.
   b. A copy of a current and valid DEA certificate (if applicable).
   c. A copy of a current malpractice insurance certificate with the practitioner listed as an insured with the minimum required coverage.
   d. A current curriculum vitae (CV).
   e. A copy of the ECFMG certificate (if applicable).
   f. A written explanation regarding any sanction activity, malpractice judgments in the last five (5) years or pending claims, restriction of privileges, etc.

4. Upon receipt of a completed application, Care1st will obtain and verify the information in accordance to its policies and procedures.

5. When an incomplete application (e.g., missing information, unaccompanied by all the supporting documentation, dated more than three months prior to receipt, etc.) is received, the Credentialing Department will contact the applicant for the missing information. Failure to submit the information within after the third attempt will be considered a voluntary withdrawal of the application.

6. An initial facility site review/medical record review of all PCP offices is required prior to inclusion into the Care1st network. This will be a structured visit, in accordance with the QI facility site review and medical record procedures. The FSR must be conducted within three (3) years prior to initial credentialing. A physician who joins the practice of an existing Care1st practitioner/provider, who has passed a FSR within the last three years, may be credentialed pending a medical record review within six (6) months of joining the network.
7. Upon completion of the credentialing verification process, a report summarizing each applicant’s credentials is forwarded to the Credentials Committee for review and action. If the Committee recommends denial, limitation, suspension, or termination of Membership based on a medical disciplinary cause or reason, the practitioner shall be entitled to a formal hearing pursuant to the Fair Hearing policy. The Fair Hearing policy does not apply to mid-level practitioners/providers.

8. A report of the Credentialing Committee’s decisions is forwarded to the Board of Directors for final approval. The Credentialing Department will notify practitioners/providers of the Board of Director’s final decision by mail. The Credentialing Committee’s approval date is considered the approval date for determining that the individual credentials verifications meet the 180-day time limit.

9. The Credentialing Department notifies the Contracting Department or the Provider Network Administration responsible for the approved practitioners/providers of the final credentialing decision. A practitioner/provider profile outlining each newly credentialed practitioner/provider’s credentials is generated to the responsible Provider Network Administrator. The Contracting Department will follow their procedures for executing the contract and adding the practitioner/provider to the network.

9.14.4: Recredentialing

At least every three (3) years, a practitioner/provider must complete recredentialing to maintain his/her Membership with Care1st. Approximately 30 months after the last credentialing date, the practitioner/provider will be mailed a recredentialing application containing information from the credentialing database for review. The practitioner/provider will be instructed to review and update the application with current information, complete a new attestation questionnaire, sign and date the appropriate pages, and return it with the supporting documentation as required in the initial application process to the Credentialing Department within 30 days. A cover letter stating that failure to return the recredentialing application by its deadline may be considered a voluntary resignation by the practitioner/provider will be included with the recredentialing application. Upon receipt of a completed recredentialing application, the Credentialing Department will follow its procedures in processing the application for recredentialing. After 30 days, a follow-up for recredentialing will be mailed to the practitioners/providers who have not returned their application. A final follow-up will be sent to practitioners/providers who have not returned their applications after 60 days from the initial mailing. The Contracting Department will be notified of the practitioners/providers who are non-responsive to the recredentialing requests and will follow their procedures for action.

9.14.5: Practitioners/Providers’ Rights

Practitioners/Providers shall have the right to:

1. Review all non-protected information obtained from any outside source in support of their credentialing applications, except references or recommendations protected by peer review laws from disclosure.
2. Respond to information obtained during the credentialing process that varies substantially from the information provided by the practitioner/provider.
3. Correct erroneous information supplied by another source during the credentialing process.
4. Practitioners will be notified of their rights in the initial and recredentialing application packet.

9.14.6: Confidentiality of Credentials Information

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in locked file cabinets in the Credentialing Department, which is kept locked when not occupied. Only authorized personnel will have access to credentials files. Practitioners/Providers may access their files in accordance with the established policies. All confidential electronic data will be access-controlled through passwords. Access will be assigned based on job responsibility, and also on a need-to-know basis. All Credentials Committee Members, guests, and staff involved in the credentialing process will sign a confidentiality agreement at least annually.

9.14.7: Sanction Review

Care1st queries the National Practitioner Data Bank, Health Integrity and Protection Data Bank, Federation of State Medical Boards, Office of Inspector General, Medi-Cal, and state licensing agencies at the time of initial and recredentialing to determine if there have been any sanctions placed against a practitioner/provider. Care1st also reviews the monthly Medical Board of California (MBC) Hot Sheets and Medi-Cal discipline reports to determine if any sanctions have been placed against or lifted from any network practitioners/providers. Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner/provider is contracted directly with Care1st, then the practitioner/provider is notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome. If the practitioner/provider is delegated to a PPG, then the affected PPG is notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the PPG’s response, is forwarded to the Credentials Committee for review and action.

Summary Suspension of a Practitioner’s Privileges
1. Immediate action will be taken to suspend a practitioner’s privileges in the event of a serious adverse event. A serious adverse event is defined as any event that could substantially impair the health or safety of any Member.

2. Immediate action will also be taken to suspend a practitioner’s privileges in the event the practitioner fails to meet the following minimum credentialing criteria:
   a. The practitioner’s license to practice has been revoked, suspended, or under any type of restriction or stipulation, including probation, by the state licensing agency.
   b. The practitioner has been suspended from the Medi-Cal program; however, this does not apply to practitioners who participate in only in the Healthy Families program.
   c. The practitioner fails to maintain the minimum malpractice liability coverage.

3. Should a practitioner/provider fail to meet the minimum credentialing criteria as described above, Care1st will allow the practitioner/provider a chance to correct the deficiency before inactivating the practitioner/provider. Upon knowing that a practitioner/provider is noncompliant, the Credentialing Department will notify the practitioner/provider immediately in writing of the deficiency. The notification will specify the methods available for correcting the deficiency and the timeframe allowed for the submission, and that failure to correct the deficiency will result in immediate inactivation. The timeframe allowed for
correcting the deficiency and the date of inactivation will depend on the following:

a. If the deficiency is known by the Credentialing Department before the 13th day of the month, the practitioner/provider will be inactivated on the 1st Day of the following month unless the practitioner/provider is able to correct the deficiency prior to the monthly upload, usually landing on the 13th day of each month. If Members are assigned to the affected practitioner/provider, then the Members will be transferred to another practitioner/provider by the effective date of said inactivation.

b. If the deficiency is known by the Credentialing Department after the 13th day of the month, the inactivation should become effective on the 1st day of the 2nd month after the deficiency is known unless the practitioner/provider is able to correct the deficiency prior to the monthly upload, usually landing on the 13th day of each month. If Members are assigned to the affected practitioner/provider, the Members will be transferred to another practitioner/provider by the effective date of said inactivation.

4. Any information regarding an adverse event will be forwarded to the QI Department as a potential quality issue (PQI) and handled in accordance with the established policies and procedures.

5. The Chief Medical Officer has the authority to immediately suspend any or all portions of a practitioner’s privileges in the event of a serious adverse event (as defined above). The involved practitioner will be notified in writing within two working days of the suspension or restriction. The written notice will include a notice of the practitioner’s right to a Fair Hearing.

6. A summary suspension shall become effective immediately upon imposition. The notice of suspension shall be given to the Board of Directors for ratification. In the event of suspension, the practitioner’s Members shall be assigned to another practitioner. The wishes of the patient shall be considered, where feasible, in choosing another practitioner.

7. Care1st will adhere to the California Business and Professional Codes requirements for submitting 805 reports to the Medical Board of California and to the Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner Data Bank and to the Health Insurance Portability and Accountability Act of 1996 for reporting to the Health Integrity and Protection Data Bank.

9.14.8: Health Delivery Organizations

1. Prior to contracting with, and at least every three (3) years thereafter, Care1st will evaluate health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, and nursing homes to ensure they have appropriate structures and mechanisms in place to render quality care and services. The evaluation process includes confirmation of the following:
   a. In good standing with the state and federal regulatory bodies.
   b. Current accreditation by a Care1st recognized accrediting bodies.
   c. If not accredited, the HDO has been reviewed and approved by HCFA or DHHS.

2. Care1st will not contract with HDOs that have not been approved by a recognized accrediting body or passed a HCFA or DHHS site review.
SECTION 10: PHARMACY & MEDICATIONS

10.1: Drug Formulary

Policy

Care1st Members shall have access to all FDA-approved drugs that are medically necessary via the drug formulary or prior authorization procedures. In order to ensure Members receive high quality, cost-effective and appropriate drug therapy, Care1st will maintain drug formularies consistent with the required pharmacy benefit design for all contracted product lines. The formularies will be maintained by the Care1st Pharmacy & Therapeutics (P&T) Committee.

Procedure

1. The P&T Committee is responsible for developing, periodically reviewing and amending the drug formularies.
2. The Care1st Medi-Cal drug formulary will include, at a minimum, representative drugs in all the therapeutic categories listed in the Medi-Cal fee-for-service formulary including non-legend and over-the-counter (OTC) drugs.
3. Care1st drug formularies will indicate which pharmaceuticals require prior authorization. Any limitations on quantities, the number of refills, dosage or length of therapy will be noted.
4. Step Therapy: In some cases, Care1st will require that the patient has a trial of a first-line medication, prior to approving a second-line medication.
5. Therapeutic interchange: Is the practice of offering clinically appropriate, cost effective formulary alternatives. Therapeutic interchange programs are reviewed and approved by the Pharmacy and Therapeutics Committee. Care1st will work with the prescribing physician's to get this accomplished.
6. Any provider may request the P&T Committee to consider an addition, deletion or modification to the drug formularies. Requests must be made in writing to the Chief Medical Officer (CMO). The Care1st pharmacists are responsible for researching all requests and submitting information and a recommendation to the P&T Committee.
7. The P&T Committee considers all requests for formulary changes at its regular quarterly meeting. The committee will take into account at a minimum the safety, effectiveness, efficacy and cost when considering a change to the formularies.
8. Providers and pharmacies will be notified of all formulary changes via newsletter or special notice. The newsletters will reference the Care1st website which maintains updated formularies/formulary search capabilities.
9. Providers may access the drug formularies at any time on the Care1st website at www.care1st.com. Formularies will be provided to all Care1st PCPs. Formularies will be made available upon request to all network providers and Members. Members are informed of the availability of the formulary upon enrollment and annually. Notices of their availability will be included in the Member Service Handbook, Provider Manual, newsletters and/or special notices. The formulary will provide an explanation of limits and quotas, along with step-therapy protocols.
10. The formularies, in their entirety, will be reviewed at least annually by the P&T Committee. The review may be divided into drug categories.
11. All formulary changes will be submitted to the appropriate regulatory agency within 30 days of approval.
12. Non-formulary drugs that are deemed medically necessary are available through the prior authorization review process.
13. Members will be provided an evidence of coverage (EOC) handbook annually and upon enrollment, which will explain what a formulary is, and the pharmaceutical management procedures. The EOC will also contain information explaining Care1st's process for generic substitution and therapeutic interchange. Practitioners will be made aware of pharmaceutical management procedures, including generic substitution, therapeutic interchange, and step-therapy protocols, via the Care1st website, wall charts distributed annually, formulary book, and newsletters. The Care1st website and formulary book will also communicate to the prescribing practitioners of how they can provide information to support an exception request.

Review of medication requests for non-FDA approved indications:
1. In accordance with Section 1367.21 of the Health and Safety Code, Care1st will not limit or exclude coverage for a drug on the basis that the drug prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
   a. The drug is approved by the FDA;
   b. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition or the drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the Care1st formulary. If the drug is not on the Care1st formulary, the participating subscriber's request shall be processed as a non-formulary drug request in accordance with the appropriate policies and procedures. (Refer to Prior Authorizations Policy and Procedure in this section 10.3); and
   c. The drug has been recognized for treatment of that condition by one of the following:
      - The Elsevier Gold Standard’s Clinical Pharmacology.
      - The American Hospital Formulary Service Drug Information.
      - Thompson Micromedex DRUGDEX.
      - Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

2. It shall be the responsibility of the participating prescriber to submit to Care1st documentation supporting compliance with the above mentioned requirements when requested by the plan.

3. Any coverage required by this section shall also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.

4. For purposes of this section, "life-threatening" means either or both of the following:
   a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
   b. Diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

5. For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

6. The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of Care1st.
7. Nothing in this section shall be construed to prohibit the use of a formulary, co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

10.2: Continuity of Care for Medications

Policy

Newly enrolled Members with certain conditions who have been on an established medication that is not on the current formulary will have uninterrupted access to that medication. A new Member with prescriptions for specific conditions will not be denied a refill until the Member has been given an opportunity to be seen by his/her PCP.

Procedure

1. When new Care1st Members, or their pharmacies, request either refills or new prescriptions for ongoing treatment involving the medications for specific conditions listed below, Care1st will assure treatment is not interrupted by implementing one of the following procedures:
   a. Assuring the provision of an appointment prior to the time the prescription is exhausted.
   b. Assuring the provision of limited refills or new prescriptions by the PCP or the specialist designated as the care alternate.

2. The following medications and conditions are covered under this policy:
   a. Anti-hypertensives
   b. Diabetic medications and supplies
   c. Antiasthma medications
   d. Anticonvulsants
   e. Other medications/conditions evaluated on an individual basis and determined to be medically necessary for an immediate prescription refill and any other drug utilized for a chronic condition.

3. Refills will be limited to the interval until the Member is seen and should not exceed a 30-day supply.

4. New prescriptions for ongoing treatment programs will be limited to a seven (7) day supply. An appointment for the Member to see his/her PCP will be scheduled and verified with the patient within seven (7) days in order to prevent any interruption in the Member’s current medication regimen.

10.3: Prior Authorizations (“P.A.”)

Policy

The Care1st Pharmacy Department will ensure a timely and accurate review of all medication authorization requests. Prior authorization requests will be determined 72 hours after receipt of complete information from the provider for Standard determinations. Expedited reviews will be determined within 24 hours after receipt of complete information from the provider. Care1st shall provide an expedited determination if it determines that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.
Medication authorizations requests may be submitted by the member, member’s representative, member’s prescribing physician, or other physicians.

Medications requiring authorization include (but are not limited to):

- Medications on the Care1st formularies requiring a prior authorization (P.A.) review
- Non-formulary medications
- Part B versus Part D determinations

The Care1st Pharmacy Department will provide written communication of the prior authorization determination to the Member and provider.

Definitions

“Approved” – Care1st agrees to cover the requested medication.

“Modified” – The physician agrees to modify the original medication request to a formulary medication.

“Denied” – The medication request was not approved.

“Non-formulary” – A medication not listed on the Care1st formulary.

“P.A. Required” – A medication on the Care1st formulary that requires P.A. review.

“Specialty Pharmaceutical” – Defined by the criteria included in AB2420.

Procedure

1. Most medications on the Care1st drug formulary do not require prior authorization. The Member simply obtains a prescription from his/her provider and has it filled at a participating pharmacy.

2. The P&T Committee may require P.A. for certain medications in order to promote appropriate use. Products designated as requiring P.A. will not be covered unless approved in advance for a specific patient, product and length of therapy.

3. The P&T Committee reviews and approves the medications included in the Care1st formularies on an ongoing basis to ensure that the formularies are clinically appropriate and consistent with current pharmaceutical treatment guidelines. In a situation where the provider identifies a need for the Member to receive a medication not on the Care1st formularies, he/she may submit a request by completing the Care1st Medication Prior Authorization Form (See Appendix 10).

4. The prescriber or prescriber’s staff, but not the patient, may make an exception request based on medical necessity by submitting a P.A. request by telephone or fax to the Care1st Pharmacy Department. The member may also make an exception request by calling member services, at which point the Care1st Pharmacy Department will initiate a prior authorization request. The Care1st formularies identify the medications requiring P.A. Providers may not utilize a third party agent to assist with the preparation of a medication P.A. Third party agents may not submit P.A. requests on behalf of the provider.
5. The Care1st Pharmacy Department captures the date and time of the P.A. request by the fax received stamp on the P.A. form. If a provider telephones in the request the Care1st Pharmacy staff will complete the request and document the date and time received in the Pharmacy P.A. database.

6. The request will be reviewed pursuant to the P&T Committee’s approved P.A. guidelines to ensure the safe, efficacious, appropriate and cost-effective use of the medication.

7. If a Member presents a prescription at a retail pharmacy requiring a P.A. that has not been processed, the pharmacy will contact the prescribing practitioner and request a therapeutic substitution. The pharmacy staff may contact the Care1st Pharmacy Department for assistance with the identification of formulary alternatives.

8. If the practitioner does not agree to the substitution, the retail pharmacy will inform the prescriber that he/she may contact the Care1st Pharmacy Department.

9. Once contacted, the Care1st Pharmacy staff will initiate the process for obtaining medical necessity information from prescribing practitioners. In most circumstances, this is done via fax on a standardized form. Due to the need for timeliness, it may be necessary to discuss the request telephonically with the prescribing practitioner:
   a. The Care1st Pharmacy staff will review the request against a written protocol which the P&T Committee has approved. If the P.A. information submitted does not meet the criteria outlined in the P.A. guidelines, it will be forwarded to the Care1st clinical pharmacist.
   b. The clinical pharmacist will review the request and may consider it appropriate as requested, or may determine another formulary medication may be a reasonable therapeutic substitution.
   c. If the request is medically appropriate an override will be entered in the pharmacy benefit managers (PBM) system so the medication can be processed.
   d. If there is a formulary alternative available the clinical pharmacist will advise the Care1st Pharmacy staff in providing the appropriate attention; the clinical pharmacist will contact the provider directly. For non-urgent medication requests, the suggestion of an alternate formulary agent may be communicated by written notification.
   e. If the clinical pharmacist determines the need for additional medical information he/she will provide written documentation requesting that the Care1st Pharmacy staff assist in requesting the necessary data.
   f. The Pharmacy staff will document the date and time for each request submitted to the provider’s office. This includes requests for routine P.A. information and additional information as authorized.
   g. The Pharmacy staff will solicit a response from the physician’s office daily for three (3) consecutive business days. The request for information will be sent by facsimile. If the request for information is made verbally, this action will be documented in the Care1st P.A. database.
   h. If the required information is not obtained by the third business day from receipt of the initial P.A. request, a request for additional information letter will be sent to the member providing notice that Care1st is unable to render a determination due to the fact that the required information has not been submitted to Care1st. The P.A. request will be placed in a deferred or pended status and remain active for fourteen (14) calendar days, upon which Care1st will provide written notice informing the member that the required information is still outstanding and the request cannot be approved due to the lack of information submitted. If the required information is submitted prior to the expiration of the fourteen (14) calendar day period the P.A. request will be
reviewed by the Clinical Pharmacist and Chief Medical Officer or designated physician reviewer, and a decision will be rendered within one (1) business day of receipt of complete information. If the required information is submitted after the fourteen (14) calendar day period, the P.A. review process will be reinstated.

10. If the clinical pharmacist cannot approve the medication, the P.A. request along with all applicable information will be forwarded to the Care1st CMO or designated physician reviewer.

11. The CMO or designated physician reviewer will review all deferred cases for medical appropriateness and to identify opportunities to educate providers.

12. All P.A. denials are determined by the Care1st Chief Medical Officer or designated physician reviewer except administrative denials to include but not limited to denials due to member’s non-eligibility with Care1st Health Plan or due to carve out medications, which can be denied by the reviewing pharmacist. If a PA request is denied, a denial letter will be sent by the Pharmacy Department to the member within one business day of the determination. In addition, a copy of the denial letter will be faxed to the prescribing physician or PCP. The notification will include the following elements:
   a. A clear and concise explanation of the reason for the denial or modification.
   b. For denials of medications based on the absence of a trial or failure of formulary agents, Care1st will provide a list of the potentially applicable formulary agents.
   c. Criteria, clinical guidelines or medical policies used in reaching the determination.
   d. Information regarding the member’s right to appeal the decision and the steps for submitting either a standard or expedited grievance.
   e. The Care1st toll-free phone number and address for submitting grievances.
   f. For denials based on the fact that the requested service is not a covered benefit, the notification will identify the document and page where the provision is found and provide a clear concise explanation of the application of the exclusion to the service requested.

13. Additionally, the information regarding the denial/modification including the Member outcome will be logged into the pharmacy database system. When the decision is made and sent out to the provider, Member or pharmacy, it will be dated and time stamped to comply with the turn-around-time requirement for processing. Turn-around-time measurements are based on the date and time of receipt of all information necessary to make an informed clinical determination.

14. If a P.A. request is approved, the prescriber or PCP will receive a faxed override letter as notice of the approval. The override letter will inform the physician of the date and term of the approval.

15. If a P.A. request from the prescriber or PCP is modified, the prescriber or PCP will receive, within one business day, an information notice of the modification. However, if the P.A. request was initiated by the member, a denial notice will be provided to the prescriber/PCP. The member will also receive the denial notice informing him/her of the modification to a formulary alternative medication by the physician.

16. If a P.A. approval is required for coverage of an antibiotic or life-sustaining medication (other than excluded products), an emergency supply will be covered under the following circumstances if the outlined procedure is followed (even if a subsequent formal application for P.A. is denied):
a. A pharmacist receives the prescription and attempts, but is unable, to contact
the prescriber to prompt a request for a P.A. medical necessity approval or
prescription change to a product not requiring such approval for coverage,
b. If the pharmacist telephones or faxes Care1st and is unable to get through
due to technical difficulties during Care1st’s normal business hours.
c. If the pharmacist determines the situation warrants it the pharmacist
dispenses an emergency supply of the product, usually a 72-hour supply
(although up to a four or five-day supply may be dispensed under extenuating
circumstances, e.g., a Friday evening or holiday weekend).
d. On the following business day the pharmacist contacts the Care1st Pharmacy
Department providing the Member’s demographic information, the medication
dispensed (including the amount and strength), the prescriber’s name and
office phone number, and the circumstances of the emergency.
e. The pharmacist contacts the prescriber regarding the need to apply for the
required P.A. approval or to change the prescription to a product not requiring
approval for coverage.

