# Welcome

**Care1st Health Plan**

**Medicare Provider Manual**

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Thank you for being a Care1st Health Plan provider. As a provider you play a very important role in the delivery of health care services to our Members.

The Care1st Medicare Provider Manual is intended to be used as a guideline for the provision of covered services to Care1st Medicare beneficiaries. This manual contains policies, procedures, and general reference information, including minimum standards of care which are required of Care1st providers. This manual also contains a brief history of the company as well as an overview of the Medicare Advantage Program, which is one of our products.

As a Care1st provider, we hope this information will help you better understand Care1st's operations. This Manual is applicable to the Care1st Medicare line of business only. Should you or your staff have any questions about the information contained in this manual or anything else pertaining to Care1st, please contact our Provider Network Operations Department at 1-323-889-6638.

Care1st works closely with our contracted Primary Care Physicians (PCPs), Specialists, and other providers to ensure that our Members receive medically necessary and clinically appropriate covered services. We are a managed care delivery system in which the PCPs serve as a “gatekeeper” for Member care. PCPs are responsible for coordinating and overseeing the delivery of services to Members on their patient panel. We look forward to working with you and your staff to provide quality health care services to Care1st Members.

INTRODUCTION

Medicare History

In December 2003, the U.S. Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act, or MMA). This federal law produced the largest overhaul of Medicare in the program’s 38-year history, in part by establishing the Medicare Advantage program. Most significantly, it created the Medicare Prescription Drug program, Medicare Part D. The MMA also changed the name of the Medicare managed program from Medicare+Choice to Medicare Advantage (MA). Care1st Health Plan is a Medicare Advantage organization that also provides prescription drug coverage (MA-PD).

Care1st Health Plan is under the oversight of the Centers for Medicare & Medicaid Services (CMS), which administers the requirements governing the Medicare Advantage Program. All practitioners and providers who are contracted with Care1st Health Plan are also subject to the requirements of the Medicare Advantage Program. In order to be a Care1st Health Plan Medicare Advantage practitioner or provider you must be eligible for payment by Medicare. This means that you cannot be excluded from participation in any federal health care program or that you have not opted out of the Medicare Program.

Care1st Health Plan is a Medicare contractor and is therefore a recipient of federal payments. As contractors of an organization that receive federal funds, Care1st Health Plan's practitioners and providers are subject to the laws and requirements of the federal government.
Care1st History: A Timeline

1994
• Care1st Health Plan ("Care1st") is established as a California corporation by three Traditional Safety Net provider groups, and two large disproportionate share hospitals, all with extensive experience in providing health care services under government sponsored as well as commercial health care programs.

1995
• Care1st receives its California full service health plan ("Knox-Keene") license.
• Care1st becomes a Plan Partner of LA Care.

1998
• Care1st enters into a Global Services Agreement with LA Care, to provide Covered Services to eligible Healthy Families Program ("HFP") children through 2001.

2000
• Care1st receives its own direct HFP contract from the Managed Risk Medical Insurance Board ("MRMIB").
• Care1st enters into a contract with the Department of Health Services - Dental ("DHS - Dental") to provide dental services to eligible Medi-Cal enrollees.

2001
• Care1st adopts the National Standards for Culturally and Linguistically Appropriate Services ("CLAS Standards").
• With the approval of the U.S. Bankruptcy Court, the State Department of Health Service and the Department of Managed Care, Care1st acquires the contract between Maxicare and L.A. Care. (December)

2002
• Through June 2004, Care1st is designated by Managed Risk Medical Insurance Board ("MRMIB") to be the administrator of its Access for Infants and Mothers ("AIM") program. (March)

2003
• Care1st is selected by the Arizona Health Care Cost Containment System (AHCCCS), the State of Arizona's Medicaid management agency to provide services to Medicaid Members in Maricopa County of Arizona.