17. Routine Pharmacy Denial Activity reports will be submitted to the P&T Committee for
review.

10.3.1: Health Insurance Portability and Accountability Act (HIPAA)
Requirements

1. The Care1st Pharmacy staff may obtain from the physician, physician’s office staff or
the pharmacist only the minimum necessary information required to process the prior
authorization. This information includes: Member’s name; Member’s ID#; Member’s
date of birth; name of medication requested; medication strength; prescribed dosing
regimen; medication formulation; medication quantity; diagnosis; past medications
tried and failed; and reasons for past medication failures (i.e., adverse drug
reactions, no improvement, etc.), and pertinent current medications.
2. In addition to the minimum necessary information, the CMO, designated physician
reviewer, Pharmacy Director or clinical pharmacist may determine the need for
further medical justification, which may include a request for medical records,
physician progress notes, laboratory results, consultant notes, literature references
or any other pertinent medical information deemed necessary to evaluate the P.A.
request.
3. All Care1st Pharmacy staff is required to handle protected health information in a
manner that protects the privacy of the Members. In order to ensure Member
privacy, communications related to the details of a P.A. case should be limited to
appropriate pharmacy personnel and, when necessary, to the appropriate Utilization
Management and Member Services staff only. This information should not be
available for viewing by any personnel other than those directly involved in the
processing of the pharmacy P.A. request. All protected health information should be
maintained in a confidential manner and destroyed in accordance with the Care1st
corporate document policy.

10.3.2: Effectiveness Monitoring

The Pharmacy Director and clinical pharmacist will oversee and enforce adherence to the
procedures outlined in this policy.
10.4: Emergency Supply of Drugs

Policy

Care1st Health Plan (“Care1st”) will make every effort to ensure that members receive medications when appropriately prescribed by network providers. In most cases, the member simply obtains a prescription from his/her provider and has it filled at a participating pharmacy. However, there may be instances when approval is required for a Prior Authorization or a non-formulary drug and the pharmacy is unable to contact the Pharmacy Benefits Manager (“PBM”) in a timely manner or when the pharmacy is unable to verify eligibility after hours or on weekends. In these instances, the pharmacy will be authorized to dispense an emergency supply of drugs, usually not to exceed a 72-hour supply.

Procedure

1. If P.A. approval or a non-formulary drug is required for coverage of an antibiotic or life-sustaining medication (other than excluded products), an emergency supply will be covered under the following circumstances if the following procedure is followed (even if a subsequent formal application for P.A. or non-formulary drug is denied):
   a. A pharmacist receives the prescription and attempts, but is unable to contact the prescriber to prompt a request for Prior Authorization, or prescription change to a product not requiring such approval for coverage.
   b. If the pharmacist phones or faxes the P.A. request during Care1st’s normal business hours and is unable to get through due to technical difficulties. Care1st provides physicians and pharmacies with direct, toll-free access to the Pharmacy Department.
   c. If the pharmacist determines the situation warrants it, the pharmacist dispenses an emergency supply of the product, usually a 72-hour supply (although up to a four or five-day supply may be dispensed under extenuating circumstances, e.g., a Friday evening or holiday weekend).
   d. On the following business day, the pharmacist contacts Care1st, providing the Member’s demographic information, the medication dispensed (including the amount and strength), the prescriber’s name and office phone number, and the circumstances of the emergency.
   e. The pharmacist contacts the prescriber regarding the need to submit a Prior Authorization form, or to change the prescription to a product not requiring approval for coverage.

2. If the pharmacist is unable after hours, on weekends or holidays to verify Member eligibility and if the pharmacist determines the situation warrants it, he/she may dispense an emergency supply of the product, usually a 72-hour supply (although up to a four or five-day supply may be dispensed under extenuating circumstances, e.g., a Friday evening or holiday weekend).
   a. On the following business day the pharmacist contacts Care1st providing the Member’s demographic information, the medication dispensed (including the amount and strength), the prescriber’s name and office phone number, and the circumstances of the emergency.
   b. The pharmacist verifies eligibility on the next business day.
10.5: Requirements for Hospital Emergency Rooms to Furnish Emergency Drugs

Policy

Care1st Health Plan ("Care1st") requires all contracted hospitals have provisions for furnishing emergency drugs for health plan members who seek treatment through the hospital's emergency room.

Procedure

1. Care1st's hospital contract will contain language requiring the hospital have in place emergency room policies, procedures and systems that permit the furnishing of appropriate quantities of emergency drugs to last a Member until he/she can reasonably have a prescription filled at a network participating pharmacy.
2. Any reported violations of this policy will be reviewed by the Pharmacy Department, forwarded to the Quality Management Department as a potential quality issue, will be investigated, and acted upon in accordance with established policies and procedures.

10.6: Drug Storage & Dispensing in Provider Offices

Policy

All medications, including vaccines and drug samples, used at provider sites will be stored, handled and administered according to SDHS and other state or federal regulations and according to manufacturers’ recommendations.

Procedure

1. Each site shall maintain and periodically update a set of internal medication/pharmacy policies and procedures.
2. All medications shall be stored in their original containers. This does not apply to cleaning or antiseptic solutions that may be poured into other dispensing containers.
3. Germicides, disinfectants, test reagents and household cleaning substances shall be stored separately from medications.
4. All multiple dose containers shall be labeled with the date they are originally opened.
5. All medications and related items including sample drugs shall be routinely checked for expired items.
6. All medications shall be discarded, per Title 22 requirements, when they reach their expiration date.
7. Medications shall be stored in a segregated manner according to their route of administration (i.e., oral, injectable, topical).
8. All medications, needles, and syringes are to be stored in an area only to authorized personnel.
9. Medications shall be stored at temperature levels specified by the manufacturer (i.e., room temperature, refrigerated at 35-45 degrees F or frozen at less than 7 degrees F).
10. Controlled substances (Schedule II or III) are to be stored separately from other medications in a securely locked cabinet. Controlled substances shall be inventoried, logged, and controlled. The physician is responsible for the use, storage and
inventory of all controlled substances.

11. Items other than medications that are stored in a refrigerator are kept in a separate compartment from drugs.

12. Medications that are transferred from the original container into another are classified as "re-packaged". The following information is required on the new container: date of re-packaging, initials of re-packager, manufacturer name and original lot number.

13. Medications shall be prepared in a designated, clean area of sufficient size as to minimize the potential for medication errors.

14. Drugs for emergency use should be stored in a secure, locked area and a location that is accessible in an emergency.

15. A list of contents and expiration dates should be on the outside of the emergency "box".

16. The contents of the emergency "box" should match the contents list.

17. The use and/or dispensing of sample medications is discouraged. If a provider elects to use and/or dispense sample medications, the following standards must be met:
   a. A physician or pharmacist shall be responsible for the storage, inventory, and dispensing of sample medications.
   b. Only a physician or pharmacist shall dispense sample medications. This cannot be delegated to other office staff.
   c. Sample medications shall be logged when received, including the medication name, quantity, manufacturer name, lot number, and expiration date.
   d. Samples may only be dispensed to the provider’s own patients.
   e. Samples may not be sold.
   f. Samples must be stored in a secure manner.
   g. If samples are dispensed, they must meet all labeling requirements.
   h. An appropriate entry is made in the patient’s medical chart in a similar manner as if a prescription had been written.

10.7: Generic Drug Interchange

Policy

Care1st will ensure the use or substitution of a generic drug for a brand name drug wherever an FDA-approved bio-equivalent generic product is available and there is no contraindication to patient use of the generic product.

Procedure

1. The P&T Committee may designate certain drugs for non-substitution for reasons of Narrow Therapeutic Index (NTI). (NTI is a reference to a drug with a relatively small margin of safety between the drug’s therapeutic dose range and either a sub-therapeutic or toxic dose).

2. A prescriber may, for medical reasons, request that a prescription be Dispensed as Written (DAW), subject to review and approval by the health plan.

3. The Care1st pharmacy benefits manager (PBM) is responsible for the implementation and administration of the formulary edits promoting use of the bio-equivalent generic drugs, when appropriate.

4. The PBM provides a report, not less than quarterly, of the percentage and cost of generic drugs dispensed.
10.8: Prescription Dispensing and Quantity Limits

Policy

Care1st will ensure the quantity of drugs dispensed to its Members is consistent with the term of treatment and in compliance with the manufacturer recommended dose.

Procedure

1. The quantity of drugs ordered and dispensed to a Member for the treatment of an acute or short-term medical problem should not exceed an amount consistent with the short-term nature of the problem.
2. For the treatment of a chronic or long-term medical problem, a Member should be provided a minimum of 30 days of therapy. The maximum quantity of a drug dispensed at any one time cannot exceed a 90-day supply, except as designated in the Care1st formulary.
3. No prescription submitted by a pharmacy provider will be reimbursed for a supply greater than the quantity or days’ supply required by the state and/or federal law.
4. Pharmacy provider “splitting” of prescription orders for purposes of generating additional fees is prohibited.
5. Quality of care and good pharmaceutical practices suggest a prescription order be reconfirmed with the prescriber following one year from the date the medication was ordered.
6. When a prescription is written with multiple refills it is the responsibility of the pharmacy provider to confirm Member plan eligibility each time the medication is dispensed.
7. Participating pharmacies shall impose no limit on the number of prescriptions that a Member may obtain during any given month.
8. Care1st will maintain a prior authorization process to allow override of quantity limitations when medically necessary.
9. Care1st’s contracted pharmacy benefit manager (PBM) will implement and administer the provision for prescription quantity limits.

10.9: Non Legend/Over the Counter (OTC) Drug Benefit

Policy

Medi-Cal

Care1st will include as a health plan benefit a reasonable selection of those non-legend or OTC drugs, supplies and devices that are listed on the Medi-Cal fee-for-service formulary, or a suitable therapeutic alternative, when requested on the prescription order of a plan participating provider and obtained from a participating plan Pharmacy.

Procedure

1. When ordered pursuant to a physician’s prescription, a reasonable selection of drugs, supplies and devices that can be purchased without a prescription (OTC) that are included on the Department of Health Care Services (DHCS) Medi-Cal drug formulary, or a suitable therapeutic alternative, will be provided as a plan benefit for Medi-Cal members.
2. Other OTC drugs, not included on the Medi-Cal drug formulary, may be designated as formulary drugs by the Pharmacy & Therapeutics Committee.

3. The Pharmacy Benefits Manager ("PBM") is responsible for the implementation and administration of dispensing designated OTC drugs, supplies and devices pursuant to a provider order.

10.10: Member Charges for Pharmacy Services – Medi-Cal

Policy

Care1st Medi-Cal Members are not required to make a co-payment or pay a fee for service in any amount for any services included under the health plan’s pharmacy services benefit.

Procedure

1. Participating pharmacy providers are required to make every attempt to verify eligibility prior to rendering or denying services. Eligibility may be verified by contacting:
   a. Care1st’s PBM
   b. Care1st’s Member Services Department or on-call nurses, if after hours
   c. The DHCS Automated Eligibility Verification System (AEVS)
   d. The L.A. Care Member Services Desk

2. If eligibility cannot be determined, the pharmacy shall dispense a minimum quantity of medication at the discretion of the pharmacist (up to a 3-day or 72 hour supply) to Members at no charge. An additional attempt to verify eligibility must be made at the earliest opportunity on the next business day. Once eligibility and benefit status have been verified, the pharmacy must contact the Member with instructions to return to the pharmacy and receive the balance of the medication order.

3. If prior authorization of a product or service is required, the pharmacy shall comply with the Care1st prior authorization requirements before denying plan benefit services. (Refer to Prior Authorizations Policy and Procedure in this section 10.3)

4. It is unlawful to charge Medi-Cal Members for pharmacy prescriptions unless a request for prior authorization has been denied by the CMO. Once a denial has been determined, the informed Members may, on their own volition, pay for the medication out-of-pocket. Plan Members may appeal modifications and denials of pharmaceutical care.

10.11: Pharmacy Interpreter Service Requirement

Policy

Care1st will make interpreter services available to Members when accessing pharmacy services at network pharmacies during pharmacy service hours. At a minimum, telephone interpreter services will be made available, if requested, through an interpreter service for pharmacy counseling on drug dosages, drug interactions, contraindications and adverse reactions.

Procedure

1. Pharmacists and Members may access interpreter services by calling the Care1st toll-free Member Services number.

2. Pharmacies and Members will be notified via newsletters, handbooks, special notices, and of the availability of interpreter services.
10.12: Access to Emergency Contraception Therapy

Care1st will ensure appropriate Member access to emergency contraception services by requiring that the Plan’s pharmacy benefit manager, MedImpact, maintains within its pharmacy network competent pharmacists who have completed the proper emergency contraception training and practice in accordance with established physician-guided protocols. Pharmacy network access to emergency contraception services will be monitored through a variety of methods. The CMO is ultimately responsible for resolving all Member issues related to pharmaceutical access.

Procedure

1. The PBM will ensure that all pharmacists providing emergency contraception therapy are acting in accordance with the standards established in SB1169.
2. The PBM will provide to Care1st on a quarterly basis a current list of the pharmacists within the pharmacy network who are qualified to provide emergency contraception therapy along with their site of practice. This list will be accessible to the Care1st Member Services representatives to assist Members requesting access to the provision of such services.
3. The PBM will ensure that authorized pharmacists are permitted to adjudicate claims electronically without requiring submission of a prescribing physician’s identifier.
4. Member access issues related to pharmaceutical care or services are identified through a variety of methods, including but not limited to:
   a. Member grievances
   b. Potential quality issues (PQIs)
   c. Utilization management
   d. Pharmacy benefit manager
   e. Pharmacy credentialing and auditing
5. Access issues will be handled through the same process as other identified grievances or potential quality issues. (Please refer to the Member Services and Quality Management Departments’ policies).
6. When necessary, pharmacy access issues will be referred to the Pharmacy & Therapeutic Committee for review and action.

10.13: Access to Pharmaceutical Care and Services

Policy

Care1st Health Plan (“Care1st”) will ensure appropriate member access to pharmaceutical care or services. If the member requires pharmaceutical care outside of Care1st network, the Member Services Department can direct the member to the closest network provider or pharmacy, including national pharmacy chains or mail order pharmacy for medication access.

Access to pharmaceutical care or services will be monitored through a variety of methods. The Chief Medical Officer is ultimately responsible for resolving all member issues related to pharmaceutical access.
Procedure

1. Member access issues related to pharmaceutical care or services are identified through a variety of methods, including but not limited to:
   a. Member reimbursement requests
   b. Member grievances
   c. Potential quality issues (PQIs)
   d. Utilization management
   e. Pharmacy benefit manager
   f. Pharmacy credentialing and auditing
   g. Prior authorization reports
2. Access issues will be handled through the same process as other identified Management Department policies.
3. When necessary, pharmacy access issues will be referred to the Pharmacy and Therapeutic Committee for review and action.

10.14: Drug Use Review

Policy

Care1st Health Plan will provide a prospective drug use review (DUR) program focused on ensuring that outpatient drugs are appropriate, medically necessary and not likely to result in adverse medical reactions. The purpose of the DUR program is to improve the quality and cost effectiveness of drug use. Care1st will also conduct a drug use evaluation (DUE) program that collects, reviews and analyzes pharmacotherapeutic data and presents the information to the Care1st Pharmacy and Therapeutics Committee. The Omnibus Reconciliation Act of 1990 (OBRA 90) requires all states to develop a DUE plan for Medicaid patients.

Procedure

1. Prospective DURs are performed at the point of sale in a real time environment before the dispensing has occurred. DUR edits includes but not limited to:
   - Drug-Age Interactions- Identifies drugs that may be used with caution or inappropriate for the submitted age of the patient.
   - Drug-Gender Interactions- Identifies drugs that may be used with caution or inappropriate for the submitted gender of the patient.
   - Drug-Drug Interactions- this interaction are coded based on severity by First Data Bank DUR module. Pharmacy are required to enter an override code for the level 1 identified interactions, most severe type of interaction.
   - Drug-Pregnancy Precautions- Identifies drugs that may be used with caution or inappropriate for women that maybe pregnant.
   - Duplication of therapy- Based on claim with the same member information, if filled on the same day or with in the same therapeutic category.
   - Incorrect Dosage Alert- Based on the quantity and day supply submitted, First Data Bank DUR module with alert the pharmacy if high/low dose is identified.
   - Drug-Disease Contraindications- Based on First Data Bank’s DUR module, this interaction is inferred based on current drug therapy.
   - Clinical Abuse or Misuse- Point of sale system edits that serve to limit clinical abuse or misuse within prescription drug programs. Edits include Step Therapy, Refill too soon, Prior Authorization and quantity limits programs.
If any of the concurrent DUR edits are identified, the dispensing pharmacy will be provided a warning message per NCPDP standards. Pharmacists are to consult with prescribing physician about the interactions. Prospective DUR reports will be evaluated on quarterly bases to identify conformance with accepted standards. These results will be presented to the P&T committee meeting.

2. Quarterly Retrospective DURs are submitted to the Care1st Pharmacy and Therapeutics Committee, any outliers, inappropriateness or trends will be presented with proposal of relevant strategies to improve the quality of patient care.

3. Retrospective DURs monitor the following:
   - Therapeutic appropriateness,
   - Over-utilization,
   - Under-utilization,
   - Appropriate generic use,
   - Inappropriate duration of treatment,
   - Incorrect drug dosage,
   - Pharmacologic duplication,
   - Drug-drug interactions, and
   - Clinical abuse and or misuse.

4. The Clinical Pharmacist performs retrospective DURs or Drug Use Evaluations (DUEs). DUEs utilize predetermined criteria and standards to monitor for: compliance with evidence-based medication recommendations, appropriate management of medication-related complications, medically unnecessary care, probable fraud, abuse, overutilization and underutilization.

5. Statistical analysis of the drug utilization data by Care1st staff, identifies those prescribing, dispensing and drug use practices which may be out of conformance with accepted standards and or may result in medically unjustified costs.

6. Care1st will provide educational interventions, which include both oral presentations to physicians and pharmacists, and ongoing transfer of information through written materials on clinically important, drug specific therapy problems.

7. Monthly reports will be reviewed by the Care1st Clinical Pharmacist to identify drug use problems.

8. Medication errors which could include:
   - Incorrect dosage dispensed
   - Incorrect labeling
   - Incorrect medication dispensed
   - Incorrect duration
     a. Shall be reported to the Pharmacist, a list of errors will be maintained for tracking and trending. Based on discussions with the Chief Medical Officer, this information will be communicated to the FDA or DEA and to downstream contracts (i.e. PBM, Network Pharmacy).
     b. Network Physicians and Pharmacies will be encouraged to report serious adverse events, product quality problems and product use errors to the FDA Medwatch Program.

9. Record Keeping
   a. Care1st will comply with federal and state requirements
   b. Care1st Health Plan Health Plan will retain its files, including relevant materials review by the Health Plan to reach a decision, for a period of ten (10) years.
   c. All plan documents will be retained in hard copy or electronic and readily retrievable.
10.15: Specialty Pharmaceuticals

Purpose

To establish clear policy and procedures for prescribing specialty pharmaceuticals and ensuring reliable access to these medications.

Policy

As of July 1, 2003, Care1st Health Plan will no longer require a health care service provider to assume or be at financial risk for any item described as a qualifying self-administered specialty pharmaceutical. The health care provider is permitted to assume financial risk for these items after making the request in writing at the time of negotiating an initial contract or renewing a contract with Care1st Health Plan.

The items included in AB 2420 are:

- Injectable chemotherapeutic medications and injectable pharmaceutical therapies for side effects adjunct
- Injectable medications or blood products used for hemophilia. Injectable medications related to transplant services.
- Adult vaccines.
- Self-injectable medications.

Other injectable medication or medication in an implantable dosage form costing more than $250 per dose.

Care1st will establish and maintain contract(s) with a credentialed specialty pharmacy vendor(s) to ensure appropriate access to and timely delivery of specialty pharmaceuticals.

All specialty pharmaceuticals prescribed for Members associated with a non-risk medical group will require prior authorization review. The Care1st Pharmacy Department will conduct the prior authorization review utilizing criteria and guidelines approved by the Care1st Pharmacy & Therapeutics Committee.

Procedure

Participating Provider Group “PPG” Not Retaining Specialty Pharmaceutical Risk and Care1st Directly Contracted Physicians:

1. In situations where the Member is assigned to a PPG or Care1st directly contracted physician where Care1st Health Plan assumes the risk for providing specialty pharmaceuticals, physicians must obtain a prior authorization approval regardless of whether they utilize office stock or require the services of a specialty pharmacy vendor.

2. Physicians who plan to prescribe a specialty pharmaceutical will submit a prior authorization request to the Care1st Pharmacy Department. Physicians may obtain a prior authorization form by calling the Care1st Pharmacy Department.

3. The Care1st Pharmacy Department will review the submitted request. All determinations will be based on the Care1st prior authorization guide lines and nationally accepted evidence-based guidelines.
4. If additional information is needed to make a final determination, the Pharmacy Department will send a request to the prescribing physician or the primary care physician. Pharmacy personnel will adhere to the HIPAA minimum necessary information requirements.

5. If the prior authorization request is approved the Care1st Pharmacy Department will enter a prior authorization override that permits the processing of the prescription claim by the specialty pharmacy.

6. The Care1st Pharmacy Department will notify the provider, Member and the specialty pharmacy in writing of the medication approval. Letters of approval will be mailed to the Care1st Member and a copy will be faxed to the provider. The specialty pharmacy will receive a faxed copy of the approved prior authorization form and prescription.

7. If the prior authorization request is modified or denied, the Care1st Pharmacy Department will notify the Member and the physician in writing.

8. All denials based on insufficient medical necessity will reference the appropriate guidelines utilized when evaluating the prior authorization request. For denials based on treatment of a condition that is not a covered benefit, the denial letter will reference the applicable state or federal regulation.

9. Upon notice of an authorized prescription, the specialty pharmacy will process the prescription in accordance with their dispensing procedures. The dispensing process will include coordination of delivery.

10. The specialty pharmacy will be responsible for verifying ongoing Member eligibility and PPG assignment for all new and refill prescriptions. If the Member is no longer eligible with Care1st Health Plan, then subsequent authorization and dispensing of the specialty pharmaceutical will be based on the procedures established by the newly assigned health plan.

11. In the event that the physician needs to utilize a medication stocked in his/her office, he or she will need to indicate this on the prior authorization form. If the medication and the in-office stock use are approved the physician will receive an approval notice.

12. Approval notices for specialty pharmaceuticals will include the specific medication NDC (National Drug Code). All claims should be billed utilizing the appropriate NDC code. A manual HCFA 1500 claim may be subsequently submitted to Care1st for reimbursement.

**Participating Provider Group “PPG” Retaining Specialty Pharmaceutical Risk**

If a Member is assigned to a PPG that has elected to keep the financial risk for specialty pharmaceuticals, Care1st will refer the provider and Member to the PPG for review of the prior authorization request.

**SECTION 11 HEALTH EDUCATION**

**11.1: Health Education Program**

**Purpose**

The Health Education (HE) Program is committed to improving and maintaining the health and wellness of Care1st Members through health promotion and disease management offered in a culturally sensitive and linguistically appropriate manner.
Goals

- Promote appropriate use of health services.
- Encourage Member involvement with their primary care physician (PCP) in the management of their personal health.
- Increase use of preventive health services.
- Encourage behavior change for high-risk behaviors.
- Increase Member’s knowledge and skills in coping with chronic conditions.

11.2: Scope of Health Education (HE) Program

11.2.1: Member Education

The Care1st HE Department is dedicated to ensuring quality health education services that are culturally sensitive and linguistically appropriate to all Members. The Health Education Program promotes knowledge and skills for self-management of health for Members and their families. The following programs are available to Care1st Members through self-referral or referral from their PCP.

Members and providers may obtain more information about these programs and services by calling the HE Department.

Health Education Classes
The Health Education (HE) Department or the Utilization Management (UM) Department handles referrals for HE classes and/or other interventions. Care1st direct providers may refer their patients to HE by completing and submitting the Health Education Referral Form (See Appendix 12: Health Education Referral Form) or the Treatment Authorization Request Form. This form may be faxed or mailed to the Care1st HE Department or the UM Department. Once the referral is received, HE will locate a health education class. If no class is available, HE will send written information to the Member on the requested topic. The PCP will receive documentation of the final outcome. PCP’s contracted through a PPG should contact the HE liaison at the PPG to determine the referral process for health education.

Community Outreach
The HE Department participates in health fairs and community events to provide and distribute brochures and information in order to promote personal health awareness and appropriate health behavior change among Care1st Members and other Members of the community.

Health Education Materials
A variety of brochures and handouts are made available to providers at no cost. All materials selected are culturally sensitive and linguistically appropriate (refer to Section X VII Cultural and Linguistic Appropriate Services for definitions), and do not exceed the 6th grade reading level as required by the Department of Health Care Services (DHCS).

Ordering Health Education Materials
The HE Department has a variety of materials in English, Spanish, and other threshold languages available to Members and providers. Materials in languages other than English are also reviewed for cultural sensitivity and linguistic appropriateness for the target population. Materials are also available in alternative formats. Please go to Care1st Website at https://www.care1st.com/ca/members/health-education/health-education-materials.asp to download materials. If you need materials in alternative formats, call the HE department.
For providers contracted with a PPG
Please contact the health education liaison at your affiliated PPG to order health education materials.

For providers contracted directly with Care1st
Please call the Care1st HE Department to request a materials order form.

Member Resources
The HE Department informs Members of available health education services through the Care1st Member newsletter, provider referrals, Member service lines, targeted mailings and community outreach events. The Member newsletter is mailed to each Member household and includes brief articles on a variety of health topics as well as information on Care1st health education programs. Members may call the HE Department to request HE brochures or information on health education classes, and/or other interventions. Access to an over-the-phone interpreter service is also available for Members requiring interpretation.

11.2.2: Mandated Health Education Topics

The following health related topics are those mandated by the CA DHCS:
- Age Specific Anticipatory Guidance
- Asthma
- Breastfeeding
- Complementary and Alternative Medicine
- Diabetes
- Exercise/Physical Activity
- Family Planning
- HIV/STD Prevention
- Hypertension
- Immunizations
- Injury Prevention (intentional & unintentional)
- Nutrition
- Obesiy
- Parenting
- Perinatal
- Substance Abuse
- Tobacco Prevention and Cessation

The mandated health education topics will be provided to all Members by the following methods:
- Displaying health education materials in PCP/PPG office;
- Sending health education materials to the Member’s home;
- Providing health education classes;
- Providing Member newsletters;
- Providing outreach activities;
- Referring to health education community services; and
- Providing 24-hour nurse availability.
11.2.3: Selection of Health Education Materials

Care1st health education material standards represent the needs of the Care1st member population. All materials selected are culturally sensitive and linguistically appropriate and are less than 6th grade reading level. A Readability and Suitability Checklist is completed for all materials. This form identifies the reviewed material’s reading level, medical accuracy and cultural and linguistic appropriateness. It also includes a review of the material’s content and layout. These materials and their corresponding Readability and Suitability Checklist are kept on file for review for audit purposes.

- Culturally Appropriate: Represents the member population’s ethnic group, practices and behaviors based on their cultural background. Understanding of the members’ cultural background is a key factor in providing quality and appropriate delivery of health education.

- Linguistically Appropriate: Represents all appropriate languages based on member population in the provider office. Selection of translation methods plays a critical role in communicating needs. Patient rights mandate that patients receive understandable information on illness, injuries, etc. Proper translation of English language material ensures that these rights are not violated.

Methods of Testing Reading Levels of Health Education Material
All member health education materials must be reviewed and tested using an approved tool. The Fry Readability Formula is based on the assessment of three 100-word passages from an article. The average number of syllables and average number of sentences per 100 words are plotted on a grade level graph to determine the approximate grade level. This method will be used for most materials distributed from Care1st.

Health Education Material Standards
Care1st Health Plan is highly committed to the delivery of quality health promotion and educational materials. Before materials are purchased or created for the member population, they are carefully selected and screened. A Readability and Suitability Checklist is completed for each material. In addition to the reading level methods listed above, standards for health education materials are based on the following:

- Content/Style
- Layout/Appearance
- Visuals
- Cultural Competency
- Field Testing (if applicable)
- Medical Accuracy

11.2.4: Provider Education

The Health Education department coordinates provider education specific to Health Education. This includes providing materials on all state mandated health topics, cultural linguistic requirements, and effective techniques in patient education and communication. This is done via provider in-service education, blast faxes as well as presenting a provider health education packet during provider site visits. The provider health education packets include information on health education and culture and linguistic requirements from DHCS, upcoming provider education programs, and health education materials.
The Health Education Department also educates providers on the findings from Group Needs Assessments.

Health Education information is also disseminated via provider meetings (i.e. IPA Joint Operations Committees, IPA Forums, and Medical Services Committee Meetings), provider newsletters, and special mailings.

All other operational provider information is the responsibility of the appropriate Care1st department. Because many provider issues overlap with health education, the Health Education Department is readily available to assist these areas in the provision of provider educational services.

11.3: Member Education Contractual Requirement

11.3.1: Provider’s Responsibility to Health Education

Pursuant to the contractual agreement under the Department of Health Care Services (DHCS), Member education must include the following:

- Promotion of preventive services, education and counseling.
- Promotion of appropriate use of Medi-Cal managed care plan services.
- Education of the availability of local social healthcare programs.

The provider is responsible for providing culturally sensitive and linguistically appropriate health education, prevention, and counseling services to the Member population based on their needs (See Appendix 14: Health Education State Requirements for Providers). Providers are responsible for implementing the Staying Healthy Assessment Tool. (See specifics under 11.4 of this section) Providers are strongly encouraged to guide their patients to take increased responsibility for their personal health. The Care1st HE Department is responsible for providing all state mandated health education materials and associated services to Members via contracted providers. Also, 24-hour free interpretation services are available to providers with LEP patients needing interpreter services.

The provider is responsible for promoting breastfeeding to his or her patients. Research shows that breastfeeding brings many benefits to both the infant and mother. These benefits include health, nutritional, immunologic, developmental, economic and environmental.

Additionally, providers should not distribute samples or materials with formula company logos on them to their patients, as per MMCD policy letter 98-10. Providers are encouraged to refer Medi-Cal patients to WIC services.

11.3.2: PPG Provision of Health Education

The HE Department assesses the effectiveness and quality of services offered through the PPG by an annual review of the PPG’s health education program. This assessment includes but is not limited to:

- Review of the HE program description and work plan
- Review of HE Policies and Procedures
- Review of the process outlining distribution of HE materials available to providers and Members
- Process outlining HE referrals from providers to PPG
- Review of provider education on all DHCS requirements
- Submission of quarterly HE utilization reports

11.3.3: Monitoring Provisions of Health Education

The HE Department assesses the effectiveness and quality of health education services offered by providers using the following methods:

- Audits of medical records at provider sites performed by Care1st or L.A. Care.
- Focused review studies conducted by the Quality Management Department, assessing data obtained from various sources (i.e. medical records, encounter data, provider and Member surveys, etc.).

Medical Record Documentation of Health Education Services  

Documentation of health education in medical records should include the following:

- Health education relative to the diagnosis and/or presenting problem.
- Brochures or other HE information given to the patient.
- Patient’s understanding of the education provided.
- Referral to HE services (i.e., classes, counseling, program, etc.).
- Documentation of the interpreter services by the patient).
- Signature and title of all staff providing HE to patient.

11.4: Staying Healthy Assessment Tool

All contracted Primary Care Providers must administer the SHA to Medi-Cal managed care members. The goal of the tool is to identify high-risk behaviors of individual plan members, prioritize individual health education needs related to lifestyle, environment, cultural linguistic background, and to assist providers to initiate and document focused health education interventions, referral and follow-up. Contract Medical Groups and PCPs must ensure that the SHA is administered. The tools have been updated. There are nine separate age categories. The tools have been translated into twelve non-English languages. You can access the updated (dated 12/13) Staying Healthy tools at https://www.care1st.com/ca/providers/health-education/health-education-for-providers-medi-cal.asp

- Providers must distribute the SHA to new members within 120 days of enrollment as part of the IHA. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System that a member is eligible to receive benefits. Providers must distribute the SHA to current members who have not completed an updated SHA during the next preventive care office visit (e.g. well baby, well-child, well-woman exam), according to the SHA periodicity table.

- Providers must distribute the SHA to pediatric members 0-17 years of age during the first scheduled preventive care office visit upon reaching a new SHA age group. PCP’s must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.

- Providers must distribute the SHA to Adolescents (12-17 years) without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase the likelihood of obtaining accurate responses to sensitive questions. The PCP will determine the most appropriate age, based on discussion with the parent/guardian and the families’ ethnic/cultural background.
- Providers must distribute adult and senior assessments to patients 18 years and older. Although the adult assessment is intended for use by 18-55 year olds, the age at which the PCP should begin administering the senior assessment to a patient should be based on the patient’s health and medical status, and not exclusively on the patient’s age. The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

- Annual administration of the SHA is highly recommended (not required) for the adolescent and senior groups because behavioral risk factors change frequently during these years.

- The PCP must review the completed SHA with the member and initiate a discussion with the member regarding behavioral risks the member identified in the assessment. Clinic staff members may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.

- If the member refuses to complete the assessment, the refusal should be documented in the medical records.

The following will be continuous throughout the year:

- Provider training to assure appropriate implementation of the SHA.
- Distribution of the tool in English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Vietnamese, Hmong, Korean, Tagalog and Russian to all contracted PCPs (upon request or reorder). The tool will also be posted on the Care1st website.
- Evaluation of implementation efforts
- Monitoring will include:
  - QI chart audits
  - Encounter data

11.5: Program Resources

11.5.1: Health Education Staff

Health Education Director

The HE Director reports to the AVP of Medical Services, and works in conjunction with other Care1st departments in order to implement HE programs that are appropriate to identified needs of Members and providers. The HE Director is responsible for managing, developing, implementing, and evaluating the Member education and provider education programs. The HE Director oversees all program development and ensures that materials and programs are culturally sensitive and linguistically appropriate to the Member population.

The HE Director is responsible for the HE program and all related activities including, but not limited to:

- Development of the program and annual HE work plan
- Development of the HE policies and procedures
- Oversight, development, implementation, and evaluation of the provider, Member, and condition specific programs
- Oversight of evaluation and distribution of the culturally and linguistically appropriate Member education materials
- Meeting the requirements of the CA DHCS, DMHC, L.A. Care Health Plan and/or other regulatory agencies as appropriate

**Health Education Specialist**
The HE Specialist reports to the HE Director, and works in conjunction with the HE Director to implement health education programs appropriate to our Member and provider population. In addition, the HE Specialist plays a primary role in community outreach activities associated with marketing and provider relations as well as collaborates with outside agencies.

The HE Specialist assists in all aspects of program development and implementation as designated by the HE Director. The HE Specialist also assists the HE Director in the implementation/evaluation of employee health programs and materials.

**11.5.2: Departments in Collaboration with Health Education**

**Cultural and Linguistic Department**
The HE Department collaborates with the Cultural and Linguistic Department to develop and implement training sessions for providers and PPG’s. They also work together to ensure proper translation of health education materials into threshold languages.

**Quality Management Department**
The HE Department collaborates with the Quality Management Department in the implementation of HE programs and quality improvement initiatives.

**Member Services Department**
The Member Services Department serves as a liaison from the Member to the HE Department. The Member Services Department forwards to the HE Department Member inquiries regarding health education classes and materials.

**Provider Relations Department**
The Provider Relations Department works with the HE Department to help identify health education needs of the provider. In addition, the Provider Relations Department shares health education information and updates during provider education visits.

**Marketing and Community Outreach Department**
The Marketing and Community Outreach Department works with the HE Department to help identify health education needs of the provider. Additionally, the HE Department works with the Marketing and Community Outreach Department to implement monthly weight management classes at Care1st Health Plan’s Informational Resource Center.

**Utilization Management Department**
The HE Department works in collaboration with the Utilization Management Department to handle HE referrals that require authorization of services. The HE Department also assists the UM Department in locating hospital and community based HE services.
SECTION 12: PROVIDER NETWORK OPERATIONS

The Provider Network Operations Department is dedicated to educating, training, and ensuring all participating providers have a resource to voice any concern they may have.

The Provider Network Operations staff acts as a liaison between Care1st departments and the external provider network to promote positive communication, facilitate the exchange of information, and seek efficient resolution of provider issues. Please send all requests to your Provider Network Administrator and keep in mind that your Provider Network Administrator is your key contact and source of information.

The following resources are available to you and your staff:

- Provider Network Administrator
- Health Educator
- Quarterly Newsletters
- Joint Operation Committee (Participating Provider Group “PPG” and hospitals only)

We encourage you to make recommendations and suggestions to better serve our Members and to improve the processes within our organization through open discussions and meetings.

12.1: Provider Manual Distribution

Provider Manuals are distributed to all new PPGs, hospitals during Joint Operation Committee meetings and Care1st direct providers within 10 Business days of placing Provider on active status. Care1st will request and maintain documented receipt of all Provider Manuals distributed.

12.2: Provider Orientations

Orientations are conducted by the Provider Network Operations staff to educate new PPGs, hospitals and Care1st direct contracted providers on Plan operations, policies and procedures within ten (10) business days of placing a provider on active status.

Participating Provider Groups “PPG”
Care1st’s contracted PPGs are responsible for conducting provider training and orientation for its contracted providers within ten (10) days of contracting with the PPG regardless of their effective status with Care1st.

12.3: Joint Operation Committee Meetings (Participating Provider Group “PPG” & Hospitals Only)

Joint Operation Committee (JOC) meetings are conducted by the Provider Network Administrator at least annually or as needed to allow monitoring and oversight of delegated responsibilities, ensure effective problem resolution and maintain ongoing communication between Care1st and its contracted, PPGs, and Hospitals. Care1st will maintain documentation of attendees and issues discussed.
12.4: Provider Affiliations

Providers may become affiliated with Care1st through a contracted PPG or Affiliations are limited to five (5) affiliations regardless of line of business. Both PCPs and specialists must have hospital privileges at a Care1st contracted Hospital, unless alternative admitting arrangements are made.

12.5: PCP Enrollment Limits

A PCP may be assigned a maximum of 2,000 Members total. When a PCP reaches the enrollment limit the PCP’s panel is closed to new enrollment until the PCP’s Membership drops below the maximum level. State regulations require Care1st to ensure the network meets the following provider to Member ratios:

- Primary Care Physician: 1:2,000
- Mid-Level Provider: 1:1,000

A PCP can limit the growth of their enrollment by requesting to close their panel. When a provider closes their panel the provider is no longer open for the auto assignment default process or Member choice selection. Exceptions may be made for existing Members.

Additionally, Care1st has the capability of closing a provider’s panel if the provider experiences access issues or has failed a facility site review. The provider’s panel will re-open upon an approved corrective action plan (CAP).

12.6: Mid-Level Medical Practitioners

The use of Mid-Level Practitioners was designed to increase PCP Membership and Member access to primary care services. The number of potential assigned Members can be increased by 1,000 Members for each mid-level practitioner the PCP supervises to a maximum of 5,000 Members.

PCPs may supervise up to four (4) mid-level practitioners in any combination according to the following state regulated physician supervisor to mid-level provider ratios:

- Nurse Practitioner: 1:4
- Physician Assistant: 1:2
- Midwife: 1:3

The delegation of specified medical services to mid-level practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the mid-level practitioner.

12.7: Provider Network Additions (Participating Provider Group “PPG”)

As a PPG, it is recommended that the necessary information for the physicians and non-physicians available through the Group be submitted to Care1st upon notification from the listed providers below. Care1st maintains a database of the following types of providers participating through a PPG:

- Primary Care Physicians
- Specialist Physicians
• Hospitals
• Ancillary Providers

The addition of a PPG provider requires submission of individual hardcopy documentation to the Care1st Provider Network Operations Department.

1. Hardcopy documentation consists of:
   a. Front and signature pages of the executed agreement for each provider
   b. A comprehensive information sheet or credentialing application to include at a minimum:
      • Name
      • Professional Title
      • Office Address
      • Telephone & Fax Numbers
      • Office Hours
      • Provider Type (PCP/Specialty)
      • Specialty with Board Certification Status of Complete Internship/Residency Training
      • Languages Spoken by Provider and Staff
      • California Medical License Number and expiration date
      • DEA Number and expiration date
      • Tax Identification Number
      • National Provider Identifier (NPI)
      • Hospital Privileges
      • Initial Approved/Recredentialed Date
      • Birth Date
      • Medi-Cal ID
      • Gender
      • Ethnicity
   c. Other Care1st required documentation (for GP and OB/GYN PCPs only):
      • Care1st’s Addendum E (See Appendix 9). Attesting to practicing primary care medicine for the last five (5) years and indicate completion of at least one year stateside training in primary care medicine (Internal Medicine or Family Practice) or completion of at least one year of specialized training (not in primary care medicine) in United States and provide two letters of recommendation from other primary care physicians.
      • Two letters of recommendation from other PCPs if the GP or OB/GYN provider has not completed at least one (1) year of stateside primary care medicine training.
      • Current CHDP certification (for GP who wish to have pediatric Members assigned).

2. Providers must have staff privileges at a Care1st contracted hospital. (Please refer to the Care1st Provider Directory for a list of Care1st participating hospitals.)
   a. This requirement may be waived for primary care providers who utilize alternate admitting arrangements with another Care1st approved provider for hospital coverage. This arrangement must be documented and submitted with the PCP documentation.
   b. The hospital affiliation policy may also be waived for following specialty providers that typically do not require admitting privileges, such as allergy/immunology, dermatology, ophthalmology, and podiatry.
3. Providers submitted without required documentation, information or staff privileges at a Care1st contracted hospital will be unable to participate in the Care1st network.

12.8: Provider Network Changes

The provider network changes affected by policy number 70.5.4.4 include terminations, office relocations, leave of absences/vacation, enrollment status/restrictions and changes in PPG affiliation.

All provider changes require a minimum of 60-day advance written notification to the appointed Care1st Provider Network Administrator. Providers’ affiliated with Care1st through a PPG must send notification to the PPG in accordance with their contractual agreement.

12.8.1: PCP Terminations

The PPGs and/or Care1st direct providers shall send written notification for all provider withdrawals and terminations to their appointed Care1st Provider Network Administrator as soon as the Group is notified and at a minimum of 60 days in advance. The effective date of the change is the first of the month following the date of receipt. If a 60-day notification is not received in advance, the PCP/PPG is responsible for submitting a written coverage plan, if necessary. The Care1st Medical Director will review the coverage plan. If the plan is denied, Care1st will work with the PCP/PPG to determine an appropriate reassignment. Care1st cannot guarantee that Members will remain within the PCP/PPG due to Member choice.

Care1st retains the right to obligate the PCP/PPG to provide medical services for existing Members until the effective date of transfer.

Care1st Directly Contracted Physicians

1. If the terminating PCP practices under a group vendor contract, the Members will remain with the group.
2. If the terminating PCP practices under a solo vendor contract, the Members will be reassigned within the Care1st Provider Network.

Participating Provider Group “PPG”

1. If the terminating PCP practices in a FQHC, clinic or staff model, the Members will remain with the FQHC, clinic or staff model and will be transferred to an existing PCP.
2. If the terminating PCP is a solo practitioner provider and is currently affiliated with more than one PPG, the Members will be transferred to a PCP with the PPG that will cause least disruption to a) a hospital and/ or b) a specialist panel.
3. If the PCP is administratively terminated by Care1st Health Plan and/or PPG for reasons such as, but not limited to suspension of license, malpractice insurance, or Facility Site Review, the Members will remain within the PPG with an existing PCP at the PPG’s discretion.
4. When a PPG fails to designate an appropriate provider Members will be reassigned according to Care1st policy.
12.8.2: Office Relocation

Participating Provider Group “PPG” or Care1st direct providers shall send 60 day prior written notification for all office relocations to their appointed Provider Network Administrator. The PCP/PPG is responsible for submitting a coverage plan to Care1st, if necessary.

PCP that changes office locations will require a facility site review (FSR). The PCP’s panel will be closed to new Membership until the new location has successfully completed the FSR. Once the site is approved, the provider's address will be updated and Members will be transferred from the existing site to the new site. If the PCP moves outside of the former office’s geographic area, Care1st will coordinate with the PPG to reassign the Members to a new PCP within Care1st’s access standard of five (5) miles. In transferring Members, the provider’s location, specialty and language are taken into consideration. If the PPG is unable to meet this requirement, Members will be transferred to a provider in the geographic area of the former office location.

12.8.3: Provider Leave of Absence or Vacation

PCPs/PPGs must provide adequate coverage for providers on leave of absence or on vacation. PCPs/PPGs must submit a coverage plan to their appointed Care1st Provider Network Administrator for any absences greater than four (4) weeks. Absences over 90 days will require transfer of Members to another Care1st PCP.

12.8.4: Change in a Provider’s PPG Affiliation

PCPs may change their Care1st PPG affiliation by submitting written notification of the change request to the PPG that the PCP wishes to change from in accordance with the contractual agreement. A separate request is sent to Care1st along with a copy of the notification sent to the PPG.

Care1st Provider Network Administrators will request validation of this information with the PPG the PCP wishes to change from in writing via Certified Mail. If no response is received from the PPG, Care1st will process the request and the PPG will be notified of the effective date of the change. The current PPG will be financially responsible for services until the effective date of the transfer.

12.8.5: Provider Demographic Updates

A. Network Changes

1. Notice of Network Changes. MEDICAL GROUP/IPA shall provide notice to Plan of any changes regarding MEDICAL GROUP/IPA’s network (“Network Changes”), including but not limited to: (i) primary care physician (“PCP”) and specialist (“SPEC”) additions, terminations, or demographic changes; (ii) ancillary provider terminations or changes; (iii) MEDICAL GROUP/IPA acquisitions of provider practices, sites, clinics, IPAs, or medical groups; (iv) network panel or product participation changes (closed or open panels); and (v) block transfer of MEDICAL GROUP/IPA membership (“Network Change Notice”) within five business days.

   - Information to be provided, include and not limited to:
   - Name
   - Practice location(s) and contact information
   - California license number,
- National Provider Identification number,
- Area of specialty, including board certification, if any
- The provider's office email address, if available
- For physicians and surgeons, the provider group and admitting privileges, if any, at hospitals contracted with the Plan
- Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers as defined in Health and Safety Code Section 1374.73, nurse midwives, and dentists.

2. Providers can promptly verify or submit changes to the information listed in the directories through the following:
   a. By telephone (800) 605-2556
   b. E-mail at Demographicupdates@care1st.com
   c. Completing an online interface form for providers to submit verification
      i. requested changes will generate an acknowledgement of receipt from the Plan.

B. Additional Information. If Plan believes that MEDICAL GROUP/IPA’s Network Change Notice does not contain all of the necessary information required to process the change, then Plan shall notify MEDICAL GROUP/IPA in writing promptly, but in any event, no longer than five (5) business days, and will explain and identify the additional information required to process the change.

ROSTER VALIDATION/VERIFICATION

1. Processing Time. MEDICAL GROUP/IPA shall respond to network roster verification requests from Plan within 30 business days of receiving a written notice of request.

2. Confirmation of Receipt and Validation. MEDICAL GROUP/IPA shall confirm receipt of the network roster validation request and complete validation of the network roster (all required data elements in the roster is current and accurate); or update the information required to be in the directory or directories within 30 business days of confirmation of receipt and return the corrected roster to the plan.

3. Attestation Requirement: If MEDICAL GROUP/IPA does not attest to the network validation or an update is not received from the MEDICAL GROUP/IPA within 30 business days, Plan shall verify whether the information is correct or requires updates within 15 business days. Plan shall document the receipt and outcome of each attempt to verify the information. If Plan is unable to verify or update the information, a provider notification informing the provider that in 10 business days the provider will be removed from the provider directory(ies) at the next update of the provider directory.

4. Removal of Plan Provider from Directory: If no response to the each of the providers in the network validation list notice(s) is received, after the required 10 business day notice period, providers without responses shall be removed from the provider directory(ies) by the next required update; or if provider responds within the 10 business day notice period, plan provider will not be removed.
DELAYED PAYMENT/REIMBURSEMENT FOR NO RESPONSE OR DELAYED RESPONSE TO MONTHLY VALIDATION REQUEST

A. Delayed Payment/Reimbursement:

Payment may be delayed or reimbursement owed to PROVIDER/MEDICAL GROUP if the PROVIDER/MEDICAL GROUP fails to respond to the Plan’s attempt to verify the Network Validation request. The plan may delay no more than fifty (50%) percent of the next scheduled capitation payment for up to one calendar month. For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

Plan will attempt to contact the provider by telephone, in writing, and electronically before delaying payment. The plan is not permitted to delay payment unless it has attempted to verify the provider or PROVIDER MEDICAL GROUP information, and only after the 10 business day notice period as described below.

1) Notification:
Plan must notify the provider or PROVIDER/MEDICAL GROUP within ten (10) business days before it seeks to delay payment or reimbursement.

2) Length of Payment Delay:
If payment or reimbursement is delayed, the full amount must be paid:
   a. No later than three (3) business days following the date in which Plan receives the information requires to be submitted by the provider or PROVIDER/MEDICAL GROUP; or
   b. At the end of the one-calendar month delay, if the provider or PROVIDER/MEDICAL GROUP fails to provide the required information.

3) Documentation:
If Plan delays payment, it must document each instance a payment or reimbursement was delayed and report this information to the appropriate regulator annually, along with the policies and procedures require to be reported.

4) Exceptions:
A PROVIDER/MEDICAL GROUP is not subject to the payment delay if all of the following occur:
   • Their provider does not respond to the PROVIDER/MEDICAL GROUP attempt to verify the provider’s information;
   • PROVIDER/MEDICAL GROUP documents its efforts to verify the provider’s information; and,
   • PROVIDER/MEDICAL GROUP reports to the plan that the provider should be deleted from the provider group in the plan’s directory(ies)

5) PROVIDER/MEDICAL GROUP termination
The plan may terminate a contract for two or more failures within a year of the provider or PROVIDER/MEDICAL GROUP to follow this Network Management Attachment.
PROVIDER PANEL STATUS CHANGES (Open or Close to new members)

PROVIDER/MEDICAL GROUP is required to inform the PLAN within five (5) business days when either of the following occur:

b. One or more of their providers is not accepting new patients; or,
c. One or more of their providers previously did not accept new patients and is currently accepting new patients
d. If the one or more of their providers was not accepting new patients is contacted by an enrollee/Plan Member or potential enrollee/Plan Member seeking to become a new patient, the Provider shall direct the enrollee/Plan Member or potential enrollee/Plan Member to our Member Service Department at 1-800-605-2556 (Los Angeles) or TTY 711 for assistance in selecting a new provider and to the Department of Managed Healthcare (DMHC) to report the inaccuracy by telephone at 1-888-466-2219 and/or 1-877-688-9891 (TDD) or by email www.hmohelp.ca.gov.

12.9: Participating Provider Group “PPG” Specialty Network Oversight

As part of Care1st’s pre-contractual process, a complete specialist network is required to cover the PPG’s service area. Care1st monitors the specialty network to identify and communicate any deficiencies to the PPG. The PPG is responsible for obtaining specialist contracts to correct these deficiencies. If the PPG is unable to correct the deficiency, the PPG may make arrangements to utilize Care1st’s directly contracted specialists.

12.10: Changes in Management Service Organizations (PPG Only)

PPGs must provide a 90-day advance written notification of a change in management service organization (MSO) along with a copy of the executed contract between the PPG and the new MSO to Care1st’s Provider Network Operations Director.

The new MSO must meet Care1st Health Plan’s pre-contractual criteria. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the PPG/MSO to comply will result in panel closure of all providers.

12.11: Provider Grievances

See Section VI Grievances and Appeals, subsection 6.4 Provider Disputes.

12.12: Provider Directory

The Care1st provider directory is printed on an annual basis. The directory is solely used as a Member handbook referencing participation to primary care physicians, hospitals, vision providers, and pharmacies. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted PPG and/or Care1st Provider Network Administrator. Providers may also review their information on the Care1st website at www.care1st.com. Care1st is committed to ensuring the integrity of the directory.

12.13: Prohibition of Billing Members

Each provider agrees that in no event including, but not limited to, nonpayment by the
Plan, the Plan's insolvency or the Plan's breach of this agreement shall any Plan Member be liable for any sums owed by the Plan.

A provider or its agent, trustee, assignee, or any subcontractor rendering covered medical services to Plan Members may not bill, charge, collect a deposit or other sum; or seek compensation, remuneration or reimbursement from, or maintain any action at law or have any other recourse against, or make any surcharge upon, a Plan Member or other person acting on a Plan Member’s behalf to collect sums owed by Plan.

Should Care1st receive notice of any surcharge upon a Plan Member, the Plan shall take appropriate action including but not limited to terminating the provider agreement for cause. Care1st will require that the provider give the Plan Member with an immediate refund of such surcharge.

SECTION 13: MARKETING - MEDI-CAL

13.1: Introduction

Marketing is critical to the success of Care1st and plays a vital role in:

- Creating awareness.
- Building credibility to achieve enrollment growth and retention.
- Educating Members about managed care.

Care1st providers and staff are in a position to greatly influence the choices beneficiaries/patients make regarding their Medi-Cal managed health care. Providers’ may encounter patients who request guidance in choosing a plan and completing an enrollment form. Providers may assist patients with the completion of the enrollment form when patients bring the form to the provider's office. HOWEVER, PROVIDERS ARE NOT ALLOWED TO HAVE BLANK, PARTIALLY COMPLETED OR COMPLETED HCO FORMS IN THEIR OFFICES FOR PATIENT SIGNATURE. NOR ARE PROVIDERS ALLOWED TO MAIL COMPLETED ENROLLMENT FORMS FOR PATIENTS. The marketing of managed care services to Medi-Cal beneficiaries is strictly regulated and monitored by Care1st and the State Department of Health Services (SDHS); therefore, Care1st and its providers must adhere to all regulatory guidelines.

13.2: Prohibited Conduct

Prohibited conduct includes but is not limited to:

1. False or misleading claims or representations that include, for example:
   a. A specific health plan is recommended or endorsed by any state or county agency.
   b. The state or county recommends that a Medi-Cal beneficiary enroll in a specific health plan.
   c. A Medi-Cal beneficiary will lose their Medi-Cal benefits or other welfare benefits if he/she does not enroll.
   d. Any representation that office staff is an employee(s) of the state or county.
2. The offering or giving of any form of compensation, reward or loan to induce enrollment.
3. Making use of any list of Medi-Cal beneficiary names or information obtained
originally from confidential state or county data sources.

4. Providing confidential beneficiary information or data sources to health plans or other third party entities for enrollment purposes.

5. Marketing practices that discriminate against prospective Members based on marital status, religion, age, sex, national origin, language or medical condition (e.g., pregnancy, disability, etc.).

6. Engaging in any Medi-Cal marketing activity on state or county premises or any other location not authorized in Care1st’s marketing plan or by SDHS.

Care1st is responsible for monitoring marketing activities of its providers when such activity relates to Care1st and Medi-Cal. Providers must receive approval on all marketing materials containing the Care1st name and logo prior to use (See also Appendix 19: Notification to Providers – Marketing Restriction and Necessary Approvals).

Providers should submit copies of such marketing materials with the appropriate form (See Appendix 20: Marketing Materials-Request to Distribute Form) to the appropriately identified Care1st contact for review and signature of approval.

In addition to monitoring provider marketing material development, usage and distribution, Care1st shall continuously and closely monitor provider outreach efforts.

Primary care physicians may NOT:

1. Coerce, threaten or intimidate patients into making a particular health plan or doctor selection.

2. Influence patients to change health plan Membership based on financial gain to the PCP.

3. Tell patients that they could lose their Medi-Cal health benefits if they do not choose a particular health plan.

4. Make any reference to competing health plans (e.g., comparing plans in a positive or negative manner) for purposes of encouraging or influencing a patient to enroll or disenroll from a particular health plan based on the PCP’s financial interest.

5. Mail complete enrollment forms to HCO on behalf of patients.

6. Photocopy sample enrollment forms with the health plan and PCP names filled in for distribution to patients or to fill in the health plan and PCP names on blank enrollment forms for patients to sign and mail.

7. Use photocopied blank forms or plain-printed enrollment forms. (Only SDHS-supplied forms will be accepted).

8. Have health plan marketers stationed and enrolling in or outside the PCP office.

9. Allow PCP staff to receive any remuneration for marketing or enrolling beneficiaries.

13.3: Method for Members to Change Health Plans and Doctors

1. If the patient is a Member on the Commercial Plan side (i.e., Health Net, Molina,) or on regular Medi-Cal and wishes to enroll with Care1st (i.e., via Local Plan/L.A. Care Health Plan), he/she must complete an HCO Enrollment Form which can be mailed directly to them when they contact and request it from Care1st.

2. If the patient is already a local plan Member with Blue Cross, Community Health Plan or Kaiser, he/she must call L.A. Care and request a Plan Partner Transfer to Care1st Health Plan.

3. If the patient is already a Care1st Health Plan Member and wishes to select a different PCP, he/she must call Care1st and request a PCP change.

13.4: Monitoring Provider Marketing Material Development/Usage/Activity
Guidelines

When using the Care1st name/logo:

1. Providers must submit one (1) set of materials to Care1st for review and approval prior to use:
   a. If materials are general in nature, and if the provider contracts with more than one health plan, only one (1) set must be submitted to a health plan.
   b. If the materials contain the names or logos of more than one health plan, the contracted provider must submit a set of materials to each health plan mentioned for review and approval.
2. Submitted materials must contain the actual tight clear legible copy. Rough ideas are unacceptable and will not be reviewed.
3. No marketing materials are to be used and/or activities done without prior consent from Care1st Health Plan. This includes general advertising used to reach Medi-Cal beneficiaries, tactical advertising with the Care1st name and/or logo, and collateral/promotional items such as brochures, pamphlets, pens, etc.
SECTION 14 Claims

14.1 Claim Submission

Care1st Health Plan applies the appropriate regulatory requirements related to claims processing.

A. Care1st Health Plan accepts claims submitted electronically or using papers. Refer to Care1st website for updated list of electronic claims vendors. We encourage each provider to submit claims electronically as it can speed claims processing and avoid delays.

Paper claims must be submitted using the current versions of CMS-1450 (UB) and CMS-1500 forms. Paper claims and additional information such as medical records, daily summary charges and invoices must be submitted at the following address to avoid processing and payment delay:

Care1st Health Plan
Mail Stop CL001
601 Potrero Grande Dr.
Monterey Park, CA 91755

B. Providers must ensure all claims submitted to Care1st are complete and accurate. Complete claim means a claim or a portion there of, if separable, including attachments and supplemental information or documentation which provides “reasonably relevant information” as defined in Title 28 Section 1300.71 Claims Settlement Practices by section (a)(10), information necessary to determine payer liability as defined in section (a)(11); and

1. For emergency services – legible emergency department reports;
2. All required/mandatory fields in current CMS-1450 or current UB format adopted by the National Uniform Billing Committee
3. All required/mandatory fields in current CMS-1500 adopted by the National Uniform Claim Committee (NUCC).
4. Any Medi-Cal designated requirements such as Universal Product Number (UPN) for medical supplies or National Drug Codes (NDC) for pharmacy related claims.

If claims are being submitted electronically, claims must be HIPAA compliant and meet all requirements for EDI transactions.

C. Claim Filing Limits

1. Medi-Cal claims submissions must meet the time requirements based on 22 CCR § 51008 and 51008.5.
   i. Claims must be submitted within six (6) months after the month in which the service is rendered. Claims submitted beyond six months will be subject to payment reduction.
   ii. Claims submitted beyond the six (6) months filing period, maybe paid the full allowed amount if documentations supporting the reason for delay such as:
       a. Claims submitted to the wrong payer and proof of submission such as denial letter from the wrong payer is attached.
b. Failure of the patient or legal representative, due to deliberate concealment or physical or mental incapacity, to present identification as a Medi-Cal beneficiary. Delayed billing shall be submitted not later than 60 days after the date certified by the provider as the date the patient was first identified as a Medi-Cal beneficiary. The date certified by the provider as the date the patient was first identified shall not be later than one year after the month in which the service was rendered. Identification of a patient as a Medi-Cal beneficiary means presentation of any of the following for the month of service: Medi-Cal card and proof of eligibility label.

c. Legal proceeding has commenced in which the provider is attempting to obtain payment from a third party payer, the provider has one year to submit the bill after the month in which the service is rendered.

d. Circumstances beyond the control of the provider.

iii. Claims submitted beyond the six months timely filing period not meeting valid delay reasons and within twelve months after month of service will be paid reduced amount.

iv. Claims submitted after 12th month after month of service and not meeting valid delay reasons will be denied as untimely.

2. Payment reductions due to delay of submission:

i. Claims received in the 7th to 9th month after month of service are subject to a payment reduction of 25%;

ii. Claims received in the 10th to 12th month after month of service are subject to a payment reduction of 50%;

iii. Claims received after 12th month after month of service not meeting valid delay reasons are denied as untimely.

14.2: Claims Processing Overview

A. Care1st makes every effort to ensure claims that are Care1st financial responsibility are paid, denied or contested within 30 calendar days of receipt. At least 90% of claims that are Care1st financial responsibility to pay are processed within 30 calendar days of receipt or 95% within 45 working days.

- Receipt dates are based on when Care1st receives the claim the first time.

B. Misdirected Claims

- Claims that are financial responsibility of the Participating Provider Group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.

- Billing Providers receive notices from Care1st identifying the responsible payers.

C. Reimbursement Rates

- To be eligible for payment, the claim must be complete and accurate.

- Contracted providers are paid at contracted rate;

- Non-contracted providers are paid at Medi-Cal established rates.

D. Interest payments are applied to complete claims that are not paid within 45 working days. Interest is paid for the period of the time that the payment is late.
• Emergency services – the greater of $15 for each month period or 15% per annum; or
• All other complete claims - 15% per annum or daily rate of 0.000411
• Interest payments are not made for claims where additional information is received after the original claim payment or denial, claims denied due to untimely filing and later paid because evidence of timely prior filing to the incorrect payer is submitted or claim denied due to untimely filing is paid because information about a good cause for the delay is accepted.

E. Balance Billing
• Providers must not balance bill members for any covered/authorized services. Title 22, Section 51002 of the California Code of Regulations states “a provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program’s scope of benefits in addition to a claim submitted to the Medi-Cal program for that service.”

F. Overpayment Recovery
• Care1st notifies provider of service in writing within 365 days of payments when an overpayment is discovered. If the provider does not contest the overpayment within 30 working days of receipt of the notice of overpayment, Care1st will begin offsetting payments of future claims equivalent to the overpayment amount.

G. Emergency claims
• Emergency claims are paid without prior authorization. Legible emergency department reports must be submitted when billing with ER level 5. ER level 5 are forwarded and reviewed by a physician. Physician reviewer determines whether or not service meets the requirements of emergency level 5.

H. Family Planning and Sensitive Services claims
• Claims for family planning and sensitive services (such as abortion, sexually transmitted diseases, HIV testing and counseling) do not require authorizations. Claims for sensitive services must be submitted with completed and signed DHCS Consent Form (PM 330 Form). Claims submitted without the form will be rejected and not be paid. Claims will be paid upon receipt of completed and signed PM330 form.

I. Inpatient hospital claims – Emergency admission
• In the event emergency admission is not authorized prior to member’s discharge, medical records must be submitted with the claims in order to determine medical necessity and avoid delay on payments. Claims with medical records are forwarded by Claims Department to Utilization Management (“UM”) to determine appropriate level of care and medical necessity. Upon completion of UM’s review, claims are processed and paid according to approved and authorized service.

J. Inpatient hospital claims – Elective admission
• All elective inpatient admissions require prior authorization. Prior authorization, bed type and days billed versus pre-certification are verified for inpatient claims. Claims are paid according to authorized level of care. Lack of prior authorization will result in payment denials.

K. Outpatient and other claims
• Ambulatory services, outpatient surgeries, ancillary and specialty services require prior authorization. Claims for these services without prior
authorization will result in payment denials.

14.3 Claims Status Inquiry

Providers may verify a claims status within 15 days of submission to Care1st by calling 1-800-605-2556 ext. 6130 or by checking the Care1st Health Plan web portal at www.care1st.com.

14.4: Claims Oversight and Monitoring – Participating Provider Groups

Care1st is dedicated to ensuring that claim functions delegated to Participating Provider Groups (“PPG”) are processed in accordance to regulatory requirements and contractual provisions. Care1st monitors PPG’s claims monthly claims processing timeliness and performs at the minimum annual claims audits. Care1st audits include review of PPG’s claims processing timeliness and accuracy.

SECTION 15: ACCOUNTING

15.1: Financial Ratio Analysis (PPG Only)

The Accounting Department is responsible for all facets of financial reporting and data generation, timely payment of capitation, and claims.

A financial audit will be conducted by Care1st auditors/accountants or Care1st consultants at least once a year.

PPG must submit year-end financial statements audited by an independent certified public accountant firm within 150 calendar days after the close of the fiscal year. On a quarterly basis, financial statements must be submitted to Care1st within 45 calendar days after the quarter ends.

PPG must estimate and document, on a quarterly basis, the organization’s liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate or other actuarial firm certified methodology and calculation.

PPG shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability).
- A positive tangible net equity as defined in regulation 1300.76(e).
- A cash to claims ratio as defined in regulation 1300.75(f).

15.2: Capitation Payment

The Capitation Department is responsible for sending the monthly capitation payments to its contracted PPGs. Capitation payments are made on the late of the 10th of each month or within 10 days from receipt of revenue from DHCS, LA Care or CMS.

Cap reports and eligibility reports are posted on a secured site or what is widely known as a File Transfer Protocol (“FTP”) server. These reports are available to the PPGs on the 10th of each month. Each PPG is responsible for coordinating with Care1st on how to
access the FTP server. For security measures, only one individual per PPG is issued a username and password to access this site. Any changes to the PPG’s contact person will require a new password or PGP key. PPGs must fill out a new PGP Key Form and submit to Care1st’s IT Department.

**SECTION 16: REGULATORY, COMPLIANCE AND ANTI-FRAUD**

**16.1: Anti-Fraud Policy & Program**

State and federal agencies have increased investigations based on health care fraud and abuse laws and enforcement against providers and enrollees who violate these laws. State and federal authorities have in recent times prosecuted numerous healthcare providers for various fraudulent practices, and also mandated health care service Plans to establish anti-fraud programs.

Following this mandate and resultant industry trends, Care1st has developed an aggressive Compliance and Anti-Fraud Program that includes voluntary disclosure to appropriate agencies of alleged cases of fraud and abuse. Provider cooperation is essential for the success of anti-fraud and abuse efforts and as a provider of health care services to Care1st Members, we would like to draw your attention to this program and request your cooperation.

Health care fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, Member, employee, supplier or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud.

There are two ways in which providers can cooperate in Care1st’s antifraud and abuse efforts:

1. Review practices related to services to Care1st Members in order to ensure that:
   a. Fee-for-service bills, if any, accurately describe the actual services performed and duplicate billing is avoided.
   b. Fee-for-service bills are not generated for capitated services.
   c. Members are not billed for covered services except for applicable co-payments.
   d. Co-payments, when applicable, are collected.
   e. Encounter data is reported accurately.
   f. Providers participate in Care1st utilization reviews to detect and review underutilization in a capitated environment.
   g. Care1st is informed about renewals and changes to all licenses and other credentials.
   h. Diagnoses and medical necessity are stated accurately, and accurate medical records are maintained.
   i. Full cooperation is demonstrated in transferring Members to Plan hospitals when medically appropriate.
   j. Any marketing efforts for enrollment as Care1st Members are within legal
limits.

2. Report any fraud and abuse or suspicious activity that may come to your attention to the Corporate Compliance Officer, Brooks Jones, of Care1st, or the Care1st Fraud Hotline at 1-877-837-6057, anonymously. Such instances include:
   a. Any illegal or improper solicitations or offers made to you by Care1st employees.
   b. Any illegal or improper solicitations or offers made to you regarding services to Care1st Members by other providers.
   c. Any attempts by patients to use a Medi-Cal card or Care1st identity cards belonging to another.

If the matter relates to Medi-Cal services, providers may also call the State of California, Department of Health Services Medi-Cal Fraud Hotline at 1-800-822-6222, e-mail to stopmedicalfraud@dhcs.ca.gov or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

For further questions on any potential fraud or any of the above issues, please contact the Corporate Compliance Officer, Brooks Jones, of Care1st Health Plan or e-mail at ComplianceSIU@care1st.com

SECTION 17: Culturally and Linguistically Appropriate Services (CLAS)

Purpose

To ensure that members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices, and preferred language, at every medical and non-medical encounter.

Procedure

Care1st Health Plan has adopted a CLAS Policy which is consistent with the National Standards for CLAS. Contracts between Care1st and PPGs, providers, hospitals and ancillary providers include a provision requiring them to participate in and comply with the performance standards, policies, procedures, and programs established from time to time by the local initiative, and Plan with respect to cultural and linguistic services including without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to the local initiative, and Plan. PPG will educate and communicate cultural and linguistic requirements, policies, procedures, and programs to their contracted providers on an on-going basis.

17.1: Care1st and Subcontractor’s Responsibility in the Provision of CLAS

Care1st and its subcontractors will fully comply with federal and state regulations, and DHCS, L.A. Care, and DMHC contract requirements relating to CLAS. Care1st does not delegate overall responsibility for culturally and linguistically appropriate services provided to plan Members, to PPGs and other providers.
CLAS areas that Care1st will be responsible for include:
1. Hiring a cultural and linguistic specialist responsible for CLAS.
2. Developing policies and procedures on CLAS related topics and requirements.
3. Identifying LEP members and communicating information to PPGs.
4. Updating language capability of physicians and clinic staff in the provider directory.
5. Informing members of their rights to: Interpreting services at no cost; not use family members or friends for interpreting; request an interpretation during discussions of medical information and explanations of plans of care; receive translated subscriber materials in threshold languages and in alternative format (i.e. Braille, audio and large print); and file a complaint or grievance if their cultural and/or linguistic needs are not met.
6. Contracting, coordinating, and paying for 24-hour/7-day telephonic, face-to-face, and American Sign Language (ASL) interpreting services when requested by PPGs, providers and members.
7. Developing protocol on how PPGs, providers, and clinic staff can access to free interpreting services through Care1st.
8. Developing and distributing resources, tools, and materials to PPG (i.e. Signs & Language ID cards, etc.).
9. Assessing and monitoring the effectiveness of linguistic services.
10. Contracting with a qualified translation company and translate written enrollment and informational materials in the threshold languages including: Evidence of Coverage (EOC) booklet, Provider Directory, Marketing Materials, Form Letters (denial letters, complaint and grievance materials, medical care reminders, and other legal documents). Then sharing these translated materials with the PPGs.
11. Conducting or subcontracting with qualified agencies or qualified facilitators to provide cultural competency and cultural diversity training courses for PPGs, providers and clinic staff.
12. Handling CLAS related grievances presented by members and PPGs.
13. Communicating and disseminating CLAS information and requirements, and cultural competency training opportunities to PPG on an on-going basis.
14. Monitoring and overseeing CLAS programs and compliance at PPG.

CLAS areas that the Participating Provider Group “PPG” will be responsible for include:
1. Designating a person responsible for CLAS and including responsibilities in job description. CLAS function is reflected in the organizational chart.
2. Having a method to identify Limited English Proficient (LEP) and hard-of-hearing or deaf members, and recording language preferences in their medical charts.
3. Updating Provider Directory to include language capability of providers and clinic staff.
4. Distributing signs to contracted providers and ensuring signs are posted at key points of contact to inform LEP members on the availability of free interpreting services.
5. Having appropriate telephone numbers and protocol to access interpreting services through the PPG or Health Plan.
6. Ensuring access to free interpreting services to LEP and hard-of-hearing or deaf members on a 24-hour/7-day basis.
7. Having a protocol to ensure that LEP members have access to interpreting services.
8. Educating and informing providers and clinic staff on how to access interpreting services.
9. Offering interpreting services and recording requests and refusals of interpreting
10. Providing and/or promoting cultural competency training to providers and clinic staff on CLAS.

11. Making member-informing materials available to LEP members in the threshold languages and ensuring quality translation and cultural and linguistic appropriateness of materials. Informing providers and clinic staff what materials are available at Care1st and how to get them, including materials for members with disabilities (e.g. Audio, Braille, Large Print, Materials Accessible On-line or Electronic Text Files).

12. Having procedures for handling CLAS related complaints made at clinic and PPGs sites and logging grievances with CLAS related issues.

13. Educating providers and clinic staff on the need to maintain a language capability form, certification of language proficiency or interpreting training, or similar documentation on file for bilingual staff, and staff providing interpreting services to members.

14. Educating providers and staff on the process, and availability of CLAS Community resources/agencies. A list of resources/agencies must be kept on file and can be obtained from Care1st.

15. Including CLAS related questions in “Provider Satisfaction Survey” and analyzing these results to identify patterns of CLAS related problems for corrective action (optional).

16. Having written policies and procedures covering the above subjects.

17. Documenting all education of CLAS information and its dissemination to contracted providers, as well as retaining copies of agendas, sign-in sheets, handouts/materials from provider cultural competency trainings attended.

17.2: Identification of Limited English Proficient (LEP) Members

Cultural competency and linguistic capability in managed care is critically important to allow Care1st to meet the needs of our culturally and linguistically diverse population. Language is a medium used in every step of the health care system, from making appointments to understanding instructions and asking questions.

Definitions:
“Limited English proficient (LEP) Members” are those members that cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

“Threshold Languages” are primary languages spoken by limited English proficient (LEP) population groups meeting a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiaries, whichever is lower. The Department of Health Care Services (“DHCS”) designates threshold languages in each county. Languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county. The following ten threshold languages have been identified by DHCS for Los Angeles County: English, Spanish, Chinese (Cantonese and Mandarin), Arabic, Armenian, Cambodian/Khmer, Korean, Farsi, Filipino/Tagalog, Vietnamese, and Russian. For San Diego GMC, the threshold languages are Arabic, English, Spanish, Tagalog & Vietnamese (Sources: http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-10_Enclosure1.pdf).

“Materials in Alternative Formats” are information and materials that can be used by members with disabilities (e.g. Audio, Braille, Large Print, Materials Accessible On-line or Electronic Text Files).
Electronic Text File). This includes health education materials and information on how to access health plan services.

**Care1st and Subcontractor responsibilities include:**

1. Care1st and PPGs will assess their member population’s language preference distributions to determine special needs and develop appropriate plans and services.

2. Care1st will provide a monthly new member eligibility list to PPGs and providers, which will include the primary language spoken by each member. PPGs and providers may use the eligibility list as a tool to track their LEP members.

3. Care1st and subcontractors will ensure members are routinely given opportunities to declare their need for culturally and linguistically appropriate services (e.g. when making an appointment, during Initial Health Assessment, on arrival, and in the exam room, etc.). Providers and clinic staff should record each member's primary language in their medical chart.

17.3: Access to Free Interpretation Services

It is the responsibility of Care1st Health Plan and its subcontractors to provide 24-hour & 7-day interpreting services including American Sign Language necessary to afford Limited English Proficient (LEP) members meaningful access to health care services, free of charge.

Care1st and its subcontractors must not require or suggest that LEP or hard-of-hearing or deaf members provide their own interpreters or use family members or friends as interpreters. The use of such persons may compromise the reliability of medical information and could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. **Minors should not interpret for adults.**

If, after being notified of the availability of interpreters, the member elects to have a family member or friend serve as an interpreter, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality.

Providers **MUST** document the request or refusal of language interpreting services by a LEP or hard-of-hearing or deaf member in medical record. This will be monitored during the facility site review and medical records review audit.

Providers and clinic staff shall follow Care1st protocol for requesting interpreting services to access telephonic, face-to-face interpreting services for LEP members and American Sign Language interpreting services for hard-of-hearing or deaf members.

Provider and bilingual staff providing interpreting services **MUST** maintain “Employee Language Skill Self-Assessment” form, certification of language proficiency or interpreting training on file. Bilingual staff providing medical interpreting services are encouraged to take a language proficiency test by a qualified agency (e.g., Cyracom, Berlitz, Pacific Interpreters) to determine if the candidate is qualified for medical interpreting. Bilingual staff with limited bilingual capabilities or who rate "POOR" on a language proficiency test should not provide interpreting services to members, and are required to use telephonic interpreting service or schedule a face-to-face interpreter for Care1st members. This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.
17.3.1: Posting of Signs at Key Medical and Non-medical Points of Contact

Signs informing members of their right to request free interpreting services should be clearly posted at each provider office (i.e. reception area, waiting room, exam room). Care1st Health Plan and PPGs are responsible for on-going distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural & Linguistic Department.

17.3.2: Proficiency of Interpreters

Care1st and its subcontractors will ensure that limited English proficient (LEP) and hard-of-hearing or deaf members have equal access to healthcare services through the provision of high quality interpreting and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the member’s spoken language 24 hours a day, seven (7) days per week. This includes American Sign Language (ASL) interpreting services.

Definitions:

“Medical interpreter” is a qualified bilingual staff Member, or contracted interpreter, who possesses conversational fluency in both the target language and English, and the ability to interpret medical terms (e.g. physiology, symptoms, common disease names and processes, clinical procedures, instructions and treatment plans and consent forms, etc.) in English and the target language of the LEP member.

“Non-medical interpreter” is a bilingual staff member, or contracted interpreter, with conversational fluency in both the target language and English and provides assistance to Members for administrative services (i.e. Member Orientation, scheduling appointments, non-clinical consent forms, Member Services).

Care1st and Subcontractor responsibilities include:

1. Care1st and its subcontractors will use the 24-hour/7-day over-the-phone interpreting service as a supplement to in-person interpretation. Rather than to rely solely on telephonic interpretation, Care1st and its subcontractors should mobilize qualified bilingual staff (including per diem interpreters), and/or contact a qualified interpreting agency, or language appropriate community based organization (CBO) to meet its interpreting needs. Subcontractors may rely on Care1st to access interpreting services by following the interpreting services protocol. (Please refer to Section 17.2.2a.)

2. Documentation of linguistic competency of individuals providing interpreting services must be on file at Care1st and its subcontractors’ sites. Documents may include:
   a. Written or oral assessment of bi-lingual skills.
   b. Documentation of years served as interpreter/translator.
   c. Successful completion of appropriate training programs.
   d. Confidentiality agreement or verification of confidentiality clause in contract signed by interpreter through agency.
   e. Other relevant documents signifying interpreter/translator capability (e.g. out of state certificate or license).

3. All per diem interpreters who perform interpreting duties must sign a confidentiality agreement with Care1st and its subcontractors. If contracted interpreters are used (for profit or CBO); verification of a signed confidentiality agreement must be on file at Care1st or the subcontractors’ sites.

4. Care1st will retain reports of all monitoring systems for interpreting services.
Monitoring can include a record of performance measures (i.e. written and/or oral testing of bilingual skills, attendance of relevant training programs and number of years interpreting, etc.); log of 24-hour telephonic interpreting services; analysis of grievances and complaint logs regarding communication or language problems; and interpreting service satisfaction questions included in the annual member and provider satisfaction survey.

5. PPG should document interpreting services utilization and maintain on file. Documentation may include a log of 24-hour telephonic interpreting services and/or number of over-the-phone and face-to-face interpreting services requests received from contracted providers.

6. Care1st and PPGs will update annually the language capability of affiliated providers and should list the language capability of providers in the network directories. Documentation must be available of who, either the provider or the clinic staff, has the capable language skills in order to effectively communicate this information by Care1st Member Services Representatives when this question is asked by members, the State or private credentialing agencies.

7. Care1st and its PPGs may subcontract with interpreting services agencies or a language appropriate CBO to determine the qualifications of its staff and interpreters used at provider sites.

17.4: Cultural Competency Training

Care1st Health Plan values diversity as an integral component of our organization and will promote the achievement of a culturally competent organization. Care1st views cultural competency as a responsibility at both the organizational and individual level. Care1st will foster an environment of respect and dignity in the treatment of each other and our members actively address the issue of barriers and disparities in health, using multiple strategies to reach providers, members, and staff.

Cultural competency training is designed to assist in the development and enhancement of interpersonal and intra-cultural skills to improve communication, access and services, and to more effectively serve our diverse membership including Seniors and People with disabilities (SPD).

Definitions:

“Culture” is a dynamic and evolving process comprised of a group’s learned patterns of behavior, values, norms and practices.

“Cultural competency” is an increased working knowledge of how behaviors, values, norms, practices, attitudes and beliefs of disease, preventative practices and treatment affect medical and non-medical encounters.

“Organizational cultural competency” is the ability of an organization to adapt to diversity and actively apply knowledge of culture and linguistic issues in serving our diverse membership for improved access and health outcomes.

Care1st and Subcontractor responsibilities include:

1. Care1st and its subcontractors will provide and/or promote opportunities for ongoing cultural competency and cultural diversity in-services and training to providers and staff.

2. Providers and staff are strongly encouraged and recommended to attend continuing cultural awareness/competency training programs that are offered
through L.A. Care, Care1st, PPGs, or other approved cultural awareness/competency training that move towards increasing organizational cultural competence.

3. Care1st and its subcontractors will retain copies, if available, of training curriculum, documentation of attendance, and schedule of training dates.

4. Care1st and its subcontractors will keep a list of cultural resource materials used during a training program on file.

17.5: Translation of Member-Informing and Health Education Materials

Written informing documents provide essential information to Members about access and usage of services. It is the responsibility of Care1st and the PPG to provide culturally and linguistically appropriate informing materials to Members in the threshold languages determined by the Department of Health Care Services (DHCS) and at a 6th grade reading level or below.

Member informing materials include but not limited to:
- Member Handbook
- Welcome packets
- Provider directory
- Access and availability of linguistic services
- Marketing materials
- Member surveys
- Member Newsletters
- Grievance and fair hearing process
- Form letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits.

Care1st and Subcontractor responsibilities include:
1. Care1st will send the Member Handbook and Welcome Packets in all threshold languages to LEP members as determined by monthly enrollment information. A tracking system will include documenting materials sent out to members in the different languages, types of materials and volume.
2. Care1st and its PPGs will have common letters (i.e., denials letter, informed consent, etc.) available in the language(s) that is commonly encountered based on Health Plan and PPG membership; or a system to provide members the opportunity to receive these documents in their preferred languages. Care1st Health Plan will forward to the PPG translated member-informing and available health education materials.
3. A qualified translator will complete all translations. Memorandum of Understanding (MOU) contracts and information on the agencies’ qualifications should be on file at health plan and PPGs.
4. Care1st and its PPGs will use, at the minimum, the following translation process to ensure quality translation of written Member informing materials and health education materials:
   a. The document needing translation will be submitted to the “qualified translator” for translation.
   Definition:
   “Qualified translator” is a person with a formal education in English, with the ability to read, write and understand the target language and with knowledge of, and experience with, the culture of the intended audience.
b. The translated draft will be proofread and edited by a separate qualified “translation editor/proofreader” who will make any necessary modifications. The review will focus on language flow, proper grammar and syntax, as well as ensuring that the text/phrases used are culturally appropriate. By using two different qualified translators (one to translate and the other to edit), the quality of the translation will be enhanced, the risk for error will be reduced, and the diversity within a culture will be considered.

Definition:
“Translation editor/proofreader” is a qualified translator other than the original “qualified translator” who did the word-processing, desktop publishing, or typesetting. Translation editors/proofreaders are responsible for ensuring that the translation conveys all source document information (i.e., grammar, flow, completeness, accuracy, punctuation, spelling, accents/diacritical marks, and typographical errors).

c. Once the translated document is submitted back from the translation company, it will be reviewed (within Care1st and the PPG’s ability) by a Medical and/or legal “professional reviewer” (e.g., Medical Director, Health Educator, etc.).

Definition:
“Professional reviewer” is a person with the ability to read and understand the target language and with knowledge of, and experience with, the culture of the intended audience as well as healthcare and topic of the document.

17.6: CLAS Related Grievances

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual’s participation in a federally funded program or activity may not be limited on the basis of LEP.

Therefore, a Care1st Medi-Cal member has the right to file a grievance if their cultural and/or linguistic needs are not met. Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office. (See Section VI Grievances and Appeals)

CLAS related grievances presented to Care1st will be handled by following these steps:
1. The Grievance Unit receives member and provider grievances and determines if the case has a CLAS related issue.
2. Care1st Health Plan’s Grievance Unit will resolve the issue with the member whenever possible.
3. If a member or provider grievance is classified or coded to have cultural and/or linguistic issues, the case will be forwarded to the Cultural and Linguistic Department.
4. The Cultural and Linguistic (C&L) specialist will investigate, follow-up, and resolve the issue with the provider and/or office staff involved with the case.
5. The Cultural and Linguistic specialist may collaborate with the Grievance Unit, Utilization Management, Quality Management, and Provider Network Operations (PNO) Departments, when necessary.
6. A copy of the actions taken will be kept on file with the Grievance Unit, PNO, and Cultural and Linguistic Departments.
7. The Cultural and Linguistic specialist will keep statistics of CLAS related grievances for trends, and statistical information will be reviewed by the CLAS manager.
17.7: Referrals to Culturally Appropriate Community Resources & Services

1. Care1st will distribute to providers the CLAS Community Resource Directory consisting of culturally and linguistically appropriate education and counseling services on topics such as domestic violence, counseling, cultural adaptation resource, elder care, interpreter resources, etc. during site visits, mailings, trainings, etc. Providers, clinic staff, and Members can also access the CLAS Community Directory from the Care1st website at www.care1st.com. A list can also be obtained by contacting the CLAS Department.

2. Providers should document all referrals in the member’s medical chart.

3. Care1st has a closed loop system in place to monitor those Members being referred to CLAS Community Services & Resource. The CLAS referral request form can be faxed to the Care1st CLAS Department. Once the member is referred, the provider will be informed of the member’s participation to the program in an effort to encourage further follow up.

4. Providers should maintain all information provided in the member’s medical record.

17.8: IPA/Medial Group Monitoring and Reporting Requirements

In order to assess the ability of a PPG to appropriately conduct CLAS, the PPG will be assessed prior to contracting and monitored at least annually thereafter by the Cultural and Linguistic Department. Care1st will also educate the providers of their direct responsibility in complying with federal regulations relating to CLAS and the provision of services to Limited English Proficient (LEP) and hard-of-hearing or deaf members.

1. The Care1st CLAS auditor will review, at a minimum, the following documents:
   - PPG policies and procedures on CLAS.
   - LEP identification and recording process.
   - Access to interpreting services including staff knowledge of handling interpreter needs.
   - Signs posted and other communication tools used to meet needs of LEP and hard-of-hearing or deaf members.
   - Recording requests/refusals for interpreting services in medical charts.
   - Documentation on promotion and/or attendance of CLAS Training for providers and staff.
   - Materials made available to LEP members in the threshold languages.
   - Provider satisfaction surveys conducted by the Participating Provider Group “PPG”.
   - Participating Provider Group “PPG” procedures for handling CLAS related complaints made at clinic and IPA sites.
   - Access to CLAS Community Resources & Agencies, the referral process for referring members to CLAS Community Agency & Resources, and how providers are informed of the need to record the referrals in the Member’s medical chart.
   - Documentation on dissemination/communication of CLAS related information to providers and staff.
(Some of the items above will be reviewed by Care1st Facility, Medical Records, QM/UM, and Health Education review staff whose reviews will be coordinated with the Cultural & Linguistic Department.)

2. The CLAS monitoring review tool will be used by the Care1st CLAS auditor. This monitoring tool will be provided to the PPG. Providers should document all referrals in the member’s medical chart.

3. Care1st has a closed loop system in place to monitor those Members being referred to CLAS Community Services & Resource. The CLAS referral request form can be faxed to the Care1st CLAS Department. Once the member is referred, the provider will be informed of the member’s participation to the program in an effort to encourage further follow up.

4. Providers should maintain all information provided in the member’s medical record.

5. To establish a PPG readiness for CLAS responsibilities, a PPG must meet the minimum standards by scoring at least 90% of total available points. Care1st will provide guidance and educational opportunities to the IPA/PPGs for those sections that do not meet section criteria(s) within 30 days of receiving notice of the review. Care1st Health Plan criteria for monitoring are based on Federal and State regulations and contract requirements on Culturally and Linguistically Appropriate Services (CLAS).

CARE1ST HEALTH PLAN
POLICY STATEMENT ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES
(CLAS)

Care1st Health Plan's mission is to be the most provider-oriented organization that will strive to continuously improve the quality of services rendered to its Members. Care1st is aware of the cultural and linguistic diversity of the population of Los Angeles County in California whom it serves. This community is one of the most, if not the most, culturally and linguistically diverse communities in the nation. Care1st firmly believes that high quality health care services can be provided to such a population only if such services are consciously designed to be culturally and linguistically appropriate.

In order to make its health care services culturally and linguistically appropriate, Care1st will adopt, to the fullest extent feasible, the National Standards on Culturally and Linguistically Appropriate Services established in the December 22, 2000 Final Report of the Office of Minority Health of the Department of Health and Human Services.

More specifically, it will be Care1st policy to:

1. Ensure that patients receive from all staff Members’ effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices, and preferred language.

2. Implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Ensure that staff at all levels and across all disciplines receives on-going education and training in culturally and linguistically appropriate service delivery.

4. Offer and provide language assistance services, including bilingual staff and interpreting services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Provide to patients, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.
6. Assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff.
7. Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups served by Care1st.
8. Conduct initial and on-going organizational self-assessments of CLAS-related activities and to encourage the integration of cultural and linguistic competence-related measures into internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
9. Ensure that data on the individual patient's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
10. Develop participatory and collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
11. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients.
12. Regularly make available to the public information about their progress and successful innovations in implementing the CLAS policies and to provide public notice in the community about the availability of this information.

Care1st will implement these policies by developing and implementing a written Strategic Plan for Culturally and Linguistically Appropriate Services that outlines these policies, operational goals and plans, and management accountability/oversight mechanisms.

Adopted this 13th day of August 2001 by the Board of Directors, the Governing Body of Care1st Health Plan.

S.Y. Wong, M.D.
Chairman of the Board
### SECTION 18: APPENDICES

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**GRIEVANCE FORM**

**MEMBER INFORMATION**

<table>
<thead>
<tr>
<th>Member Name (Last)</th>
<th>(First)</th>
<th>Birth Date: Mo. Day Yr.</th>
<th>Effective Date of Enrollment: Mo. Day Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street)</td>
<td>(City)</td>
<td>(State) (ZIP Code)</td>
<td></td>
</tr>
<tr>
<td>Telephone (Home)</td>
<td>(Work)</td>
<td></td>
<td>Number of Plan Members in Family, Including Member Grievance:</td>
</tr>
<tr>
<td>Name of person completing form, if different from member name</td>
<td></td>
<td>(Daytime Telephone)</td>
<td></td>
</tr>
</tbody>
</table>

**Where did the problem occur? (Name of Pharmacy, Hospital or Clinic)**

<table>
<thead>
<tr>
<th>Date of Incident: Mo. Day Yr.</th>
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</thead>
</table>

**Who was involved beside yourself? (Give names of involved staff, if possible.)**

Please describe what happened as specifically as possible: (Include the sequence of events and how the problem affected you.)

**See Attachment**

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against Care1st Health Plan, you should first telephone Care1st Health Plan at **1-800-605-2556** (TDD/TTY for the hearing impaired at **1-877-735-2929**) and use Care1st Health Plan’s grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Care1st Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department of Managed Health Care also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department’s Internet web site, [http://www.hmohelp.ca.gov](http://www.hmohelp.ca.gov), has complaint forms, IMR application forms, and instructions online.

**ACTION REQUESTED**

What would you like to see done about this problem?

**See Attachment**

<table>
<thead>
<tr>
<th>Grievance Received By:</th>
<th>In Person [ ]</th>
<th>By Telephone [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received:</td>
<td>Time Received</td>
<td></td>
</tr>
</tbody>
</table>

By Mail [ ]

Online [ ]

Member’s Signature (optional)

I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION REGARDING MY COMPLAINT.
**DESCRIBE WHAT HAPPENED:**

**ACTION REQUESTED:**

**OUTCOME/RESOLUTION:**

<table>
<thead>
<tr>
<th>(Complete only if an Expedited Appeal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member was acknowledged verbally and notified of the 72 hours appeal process: Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

| Grievance Received by: | Date Received: |
FORMULARIO PARA QUEJAS

INFORMACIÓN DEL MIEMBRO

<table>
<thead>
<tr>
<th>Apellido</th>
<th>Nombre</th>
<th>Fecha de nacimiento: Mes Día Año</th>
<th>Día efectivo de inscripción: Mes Día Año</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Domicilio</th>
<th>Ciudad</th>
<th>Estado</th>
<th>Zona postal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Teléfono de la casa</th>
<th>Teléfono del trabajo</th>
<th>Número de miembros inscritos incluyendo al demandante:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nombre de la persona completando el formulario (representante), si es diferente del miembro</th>
<th>Teléfono del representante</th>
</tr>
</thead>
</table>

¿Dónde ocurrió el problema? (Nombre de la farmacia, hospital o clínica) | Fecha del incidente: Mes Día Año |
|-----------------------------------------------------------------|---------------------------------|

Además de usted, mencione al personal que está implicado en su queja.

Favor de describir lo ocurrido tan específicamente sea posible (Incluya la secuencia de eventos y de que manera le afectó este problema. Use otra página si es necesario para describirlo con más detalle.)

Vea el documento adjunto

El Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) se encarga de regular los planes de salud. Si usted tiene alguna queja sobre Care1st Health Plan, debe llamar primero a Care1st Health Plan, al 1-800-605-2556, (para las personas con problemas auditivos, el teléfono TDD/TTY es 1-877-688-9891) y seguir el trámite de quejas del plan, antes de comunicarse con el DMHC. El trámite de quejas no anula ningún derecho o recurso legal que usted pueda tener a su disposición. Si necesita ayuda con una queja relacionada con una emergencia, o con una queja que Care1st Health Plan no haya resuelto satisfactoriamente, o si su queja lleva más de treinta (30) días sin ser resuelta, puede llamar a DMHC para pedir asistencia. Es posible que también pueda solicitar una Revisión Médica Independiente (IMR, por sus siglas en inglés). Si reúne los requisitos necesarios para la IMR, este proceso hará una revisión imparcial de las decisiones médicas tomadas por su plan de salud. El objetivo de la IMR es determinar la necesidad médica de un servicio o tratamiento propuesto y tomar decisiones sobre la cobertura de tratamientos de tipo experimental o de investigación y sobre disputas por el pago de servicios médicos urgentes o de emergencia. El DMHC cuenta también con un número de teléfono sin cargo (1-888-HMO-2219) y una línea TDD (1-877-688-9891) para las personas con problemas auditivos o del habla. La página web del DMHC, http://www.hmohelp.ca.gov, incluye formularios de queja, de solicitud de IMR e instrucciones en Internet.

ACCIÓN REQUERIDA

¿Qué medida(s) quisiera que se aplicaran a este problema?

Vea el documento adjunto

Queja recibida por: En persona | Firma (Opcional) | Fecha |
|------------------|-----------------|-------|

Fecha que se recibió: Hora que se recibió: En persona

En teléfono | Por teléfono |
|-------------|--------------|

Por correo | En línea |
|------------|----------|

TENGO ENTENDIDO QUE EL PLAN SE COMUNICARÁ CONMIGO DENTRO DE 30 DÍAS PARA DARME UN INFORME SOBRE SU INVESTIGACIÓN Y/O SU ACCIÓN CON RESPECTO A ESTE PROBLEMA.
**OUTCOME/RESOLUTION:**

<table>
<thead>
<tr>
<th>(Complete only if an Expedited Appeal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member was acknowledged verbally and notified of the 72 hours appeal process: Yes □ No □</td>
</tr>
</tbody>
</table>

| Grievance Received by: | Date Received: |
This Participating Independent Physician Association / Medical Group Delegation of Utilization Management Responsibilities Agreement (“Agreement”) is made and entered into this January 1, 2014 by and between CARE1ST HEALTH PLAN, a California corporation (“PLAN”), and <Medical Group>. (“Medical Group”).

IPA/Medical Group: ____________________________ Date: __________

<table>
<thead>
<tr>
<th>Delegated UM Activity</th>
<th>Delegated or Not Delegated</th>
<th>IPA/MG Responsibility</th>
<th>CARE1st Responsibility</th>
<th>Frequency of Reporting/Due Date</th>
<th>CARE 1st Process for Performance Evaluation</th>
<th>Corrective Action if IPA/MG Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. UM Program</td>
<td>✗ Yes ☐ No</td>
<td>- Develop, implement and submit to Care 1st a UM Plan outlining structure, accountability, scope, adoption of criteria, processes and other NCQA components of UM function.</td>
<td>- Monitor and oversee delegated function to ensure regulatory standards are met.</td>
<td>- Annually: UM Program UM Program Evaluation UM Workplan</td>
<td>- Pre-delegation audit utilizing annual audit tool - Annual audit utilizing annual audit tool</td>
<td>- Request Corrective Action Plan(s) (CAPs) - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation) - Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
<tr>
<td>II. Prospective, concurrent and retrospective review – outpatient specialty referrals</td>
<td>☐ Yes ☐ No</td>
<td>- Conduct certification following approved UM criteria that are based on medical evidence and member benefit package.</td>
<td>- Establish, publish and distribute performance standards and guidelines to providers.</td>
<td>- Monthly: Referral Logs - Quarterly: UM Quarterly Updates (Coalition Report)</td>
<td>- Pre-delegation audit utilizing annual audit tool - Annual audit utilizing annual audit tool - Focused reviews to measure areas of non-compliance as warranted</td>
<td>- Request Corrective Action Plan(s) (CAPs) - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation) - Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
<tr>
<td>Delegated UM Activity</td>
<td>Delegated or Not Delegated</td>
<td>IPA/MG Responsibility</td>
<td>Care1st Responsibility</td>
<td>Frequency of Reporting/Due Date</td>
<td>Care 1st Process for Performance Evaluation</td>
<td>Corrective Action if IPA/MG Fails to Meet Responsibilities</td>
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</tr>
<tr>
<td>III. A. (Hospitalization) Inpatient concurrent review (Shared Risk)</td>
<td>[ ] Shared responsibility</td>
<td>- IPA to forward and coordinate with Care1st UM Dept. any requests which encompasses an inpatient Hospital Stay</td>
<td>- Review and make decision on referral requests for inpatient stay. - Obtain concurrent review and forward to IPAs.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>- Request Corrective Action Plan(s) (CAPs) - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation) Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
<tr>
<td></td>
<td>[ ] Delegated responsibility</td>
<td>- Review &amp; make decision on inpatient referral requests</td>
<td>Not applicable</td>
<td>Concurrently</td>
<td>Concurrent Review Discharge Planning</td>
<td>- Not applicable</td>
</tr>
</tbody>
</table>

178
<table>
<thead>
<tr>
<th>Delegated UM Activity</th>
<th>Delegated or Not Delegated</th>
<th>IPA/MG Responsibility</th>
<th>Care1st Responsibility</th>
<th>Frequency of Reporting/Due Date</th>
<th>Care 1st Process for Performance Evaluation</th>
<th>Corrective Action if IPA/MG Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>III. B. (Hospitalization)</td>
<td>□ Yes □ No</td>
<td>- Review &amp; make decision on inpatient referral requests</td>
<td>- Not applicable</td>
<td>- Concurrently</td>
<td>- Concurrent Review - Discharge Planning</td>
<td>- Request Corrective Action Plan(s) (CAPs) - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation) - Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
<tr>
<td>IV. Prospective review – professional component of outpatient procedure referrals</td>
<td>□ Yes □ No</td>
<td>- Conduct certification following approved UM criteria that are based on medical evidence and member benefit package. - Contact Care 1st within 24 hours for tracking number for facility portion of referral (Shared Risk IPAs)</td>
<td>- Establish, publish and distribute performance standards and guidelines.</td>
<td>- Monthly: Referral Logs - Quarterly: UM Quarterly Updates (Coalition Report)</td>
<td>- Pre-delegation audit utilizing annual audit tool - Annual audit utilizing annual audit tool - Focused reviews to measure areas of non-compliance as warranted</td>
<td>- Request Corrective Action Plan(s) (CAPs) - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation) Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
<tr>
<td>V. Denial of Service – Medical Necessity/ Covered Benefits</td>
<td>□ Yes □ No</td>
<td>- Establish standards for denial of service, notification of denial and timeliness of denials. - Issue denials on the basis of clinical data reviewed or</td>
<td>- Monitor and oversee delegated functions to ensure standards are met.</td>
<td>- Monthly - Denial logs - Denial letters, including patient clinical</td>
<td>- Ongoing review of denial log/denial files - Monthly – utilizing Denial Focus Audit Tool and Annual Audit Tool</td>
<td>- Request Corrective Action Plan(s) for elements of non-compliance - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation)</td>
</tr>
<tr>
<td>Delegated UM Activity</td>
<td>Delegated or Not Delegated</td>
<td>IPA/MG Responsibility</td>
<td>Care1st Responsibility</td>
<td>Frequency of Reporting/Due Date</td>
<td>Care 1st Process for Performance Evaluation</td>
<td>Corrective Action if IPA/MG Fails to Meet Responsibilities</td>
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<tr>
<td>coverage limitations.</td>
<td></td>
<td>- Track denials to include all pertinent clinical information, involvement in denial</td>
<td>- Make determinations, alternative treatment plan and required appeal language.</td>
<td>- Quarterly: UM Quarterly Updates (Coalition Report)</td>
<td>- Annual audit utilizing annual audit tool</td>
<td>- Care 1st may conduct discretionary review to re-measure former areas of non-compliance</td>
</tr>
<tr>
<td>- Monitor denial activities through UM Committee.</td>
<td></td>
<td>- Monitor and oversee delegated functions (referral and coordination of services).</td>
<td>- Monthly Logs</td>
<td>- Quarterly: For LA County Only: Submit to Care 1st using LA Care’s Quarterly Supplemental Report form.</td>
<td>- Request Corrective Action Plan(s) for elements of non-compliance</td>
<td></td>
</tr>
<tr>
<td>• IPA to identify the following and report number of cases to Care 1st:</td>
<td>□ Yes □ No</td>
<td>- CCS</td>
<td>- Sanction per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation)</td>
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<td></td>
<td></td>
<td>- DOT for TB</td>
<td>- Termination of delegation if CAP objectives are not achieved within agreed timeframe.</td>
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<td></td>
<td></td>
<td>- ESRD</td>
<td></td>
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<td>- Termination of delegation if IPC objectives are not achieved within agreed timeframe.</td>
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<tr>
<td></td>
<td></td>
<td>- Waiver Programs (home care, HIV/AIDS, etc)</td>
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<td></td>
<td></td>
<td>- Transplants</td>
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<td></td>
<td>- Mental Health</td>
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<td>- Drug/Alcohol</td>
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<td>- Hospice</td>
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<td></td>
<td>- Custodial (Long Term Care)</td>
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<td>- EPSDT Supplemental Services</td>
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<td>- HCBS for DDS</td>
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</table>

VI. Linked Services (For Medical LOB Only)
<table>
<thead>
<tr>
<th>Delegated UM Activity</th>
<th>Delegated or Not Delegated</th>
<th>IPA/MG Responsibility</th>
<th>Care1st Responsibility</th>
<th>Frequency of Reporting/Due Date</th>
<th>Care 1st Process for Performance Evaluation</th>
<th>Corrective Action if IPA/MG Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>VII. A. Complex Case Management</td>
<td>☐ Yes ☐ No</td>
<td>- Not applicable</td>
<td>- Provide complex case management services to members meeting health plan criteria.</td>
<td>- Not applicable</td>
<td>- Not applicable</td>
<td>- Not applicable</td>
</tr>
<tr>
<td>VII. B. Basic Case Management</td>
<td>☐ Yes ☐ No</td>
<td>- IPA to provide basic case management to members not eligible for Care1st Complex Case Management and Disease Management Programs.</td>
<td>- Evaluate delegated function annually and/or as requested to ensure regulatory standards are met</td>
<td>- Monthly Logs</td>
<td>- Quarterly: For LA County Only: Submit to Care 1st using LA Care’s Quarterly Supplemental Report form.</td>
<td>- Request Corrective Action Plan(s) for elements of non-compliance - Sanctions per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation - Care 1st may conduct discretionary review to re-measure former areas of non-compliance - Termination of delegation if CAP objectives are not achieved within agreed timeframe.</td>
</tr>
<tr>
<td>Delegated UM Activity</td>
<td>Delegated or Not Delegated</td>
<td>IPA/MG Responsibility</td>
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</tr>
<tr>
<td>VIII. Communicating with members</td>
<td>[ ] Yes  [ ] No</td>
<td>- All member communication must be approved by Care 1st.</td>
<td>- Evidence of coverage of communication of regulatory and legislative changes that impact members, i.e., membership cards, welcome letters, newsletters, changes in network.</td>
<td>- Ongoing</td>
<td>- Ongoing</td>
<td>- Ongoing</td>
</tr>
<tr>
<td>IX. Member Appeals/ Grievances</td>
<td>[ ] Yes  [ ] No</td>
<td>- Evidence of communication stating requests for appeals are forwarded to Care 1st upon receipt or per Care 1st guidelines.</td>
<td>- Review and resolve all appeals and grievances within established timeframes.</td>
<td>- Ongoing</td>
<td>- Not applicable</td>
<td>- Not applicable</td>
</tr>
<tr>
<td>X. Concurrent review of treatment regimen already in place (inpatient/ongoing/ambulatory services)</td>
<td>[ ] Yes  [ ] No</td>
<td>- Continue the care until treating provider has been notified of group’s decision, and care plan has been agreed upon by the treating provider.</td>
<td>- Evaluate delegated function annually to ensure regulatory standards are met</td>
<td>- Concurrently</td>
<td>- Annual audit utilizing annual audit tool</td>
<td>- Request corrective action plans (CAPs) - Sanction per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation) - Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
<tr>
<td>XI. Urgent</td>
<td>[ ] Yes  [ ] No</td>
<td>- Review and make</td>
<td>- Establish,</td>
<td>- Concurrently</td>
<td>- Annual audit</td>
<td>- Request corrective</td>
</tr>
<tr>
<td>Delegated UM Activity</td>
<td>Delegated or Not Delegated</td>
<td>IPA/MG Responsibility</td>
<td>Care1st Responsibility</td>
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</tr>
<tr>
<td>Concurrent Review/Urgent Preservice Review</td>
<td></td>
<td></td>
<td>decision on referral requests for inpatient concurrent review.</td>
<td></td>
<td>开发利用工具</td>
<td>action plans (CAPs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Provide an initial oral notification of a denial decision to practitioners and members within 72 hours of an urgent preservice request and within 24 hours of an urgent concurrent request, as long as electronic or written notification is given no later than 3 calendar days after the oral notification.</td>
<td></td>
<td>开发利用工具</td>
<td>- Sanction per IPA’s delegation agreement (i.e., CAP deduction from monthly capitation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>publish and distribute performance standards and guidelines to providers.</td>
<td></td>
<td>开发利用工具</td>
<td>- Termination of UM delegation if CAP objectives are not achieved.</td>
</tr>
</tbody>
</table>

XII. Evaluation of New Technology

- Not applicable

- Care1st evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health procedures

- Not applicable

- Not applicable

- Not applicable
<table>
<thead>
<tr>
<th>Delegated UM Activity</th>
<th>Delegated or Not Delegated</th>
<th>IPA/MG Responsibility</th>
<th>Care1st Responsibility</th>
<th>Frequency of Reporting/Due Date</th>
<th>Care 1st Process for Performance Evaluation</th>
<th>Corrective Action if IPA/MG Fails to Meet Responsibilities</th>
</tr>
</thead>
</table>

Care1st will provide Clinical Performance data (i.e., HEDIS) and Member Experience data, upon request.

The Plan and Medical Group agree to accept the terms of the above.

**Care1st Health Plan**

(“Plan”) ("Medical Group")

By: ____________________________ By: ______________

Name: Anna Tran Name: __________

Title: CEO Title: __________

Date: __________ Date: __________
# APPENDIX 5

## MEDI-CAL MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)

### PATIENT INFORMATION:

<table>
<thead>
<tr>
<th>Language Spoken</th>
<th>Member Name:</th>
<th>DOB</th>
<th>Sex</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Address:</th>
<th>City:</th>
<th>Zip Code:</th>
<th>Phone ( )</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member ID#:</th>
<th>Effective Date:</th>
</tr>
</thead>
</table>

### SERVICE INFORMATION:

- Referral Requested By [ ]

<table>
<thead>
<tr>
<th>Date of Request:</th>
<th>Provider Name:</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

- Provider Address: [ ] Phone ( ) [ ]

- Provider Address: [ ] Fax ( ) [ ]

Please check the box for the MLTSS service(s) you want Care1st to coordinate.

For more information on these programs please call Care1st.

- Community Based Adult Services (CBAS)
- In-Home Support Services (IHSS)
- Multipurpose Senior Services Program (MSSP)

*Members can self refer by calling 888-944-4477

Long Term Custodial Care at a Skilled Nursing Facility (SNF) or Subacute Care Facility.

<table>
<thead>
<tr>
<th>Diagnosis/Findings:</th>
<th>ICD 9 codes(s):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reason for Request:</th>
</tr>
</thead>
</table>

To be completed by Care1st UM Department ONLY:

1) Active Medi-Cal Eligibility?  Yes  No  2) Assigned to Care1st?  Yes  No

Meets Criteria for Program Specific Authorization Request Form:  Yes  No

Reviewer Date Anticipated F/U Date:

This form does not constitute an authorization or a referral and is not subject to appeal.
Request for Release of Mental Health Care Information

(Practioner/Provider/Clinic) ____________________________________________
(Address) _________________________________________________________
(Phone) __________________________________________________________

1. PATIENT INFORMATION

Patient Last name  First name  Middle Initial  Date of birth  Former name, if any

2. REQUESTING ENTITY

(Name) ____________________________________________________________
(Address) _________________________________________________________
(Phone) __________________________________________________________

3. REASON FOR REQUEST
I request the following mental health information regarding the above patient’s outpatient treatment with a psychotherapist (as defined by Section 1010 of the California Evidence Code). Please be specific:

____________________________________________________________________

4. INTENDED USE OF INFORMATION
This information will be used for:
0 Further medical care  0 Payment of insurance claim  0 Other
0 Applying for insurance  0 Vocational rehab evaluation  ___________
0 Disability determination  0 Legal investigation

5. TIMEFRAME FOR USE AND DESTRUCTION
This information will be kept for:
0 30 days  0 60 days  0 90 days  0 Other – Specify ___________

Justification for timeframes longer than 90 days ___________________________

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY
All mental health information obtained will remain confidential and will be used solely for the purpose(s) described in #4 above and for no other purpose.

Signature of requestor _______________________________  Date __________

For Clinic Use Only:
Date Received_____________  I.D. provided  ____________
Date Released_____________  Processed by  ____________
Notification of Extension for Use of Mental Health Care Information

(Practitioner/Provider/Clinic) ________________________________

(Address) ________________________________

(Phone) ________________________________

PATIENT INFORMATION:

Patient’s last name __________________ First name _______ M.I. _______ Date of birth _______ Former name, if any

REQUESTING ENTITY

(Name) ________________________________

(Address) ________________________________

(Phone) ________________________________

INTENDED USE OF INFORMATION

This information will be used for:
0 Further medical care 0 Payment of insurance claim 0 Other—Specify:
0 Applying for insurance 0 Vocational rehab. evaluation
0 Legal investigation 0 Disability determination

EXTENSION TIMEFRAME REQUESTED AND DESTRUCTION

We request an extension for use of this information for:
0 30 days 0 60 days 0 90 days 0 Other—Specify:

Reason for Extension: ________________________________

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY

All mental health information obtained will remain confidential and will be used solely for the purpose(s) described in #3 above and for no other purpose.

Signature of requestor ___________________________ Date: ____________

For Clinic Use Only:

Date Received ______________ I.D. provided __________________

Date Released ______________ Processed by __________________

0 sent by mail _______ 0 picked up in person ___________
## Primary Care Practitioners Access to Care Standards (PCPS)

### ATTACHMENT A

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCPs Defined as:</strong></td>
<td>All practitioners providing primary care to our members which includes: General Practice, Internal Medicine, Family Practice, Pediatrics, NPs, PAs, select OB/GYNs and other specialists assigned member for primary care services.</td>
</tr>
<tr>
<td><strong>Emergency exam</strong></td>
<td><strong>Immediately</strong>&lt;br&gt;When a member calls the Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately (preferably directing the member to the Emergency Room or calling 911)&lt;br&gt;&lt;br&gt; If the condition is a non-life threatening emergency it is still preferable for the member to be given access to care immediately but no later than six (6) hours.</td>
</tr>
<tr>
<td><strong>Urgent PCP exam</strong></td>
<td><strong>Within 48 hours if no authorization is required</strong>&lt;br&gt;<strong>Within 96 hours if an authorization is required</strong>&lt;br&gt;When a member contacts the Practitioners office with an urgent medical condition we require the member to be seen within above mentioned timeframes. We strongly encourage the Practitioner to work the member in on a walk-in basis the same day. If a situation arises where a Practitioner is not available (i.e., the Practitioner is attending to an emergency or member calls late on a Friday), the member can be seen by a covering Practitioner or directed to an urgent care, covering office or emergency room.</td>
</tr>
<tr>
<td><strong>Sensitive Services</strong></td>
<td>Sensitive services must be made available to members <strong>preferably within 24 hours</strong> but not to exceed 48 hours of appointment request. Sensitive services are services related to:&lt;br&gt;☑️ Sexual Assault&lt;br&gt;☑️ Drug or alcohol abuse for children 12 years of age or older&lt;br&gt;☑️ Pregnancy&lt;br&gt;☑️ Family Planning&lt;br&gt;☑️ Sexually Transmitted Diseases, for children 12 years of age or older&lt;br&gt;☑️ Outpatient mental health treatment and counseling, for children 12 years of age or older who are mature enough to participate intelligently and where either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims, of incest or child abuse.&lt;br&gt;&lt;br&gt; Minors under 21 years of age may receive these services without parental consent. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.</td>
</tr>
<tr>
<td><strong>Routine PCP, Non-urgent exam</strong></td>
<td><strong>Within ten (10) business Days</strong>&lt;br&gt;When a member requests an appointment for a routine, non-urgent condition (i.e., routine follow-up of blood pressure, diabetes or other condition), they must be given an appointment within 10 business days.</td>
</tr>
<tr>
<td><strong>Initial prenatal visit to OB/GYN</strong></td>
<td><strong>Within fourteen (14) Calendar Days</strong>&lt;br&gt;Access to OB/GYN network Practitioners is available without prior authorization.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Standard</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Well child visits (For child under 2 years of age) | Within fourteen (14) Calendar Days  
When a parent of a member requests an appointment for a Well Child Visit they must be given the appointment within 14 calendar days, It is acceptable for the member to be scheduled for a covering Practitioner. |
| Preventive care and physical exam                  | Within thirty (30) Calendar Days                                         |
| Initial Health Assessments and behavioral health screenings if not completed by the County Mental Health Plan or MBHO contracted Behavioral Health Practitioner previously. | Within thirty (30) calendar days upon request (must be completed within 90 calendar days from when member becomes eligible)  
Care1st encourages that this assessment is completed within the first 90 days of enrollment. Care1st actively sends reminders to members within this period of time encouraging them to schedule this appointment.  
Care1st requires that a Staying Healthy Assessment form is utilized during this visit. |
| After-hours care                                   | Physicians are required by contract to provide 24 hours, 7 days a week coverage to members. The same standards of access and availability are required by physicians “on-call”. Care1st also has a 24 hour, 7 day a week nurse advice line available through a toll free phone line to support and assure compliance with coverage and access. Care1st also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. |
| Telephone Access                                  | Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member’s call. Urgent and emergent calls must be handled by the physician or his/her “on-call” coverage within 30 minutes. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Care1st also has a 24 hour, 7 day a week nurse advice line available through a toll free phone line to support and assure compliance with coverage and access. Care1st also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.  
Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room. |
| Waiting Time when contacting Care1st              | During normal business hours members will not wait more than 10 minutes to speak to a plan representative |
| Waiting Time in office                            | Thirty (30) minutes maximum after time of appointment                   |
| Access for Disabled Members                       | Care1st audits facilities as part of the Facility Site Review Process to ensure compliance with Title III of the Americans with Disabilities Act of 1990. |
| Seldom Used Specialty Services                    | Care1st will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary. |
| Failed Appointments (Patient fails to show for a scheduled appointment) | Failed appointments must be documented in the medical record the day of the missed appointment and the member must be contacted by mail or phone to reschedule within 48 hours. According to the Practitioner’s office’s written policy |
and procedure provisions for a case-by-case review of members with repeated failed appointments could result in referring the member to the Health Plan for case management. Practitioners’ offices are responsible for counseling such members.

CARE1ST HEALTH PLAN
Specialist Access to Care Standards
ATTACHMENT B

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCPs Defined as:</td>
<td>All practitioners providing specialty care to our members, which includes all specialty types listed in Care1st Specialist network listing including dental, chiropractic, acupuncture and vision providers.</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediately</td>
</tr>
<tr>
<td></td>
<td>When the Health Plan or Emergency Room contacts a specialty Practitioners office with an emergency medical condition they must arrange for the member to be seen immediately. If a member contacts the specialist’s office with an emergency need they must contact the PCP immediately or direct the member to the Emergency Room or call 911.</td>
</tr>
<tr>
<td>Urgent Specialist Exam (no auth</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>required)</td>
<td>When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is not required the member must be seen within 48 hours or sooner as appropriate from the time the member was referred.</td>
</tr>
<tr>
<td>Urgent Specialist Exam (auth</td>
<td>Within 96 hours</td>
</tr>
<tr>
<td>required)</td>
<td>When a Practitioner refers a member for an urgent care need to a specialist (i.e., fracture) and an authorization is required the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized.</td>
</tr>
<tr>
<td>Routine specialist visit, Non-</td>
<td>Within fifteen (15) Business Days</td>
</tr>
<tr>
<td>urgent exam</td>
<td></td>
</tr>
<tr>
<td>Routine Ancillary visit, Non-</td>
<td>Within fifteen (15) Calendar Days</td>
</tr>
<tr>
<td>urgent exam</td>
<td></td>
</tr>
<tr>
<td>After-hours care</td>
<td>Physicians are required by contract to provide 24 hours, 7 days a week coverage to members. Physicians “on-call” require the same standards of access and availability. Care1st also has a 24 hour, 7 day a week nurse advice line available through a toll free phone line to support and assure compliance with coverage and access. Care1st also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues.</td>
</tr>
<tr>
<td>Telephone Access</td>
<td>Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member’s call. The physician or his/her “on-call” coverage must handle urgent and emergent calls within thirty (30) minutes. Appropriately qualified staff can only provide clinical advice (e.g.: physician, physician assistant, nurse practitioner or registered nurse). Care1st also has a 24 hours, 7 day a week nurse advice line available through a toll free phone line to support and assure compliance with coverage and access. Care1st also has nurse on-call 24 hours a day, 7 days a week to support coordination of care issues. Our Member Services Department will keep an abandonment rate less than 5%.</td>
</tr>
</tbody>
</table>
Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.

### Waiting Time when contacting Care1st

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Time in office</td>
<td><strong>Thirty (30) minutes maximum</strong> after time of appointment</td>
</tr>
<tr>
<td>Failed Appointments  (Patient fails to show for a scheduled appointment)</td>
<td>Failed appointments must be documented in the medical record and the member’s primary care Practitioner must be notified within 24 hours of the missed appointment. The member must be contacted by mail or phone to reschedule. According to the Practitioner’s office’s written policy and procedure provisions for a case-by-case review of members with repeated failed appointments can result in referring the member to the Health Plan for case management. Practitioners’ offices are responsible for counseling such members.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Standard</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Life threatening/Emergency needs</td>
<td>Will be seen immediately</td>
</tr>
<tr>
<td>Non-Life threatening emergency needs</td>
<td>Will be seen within six (6) hours</td>
</tr>
<tr>
<td>Urgent needs exam</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine office visit, Non-urgent exam</td>
<td>Within ten (10) Business Days</td>
</tr>
<tr>
<td>Non-physician BH Provider: Routine office visit, Non-urgent exam</td>
<td>Within ten (10) Business Days</td>
</tr>
<tr>
<td>After-hours care</td>
<td>Behavioral Health services for Medi-Cal “Specialty Mental Health Services” and “Alcohol and Other Drug Programs” (AOD) are the responsibility of the appropriate County Mental Health Plan (MHP). Behavioral Health Services for Medi-Cal members with mild and moderate dysfunction outpatient services, and for all other lines of business are carved out to contracted MBHOs. The MBHOs each have 24 hour a day, 7 day a week coverage. Care1st also has RN’s on-call 24 hours a day, 7 days a week to coordinate and arrange behavioral health coverage to members.</td>
</tr>
<tr>
<td>Telephone Access</td>
<td>Access by telephone for screening and triage is available 24 hours a day 7 days a week, through our contracted MBHOs and the County MHPs, as appropriate. Care1st and its contracted MBHOs require access to a non-recorded voice within thirty (30) seconds and abandonment rate is not to exceed 5%. Care1st has RN’s on-call at all times to arrange behavioral health coverage to members. Any practitioner that has an answering machine or answering service must include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.</td>
</tr>
<tr>
<td>Standard for reaching a behavioral health professional</td>
<td>Care1st, through our contracted MBHOs is available to arrange immediate access to a behavioral health professional. The County MHPs also have 24/7 access lines.</td>
</tr>
</tbody>
</table>
Hours of Operation Parity
Attachment D

Medi-Cal Laws requires organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal manage care enrollee must be comparable to those for Medi-Cal fee-for service members.
Primary Care Experience Attestation

Addendum E

This Addendum is submitted to: Care 1st Health Plan.

Please indicate below the age of the patients for whom you have provided primary care services to in the last 5 years. In order for a category to apply, it must represent at least 20% of your average practice and you must be familiar with and routinely follow standard preventive services, such as CHDP and the American Academy of Pediatrics (AAP), both for pediatrics only, and the United States Preventive Task Force (USPTF). Please check all those that apply:

☐ Adults (16 years of age and older)
☐ Pediatrics (0 to 21 years of age) – Documentation of CHDP certification is required.
☐ If you desire age limitations different from above, please specify: __________

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with Care 1st Health Plan.

Physician’s Name: ____________________________________________

Physician’s Signature: ________________________________________

(Stamped signature is not acceptable)

Date: ______________
**APPENDIX 10**

**Care1st**

**Medication Prior Authorization Form**

Pharmacy Department Fax: (323) 889 6254 or (866-712-2731)

Instructions: This form is to be used by participating physicians and pharmacies to obtain a medication that is not on the Formulary or requires prior authorization. Please complete the form and fax it to the Care1st Health Plan Pharmacy Department. For any questions regarding the Care1st Formulary and/or prior authorization process, please call 1-877- RXCARE1 (1-877-792-2731).

<table>
<thead>
<tr>
<th>Patient Name: (required)</th>
<th>Patient ID#: (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Phone Number:</th>
<th>Patient Date of Birth:</th>
<th>Sex:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Pharmacy Name:</th>
<th>Pharmacy NABP Number: (optional)</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Phone Number:</th>
<th>Pharmacy Fax Number: (optional)</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Prescribing Physician’s Name: (required)</th>
<th>Specialty: (required)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>State License Number:</th>
<th>E-mail address: (optional)</th>
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<table>
<thead>
<tr>
<th>Phone Number: (required)</th>
<th>Fax Number: (required)</th>
</tr>
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<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Requested: (required)</th>
<th>Strength: (required)</th>
<th>Formulation:</th>
<th>Quantity:</th>
<th>Days Supply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis: (required)</th>
<th>Duration of Therapy:</th>
<th>Refills:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directions, sig or a copy of prescription: (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Medications: (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Medication(s) Tried and Failed: (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Justification: (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Requestor: (required)</th>
<th>Request Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONFIDENTIAL NOTICE**: This document and any attachments are confidential and may be protected by legal privilege. If we are not the intended recipient, or if you have received this information in error, please notify the original sender immediately by telephone or return this package, along with any attachments, to sender at the address provided below. Thank you for your cooperation.
# Health Education Referral Form

Complete sections A-C.  
FAX To: 323-889-5407

## A. Patient Information

Please verify patient's current address and phone number.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dob:</td>
<td>Sex: □M □F □</td>
</tr>
<tr>
<td>Language: □E □$ □Other:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>Zip code:</td>
</tr>
<tr>
<td>Phone number:</td>
<td></td>
</tr>
</tbody>
</table>

If patient is a minor, please provide name and language of parent/legal guardian.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Language: □E □$ □Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis (include ICD-9 code) / Notes:</td>
<td></td>
</tr>
</tbody>
</table>

## B. Service Requested

- □ Class  
- □ Support Group  
- □ One-to-one Counseling*  
- □ Health Education Material

*Referrals for one-to-one nutrition counseling with a RD should be sent to patient's IPA/Medical Group.

<table>
<thead>
<tr>
<th>□ Age-Specific Ant Guidance</th>
<th>□ Family Planning</th>
<th>□ Lead Poisoning</th>
<th>□ Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Asthma</td>
<td>□ HIV/STD Prevention</td>
<td>□ Nutrition</td>
<td>□ Tobacco Cessation</td>
</tr>
<tr>
<td>□ Breastfeeding</td>
<td>□ Hypertension</td>
<td>□ Parenting</td>
<td>□ Substance Abuse</td>
</tr>
<tr>
<td>□ Dental</td>
<td>□ Immunizations</td>
<td>□ Perinatal/Pregnancy</td>
<td>□ Other:</td>
</tr>
<tr>
<td>□ Diabetes</td>
<td>□ Injury Prevention</td>
<td>□ Physical Activity</td>
<td></td>
</tr>
</tbody>
</table>

## C. Provider Information

Provider name:  
Person completing referral (if other than provider):  
Phone number:  
Fax number:  

Care1st Health Education use only
<table>
<thead>
<tr>
<th>Referral Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider notification date:</td>
</tr>
</tbody>
</table>
PREVENTIVE HEALTH GUIDELINES (2013)

Please refer to the following sources for preventive health guidelines for your patients. You can access the websites listed below by visiting our website at http://www.care1st.com.

### Ages: 0-18 years*

**Recommendations for Preventive Pediatric Health Care.** American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Bright Futures Steering Committee, 2008


**Periodicity Schedule for Health Assessment Requirements by Age Groups**, CA Department of Health Care Services, Systems of Care Division, Children’s Medical Services Branch, Child Health and Disability Prevention Program (CHDP) May 2012

[http://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx](http://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx)

**Recommended Immunization Schedule for Persons Aged 0 Through 18 Years**, Centers for Disease Control and Prevention. Recommended Immunization Schedules for Persons Aged 0–18 Years—United States, 2013. MMWR 2013; 62 (Suppl 1):2-8

[http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html)

* Medi-Cal managed care providers are required to conduct all screenings required by CHDP, however, patients need to be seen according to the schedule of the AAP Recommendations for Preventive Pediatric Health Care

### Ages: 19-64 years

**Recommendations for Adults.** U.S. Preventive Services Task Force.

[http://www.uspreventiveservicestaskforce.org/adultrec.htm](http://www.uspreventiveservicestaskforce.org/adultrec.htm)


[http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html)

### Medicare Patients

**Quick Reference Information: Preventive Services**, Centers for Medicare & Medicaid Services, Department of Health & Human Services, USA, Medicare Learning Network, May 2012

HEALTH EDUCATION STATE REQUIREMENTS FOR PROVIDERS

Please review the following Department of Health Care Services (DHCS) requirements for health education. If you need clarification on any of the requirements, please call or e-mail the Health Education Department.

Health Education Services
Document referrals to health education services in your patient’s medical record. Health education services include classes, individual counseling and support groups.

Patient Education Materials
All health education materials you provide to your Medi-Cal patients need to be between 2nd and 6th grade reading level. Additionally, these materials need to be medically accurate, culturally sensitive and linguistically appropriate. The materials we provide you have been reviewed and meet these requirements.

Health topics and threshold languages mandated by California DHCS:

- Age Specific Anticipatory Guidance
- Hypertension
- Perinatal
- Asthma
- Immunization
- Physical Activity
- Breasftfeeding
- Injury Prevention
- Substance Abuse
- Complementary & Alternative Medicine
- Nutrition Prevention
- Tobacco Prevention and Cessation
- Family Planning
- Obesity
- Parenting
- HIV/STD Prevention

County Threshold Languages

<table>
<thead>
<tr>
<th></th>
<th>English</th>
<th>Arabic</th>
<th>Armenian</th>
<th>Chinese</th>
<th>Farsi</th>
<th>Khmer</th>
<th>Korean</th>
<th>Russian</th>
<th>Spanish</th>
<th>Tagalog</th>
<th>Vietnamese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>San Diego</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
</tbody>
</table>

Ordering Materials
To order materials, please call the Health Education department to request an order form. If you are contracted with Care1st through an IPA, please call your IPA Health Education Coordinator to order materials. You may also download materials from our website at http://www.care1st.com. All health education materials listed on the order form and posted on our website have been reviewed for reading level requirement, medical accuracy, and cultural and linguistics appropriateness. Materials are available in county threshold languages and in alternative formats.

Staying Healthy Assessment- UPDATE
DHCS recently released the new Staying Healthy Assessment (SHA) via Policy Letter 13-001, “Requirements for the Staying Healthy Assessment”. The new forms are dated 12/13. Forms are available nine age categories and 12 languages. The new SHA forms must be implemented by April 1, 2014. All PCPs are required to be trained on the implementation of the SHA. To access the mandatory training, please visit https://www.care1st.com/ca/providers/health-education/health-education-for-providers-medi-cal.asp. There you can also download SHA forms, a provider office instruction sheet and health education materials. To request the use of an alternative IHEBA or to notify us of electronic implementation of the SHA, call the health education department to request the appropriate forms. Remember, a few words of advice from you can have a significant impact on changing your patients’ high-risk behavior.

Breastfeeding Promotion
The American Academy of Pediatrics (AAP) supports breastfeeding as the optimal form of nutrition for infants. We encourage you to support this position by continuing to promote breastfeeding services to your patients. Also, please continue to refer your Medi-Cal patients to WIC.

Infant Formula Logos
Please do not distribute infant formula samples, educational materials or promotional materials with formula logos to Medi-Cal patients, as per MMCD Policy Letter 98-10.

Manual Breast Pumps
Breast pumps are available for breastfeeding patients. We encourage you to promote this benefit to your patients. For more information, please call the Utilization Management Department.
Current Date

Dear Provider Partner:

You and your patients (Care1st Members) are very important to us and we are here to assist you with any questions you may have regarding marketing to Medi-Cal Members and prospects as well as any questions you may have regarding Marketing regulations.

As our partner, we have provided you with helpful information regarding the Medi-Cal program and L.A. Care Health Plan regulatory guidelines for marketing to beneficiaries. This information can be found in Section 13 of your Care1st Provider Manual. Care1st shares L.A. Care’s strict adherence to all marketing regulations and will continuously monitor provider activities to ensure compliance.

We encourage you to communicate with your current and prospective Medi-Cal patients about the program, health needs assessments, the services you offer and your participation with Care1st Health Plan. When conducting such activities, please remember these important details:

**Marketing is defined as, but not limited to, radio spots, bus benches, brochures, flyers, posters, newspaper ads, health fairs, etc.**

1. Activities directed at Medi-Cal recipients and/or materials containing the word “Medi-Cal” and/or the Care1st name/logo must be pre-approved by Care1st before you can proceed with marketing your organization.
   a. Samples of the materials and/or activity plans should be submitted to the appropriately identified Care1st contact using the *Care1st Request to Distribute* form (See attached).
   b. Care1st will expeditiously review the materials/activity plans and send you a written response within ten (10) working days.

Should you have any questions, comments, concerns or wish to discuss the appropriateness of any marketing activity, please feel free to contact me (323) 889-6638.

We look forward to a long positive partnership with you and your staff

Care1st Health Plan Marketing Department

Enc.
cc: Provider Manual
MARKETING MATERIALS FORM

<table>
<thead>
<tr>
<th>REQUEST TO DISTRIBUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Providers</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Office Address:</td>
</tr>
<tr>
<td>City, State, ZIP</td>
</tr>
<tr>
<td>Phone #:</td>
</tr>
<tr>
<td>Fax #:</td>
</tr>
<tr>
<td>Contact Name:</td>
</tr>
</tbody>
</table>

This form is to be completed and submitted with marketing materials created for use in reaching Medi-Cal patients. Any use of the term “Medi-Cal” in affiliation with Care1st Health Plan (a Plan Partner of LA Care Health Plan) requires authorization and acknowledgement from the appropriately identified Care1st contact. The respective provider listed above is submitting this form seeking permission to distribute/conduct the following:

- [ ] Brochures (attached copy & layout)
- [ ] Flyers (attached copy & layout)
- [ ] Newspaper Ad (attached copy & layout)
- [ ] Radio spot (attached copy)
- [ ] Television Ad (attached script)
- [ ] Community Event/Health Fair (attached invitation/Event Flyer)
- [ ] OTHER (Please explain):

Care1st Health Plan – Marketing Department Use Only

<table>
<thead>
<tr>
<th>Date Request Received:</th>
<th>________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewer:</td>
<td>________________</td>
</tr>
<tr>
<td>Title:</td>
<td>________________</td>
</tr>
<tr>
<td>Date:</td>
<td>_______</td>
</tr>
</tbody>
</table>

D APPROVED   D PENDING CHANGES   D DENIED

Comments: ________________________________

__________________________________________
Request/Refusal Form for Interpretive Services

Patient name: ____________________________________________________________

Primary language: _______________________________________________________

Yes, I am requesting interpretive services.
Language(s): ____________________________________________________________

No, I prefer to use my family or friend as an interpreter.

No, I do not require interpretive services.

Not Applicable.

Please explain: ___________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

_________________________________  ________________________________
Patient Signature                      Date
Please place this form in the patient’s medical record.

Request/Refusal - English
Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente: ____________________________________________

Idioma preferido: ____________________________________________

Si, necesito servicios de intérprete.
   Idioma(s): ____________________________________________

No, Prefiero utilizar un familiar o amistad como intérprete.

No, requiero servicios de intérprete.

No, me corresponde.

Por favor explique: ____________________________________________

_____________________________________________________________

_________________________  ________________________________
Firma del paciente          Fecha

Please place this form in the patient’s medical record.
| Request/Refusal | - | Spanish |
Protocol for How to Access Interpreting Services

Why Care1st provides Free Interpreting Services? “Federal Law requires that health care providers who see all government programs members provide free language assistance to limited English proficient (LEP) and hard-of-hearing or deaf persons. In order for you to meet this legal requirement, Care1st Health Plan is providing telephone, face-to-face and sign language interpreting services at no cost to providers and members.”

When is Telephone Interpreting Services recommended?
- When you identify a patient as being limited English proficient (LEP) and the patient is already present at the office, telephone interpretation should be used immediately to avoid any delay in service. Telephone interpretation is available 24 HOURS A DAY, 7 DAYS A WEEK.
- When a LEP patient requests it.

A) During Business Hours:
1. Call Care1st Member Service Department
   Or
   1-800-605-2556 Medi-Cal & Healthy Families (All counties)
   1-800-544-0088 Medicare & Commercial (All counties)

2. Call Pacific Interpreters
   1-877-904-8195 Los Angeles (ACCESS CODE: 840609)
   1-877-904-8195 San Diego (ACCESS CODE: 838600)
   1-877-904-8195 Santa Clara (ACCESS CODE: 841676)

B) After Business Hours:
1. Call Pacific Interpreters
   1-877-904-8195 Los Angeles, San Diego & Santa Clara
   (ACCESS CODE: 828201)

A Pacific Interpreter Customer Service Agent will ask for the following information:
ACCESS CODE
Caller’s First & Last Name
Member’s First & Last Name & Care1st ID#
Language Needed

2. If your calls are answered:
- By a live person (e.g. answering services, on-call provider, or centralized triage), please ensure that staff know how to access interpreter services.

- By an answering machine, please ensure that you direct the patient to call their health plan for language assistance.
When are face-to-face and sign language interpreting services recommended?

- To explain complex medical consultation or education (i.e. medical diagnosis, treatment options, insulin instructions, etc.) to a LEP or a hard-of-hearing or deaf member.
- When a LEP patient requests it.

Please contact Care1st Member Service Department 5-7 days in advance to request a face-to-face or sign language interpreter:

Medi-Cal & Healthy Families: 1-800-605-2556
Medicare & Commercial: 1-800-544-0088

When is LifeSigns (American Sign Language) recommended?

- In case of emergency or after business hours for sign language interpreter, please call:

  LifeSigns at 1-800-633-8883

Please contact Care1st Member Service Department at least 48 Hours in advance if the appointment has been CANCELLED or RESCHEDULED.

When is California Relay Service recommended?

- To communicate with the hard-of-hearing or deaf patients, please call California Relay Service:

  English 1-888-877-5379
  Spanish 1-888-877-5381

- When your hard-of-hearing or deaf patients need assistance to call your office:
  1-877-735-2929 (TTY users) or 711

Please keep in mind:

- Always document the member’s preferred language in the member’s medical record.
- Always document the request or refusal of interpreting services in the member’s medical record. You may get the request or refusal form in threshold languages by calling the C&L Dept. or downloading it from Care1st website at www.care1st.com
**CULTURAL & LINGUISTICALLY APPROPRIATE SERVICES REFERRAL REQUEST FORM**

Please complete sections A-C and fax to the Cultural & Linguistics Department at (323) 889-5407

### A. Patient Information

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Address:</td>
<td>City:</td>
<td>Zip Code:</td>
<td>Phone: ( )</td>
<td>DOB:</td>
</tr>
</tbody>
</table>

### B. Provider Information

<table>
<thead>
<tr>
<th>Requested by:</th>
<th>Date of Request:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
<td>Phone: ( )</td>
</tr>
<tr>
<td>Finding:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

### C. Referral Information

<table>
<thead>
<tr>
<th>Service Requested</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Service</td>
<td>African American</td>
</tr>
<tr>
<td>Support Group</td>
<td>Asian/Pacific Islander</td>
</tr>
<tr>
<td>Community Based Organization (CBO)</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>Other:</td>
<td>Amuvian/Russian</td>
</tr>
<tr>
<td>ESL Classes</td>
<td>Adoption/Foster Care</td>
</tr>
<tr>
<td>Cultural Transition</td>
<td>Citizenship</td>
</tr>
<tr>
<td>Stress/Depression</td>
<td>Immigration/Legal Assistance</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Hearing Impaired</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Youth/Teen</td>
</tr>
</tbody>
</table>

| Comments: | |

### D. Service Information

<table>
<thead>
<tr>
<th>Title of Program:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td>City:</td>
</tr>
<tr>
<td>Program Contact:</td>
<td>Phone: ( )</td>
<td></td>
</tr>
<tr>
<td>Unable to contact Member</td>
<td>Will attend program:</td>
<td></td>
</tr>
<tr>
<td>Member was contacted on:</td>
<td>Refused program:</td>
<td></td>
</tr>
</tbody>
</table>

| Instructions/Comments: | |

### E. Follow-Up

<table>
<thead>
<tr>
<th>Member attended program</th>
<th>Member did not attend program</th>
<th>Information not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

213
CHDP PM160 INFORMATION ONLY FORMS REQUEST

DATE: ________________

TO: Care1st Health Plan
601 Potrero Grande Dr
Monterey Park, CA 91755
Phone: (323) 889-6638
Fax: (323) 889-5412
Attn: Encounter Department
Angelica Vargas
Ext.6290

SHIP TO ADDRESS:
**** (For multiple providers in one office, please complete one form per provider.
Please complete all information areas requested below. PLEASE PRINT)

______________________________
Physicians First & Last Name

______________________________
Street Address, Suite or Room Number

______________________________
City, State and Zip Code

______________________________
Telephone Number

ATTENTION: __________________________

☐ Checkmark if inventory is completely depleted

An amount will be distributed based on patients the PCP has with Care1st.
Please allow 2-3 weeks for delivery.
## PROVIDER INFORMATION

**Name (First and Last):**

**Address:**

**Phone:**

**License #:**

**IPA/Medical Group:**

## Reasons for terminating patient/doctor relationship:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please give specific dates and instances of the issues you have had with this member:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

## PATIENT INFORMATION

**Name (First and Last):**

**DOB:**

**SSN:**
What actions have you taken to resolve the issues between the member and you?

CURRENTLY IDENTIFIED MEDICAL CONDITIONS REQUIRING IMMEDIATE OR ONGOING TREATMENT:

It is very important to document any non-compliant behavior by the member in the member’s medical records. Please provide Care1st with all the documentation from the members’ medical records which supports your claims. You must document your actions taken to attempt to resolve these issues with the member.

Please attach the supporting documentation and mail this to Terri Rosales at 601 Potrero Grande Drive, Monterey Park, CA 91755. You can also fax the completed form and supporting documentation to 323-889-6214 and/or call 323-889-6638 extension 3370 to ensure timeliness of the evaluation of your request.

I hereby attest that the above information is true and accurate to the best of my knowledge at this time. I also hereby attest that this request is based solely on my concern that I cannot effectively and appropriately treat the medical needs of this patient because of the above given reasons and that this request is not based on any financial motives.

Signed: ___________________________  Date: ___________________________

Medical Director’s Review:

______________________________

Recommendations:

______________________________

Signed: ___________________________  Date: ___________________________
<table>
<thead>
<tr>
<th>Visit Purpose</th>
<th>Site-Specific Certification(s)</th>
<th>Provider Type</th>
<th>Clinic Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>___Initial Full Scope</td>
<td>_____AAAHC _____JCAHO</td>
<td>____Family Practice _____Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>___Periodic Full Scope</td>
<td>_____CHDP _____NCQA</td>
<td>____Pediatics _____OB/GYN</td>
<td></td>
</tr>
<tr>
<td>___Follow-up</td>
<td>_____CPSP _____None</td>
<td>____General Practice _____Specialist</td>
<td></td>
</tr>
<tr>
<td>___Focused Review</td>
<td>_____Other _____None</td>
<td>____Mid-level (type)</td>
<td></td>
</tr>
<tr>
<td>___Other</td>
<td>_____Other _____None</td>
<td>_____Mid-level (type)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoring Procedure</th>
<th>Medical Record Scores</th>
<th>Compliance Rate</th>
</tr>
</thead>
</table>

217
Scoring is based on 10 medical records.
1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate is a percentage.

\[
\frac{\text{Total Points Given}}{\text{Adjusted Points Possible}} \times 100 = \% \text{ Compliance Rate}
\]

<table>
<thead>
<tr>
<th>Points possible</th>
<th>Yes Pts. Given</th>
<th>No's</th>
<th>N/A's</th>
<th>Sectio n Score %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Format</td>
<td>(8) x 10 = 80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Documentation</td>
<td>(7) x 10 = 70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. Continuity/ Coordination</td>
<td>(8) x 10 = 80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV. Pediatric Preventive</td>
<td>(19) x # of records</td>
<td></td>
<td></td>
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<tr>
<td>V. Adult Preventive</td>
<td>(15) x # of records</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>VI. OB/CPSP Preventive</td>
<td>(20) x # of records</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Points Possible | Yes Pts. Given | No's | N/A's |

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

**Exempted Pass: 90% or above:**
(Total score is ≥ 90% and all section scores are 80% or above)

**Conditional Pass: 80-89%:**
(Total MRR is 80-89% OR any section(s) score is < 80%)

**Not Pass: Below 80%**

__CAP Required__
__Other follow-up__

Next Review Due: ____________

Blank Page (for numbering purposes)
I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

<table>
<thead>
<tr>
<th>Criteria met: Give one (1) point.</th>
<th>Wt</th>
<th>MR #1</th>
<th>MR #2</th>
<th>MR #3</th>
<th>MR #4</th>
<th>MR #5</th>
<th>MR #6</th>
<th>MR #7</th>
<th>MR #8</th>
<th>MR #9</th>
<th>MR #10</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria not met: 0 points</td>
<td></td>
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<tr>
<td>Criteria not applicable: N/A</td>
<td></td>
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</tbody>
</table>

Age/Gender

A. An individual medical record is established for each member. 1

B. Member identification is on each page. 1

C. Individual personal biographical information is documented. 1

D. Emergency “contact” is identified. 1

E. Medical records on site are consistently organized. 1

F. Chart contents are securely fastened. 1

G. Member’s assigned primary care physician (PCP) is identified. 1

H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted. 1

Comments: Yes

<table>
<thead>
<tr>
<th>8</th>
<th>Pts. Possible</th>
</tr>
</thead>
</table>

8
N/A
## II. Documentation Criteria

Note: A Documentation section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

- **RN/MD Review only**

<table>
<thead>
<tr>
<th>Criteria met: Give one (1) point.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria not met: 0 points</td>
</tr>
<tr>
<td>Criteria not applicable: N/A</td>
</tr>
</tbody>
</table>

### Age/Gender

| A. Allergies are prominently noted.   | 1 |
|--------------------------------------|
| B. Chronic problems and/or significant conditions are listed. | 1 |
| C. Current continuous medications are listed. | 1 |
| D. Signed Informed Consents are present when any invasive procedure is performed. | 1 |
| E. Advance Health Care Directive information is offered.  |
| (Adults 18 years of age or older; Emancipated minors) | 1 |
| F. All entries are signed, dated and legible. | 1 |
| G. Errors are corrected according to legal medical documentation standards. | 1 |

### Comments:

- Yes
- No
- N/A

<table>
<thead>
<tr>
<th>Wt</th>
<th>MR #1</th>
<th>MR #2</th>
<th>MR #3</th>
<th>MR #4</th>
<th>MR #5</th>
<th>MR #6</th>
<th>MR #7</th>
<th>MR #8</th>
<th>MR #9</th>
<th>MR #10</th>
<th>Score</th>
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</tbody>
</table>

7 Pts. Possible
### III. Coordination/Continuity of Care Criteria

Note: A Coordination/Continuity section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

#### RN/MD Review only

Criteria met: Give one (1) point.
Criteria not met: 0 points
Criteria not applicable: N/A

<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>Wt</th>
<th>MR #1</th>
<th>MR #2</th>
<th>MR #3</th>
<th>MR #4</th>
<th>MR #5</th>
<th>MR #6</th>
<th>MR #7</th>
<th>MR #8</th>
<th>MR #9</th>
<th>MR #10</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

#### Comments:

- **Yes**
- **No**
- **N/A**

| History of present illness is documented. | 1 |       |       |       |       |       |       |       |       |       |        |       |
| Working diagnoses are consistent with findings. | 1 |       |       |       |       |       |       |       |       |       |        |       |
| Treatment plans are consistent with diagnoses. | 1 |       |       |       |       |       |       |       |       |       |        |       |
| Instruction for follow-up care is documented. | 1 |       |       |       |       |       |       |       |       |       |        |       |
| Unresolved/continuing problems are addressed in subsequent visit(s). | 1 |       |       |       |       |       |       |       |       |       |        |       |
| There is evidence of practitioner review of consult/referral reports and diagnostic test results. | 1 |       |       |       |       |       |       |       |       |       |        |       |
| There is evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate | 1 |       |       |       |       |       |       |       |       |       |        |       |
| Missed primary care appointments and outreach efforts/follow-up contacts are documented. | 1 |       |       |       |       |       |       |       |       |       |        |       |
## IV. Pediatric Preventive Criteria

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

### A. Initial Health Assessment (IHA) Includes H&P and IHEBA

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<th>MR #9</th>
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<tr>
<td>1. History and physical (H&amp;P)</td>
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<td>2. Individual Health Education Behavioral Assessment (IHEBA)</td>
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### B. Subsequent Periodic IHEBA

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### C. Well-child visit

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<td>4. Developmental screening</td>
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<td>6. STI screening on all sexually active adolescents, including chlamydia for females</td>
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<td>7. Pap smear on sexually active females</td>
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Note: RN/MD Review only

Criteria met: Give one (1) point.
Criteria not met: 0 points
Criteria not applicable: N/A
IV. Pediatric Preventive Criteria (continued from previous page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

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<td>Age/Gender</td>
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<tr>
<td>E. Hearing Screening</td>
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<td>F. Nutrition Assessment</td>
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<td>G. Dental Assessment</td>
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<tr>
<td>H. Blood Lead Screening Test</td>
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<tr>
<td>I. Tuberculosis Screening</td>
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<tr>
<td>J. Childhood Immunizations</td>
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<tr>
<td>1. Given according to ACIP guidelines</td>
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<tr>
<td>2. Vaccine administration documentation</td>
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<tr>
<td>3. Vaccine Information Statement (VIS) documentation</td>
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Comments: Yes

No

N/A

223
V. Adult Preventive Criteria (continued on next page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

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Age/Gender

A. Initial Health Assessment (IHA): Includes H&P and IHEBA

1. History and physical (H&P) 1
2. Individual Health Education Behavioral Assessment (IHEBA) 1

B. Subsequent Periodic IHEBA 1

C. Periodic Health Evaluation according to most recent USPSTF Guidelines 1

D. High Blood Pressure Screening 1

E. Obesity Screening 1

F. Lipid Disorders Screening 1

Adult Preventive continued on next page
V. Adult Preventive Criteria  (continued from previous page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

Criteria met: Give one (1) point.
Criteria not met: 0 points
Criteria not applicable: N/A

Age/Gender

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<td>H. Breast Cancer Screening</td>
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<td>I. Cervical Cancer Screening</td>
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<td>J. Chlamydia Infection Screening</td>
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<td>K. Colorectal Cancer Screening</td>
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L. Adult Immunizations

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Yes
VI. OB/CPSP Preventive Criteria

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

Criteria met: Give one (1) point.
Criteria not met: 0 points
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<td>8. Screening for Hepatitis B Virus</td>
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### OB/CPSP Preventive Criteria

*(continued from previous page)*

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

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<td>D. Prenatal care visit periodicity according to most recent ACOG standards</td>
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**VI. OB/CPSP Preventive Criteria** (continued from previous page)

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<td>F. Referral to WIC and assessment of Infant Feeding status</td>
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<td>I. Domestic Violence/Abuse Screening</td>
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