2004
• Care1st is one of seven (out of twenty-four) health plans recognized by the DMHC, in its survey of language services, as providing the highest rated (above average) level of language assistance services to limited English proficient Members.
• Care1st is awarded a contract by the State of Arizona Department of Economic Security, Division of Developmental Disabilities in September 2004 to provide acute care services to the developmentally disabled population in Maricopa County. In addition, Care1st begins serving small employers under the Health Care Group (HCG). (September)
2005
- Care1st Health Plan Arizona receives a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD Special Needs Plan (SNP). The Plan is called OneCare by Care1st Health Plan of Arizona. (May)
- Care1st is awarded a contract by DHCS to provide health care services to Medi-Cal beneficiaries in San Diego County. (March)
- Care1st Health Plan acquires from Watts Health Foundation (dba UHP Healthcare) its Medi-Cal, Medi-Cal Dental, Medicare and Commercial lines of business. (September)
- Care1st applies for and is granted a license by CMS to be an MAPD and MAPD-SNP Plan in Los Angeles, San Bernardino and Orange County.

2008
- In 2008 Care1st Health Plan receives the Senior Choice Gold Award of Excellence for its Medicare Plan Benefits for the San Bernardino and San Diego Counties. The Care1st Medicare Advantage Plan is the only plan in San Diego and San Bernardino counties to qualify for the 2008 Senior Choice Gold Award.
- Care1st is awarded a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD and MAPD-SNP Plan in San Diego County. (January)
- Care1st Health Plan was awarded a three-year Commendable accreditation from the National Committee for Quality Assurance (NCQA) for both its Medicare Advantage, and Medi-Cal plans. In addition, "Achieving an accreditation status of 'Commendable' from NCQA, is a sign that a health plan is serious about quality. It is awarded to plans whose service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement." (November)

2009
- Care1st is awarded a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD Plan in Riverside County, California.
- Care1st Health Plan receives the Senior Choice Gold Award for Excellence in 2009 Medicare Plan Benefits in Riverside, San Bernardino & San Diego Counties.

2010
- Care1st is awarded a contract from the Center for Medicare and Medicaid Services ("CMS") to provide services as an MAPD-SNP plan in Riverside County and as an MAPD and MAPD-SNP plan in Santa Clara County, California, effective January 1, 2011.

2011
- Care1st is awarded a contract from Center of Medicare and Medicaid Services (CMS) to provide services as an MAPD Plan Provider in San Joaquin and Stanislaus counties.
- Care1st receives a three-year Commendable Re-Accreditation from the National Committee for Quality Assurance (NCQA) for Medicare and Medi-Cal.
- Receives a three-year Medicare Advantage Deemed status from National Committee for Quality Assurance (NCQA).
- Care1st receives NCQA HEDIS Compliance Audit Seal.
2012
• Care1st receives the Senior Choice Gold Award for Excellence in 2012 Medicare Plan Benefits.
• Care1st is selected by California Department of Health Care Services (DHCS) to participate as a health plan in San Diego County’s Dual Eligible Demonstration Pilot Project.

2013
• Care1st is awarded a contract from the Center for Medicare and Medicaid Services (CMS) to provide services as an MAPD and D-SNP plan in Alameda and San Francisco Counties, effective January 1, 2013.
• Care1st receives the Senior Choice Gold Award for Excellence in 2013 Medicare Plan Benefits in 3 counties.

2014
• Care1st is awarded a contract from Center of Medicare and Medicaid Services (CMS) to provide services as an MAPD in Fresno and Kern Counties, effective January 1, 2014.
• Care1st receives the Senior Choice Gold Award for Excellence in 2014 Medicare Plan Benefits in 6 counties.

Today
Care1st currently provides healthcare benefits to a combined Membership (Medi-Cal, Dental, HFP, Medicare, Cal Medi Connect and Commercial) of over 400,000.

Care1st is recognized as a health plan making a genuine effort to ensure that the health care it provides to its diverse Membership is culturally and linguistically appropriate.

Care1st Health Plan has opened a Community Information Resource Center in the city of Huntington Park to provide enrollment assistance to the public and Care1st Health Plan Members. Additionally, the resource center provides Diabetes Management, Obesity Prevention, Asthma Self-Management, Baby Showers, Nutritional Discussions and Dental Decay Prevention classes available to the community.

Care1st’s Mission, Vision, and Values

Care1st’s Mission:
Care1st Health Plan will be the most provider-oriented managed care organization that will strive to continuously improve the quality of services rendered to its Members.

Care1st’s Vision:
Care1st Health Plan will be the leader in innovation utilizing advanced technology to achieve excellence in customer satisfaction for Members, providers, and employees.

Care1st’s Values:
Care1st Health Plan is committed to basic moral and ethical values driven by integrity, honesty, and respect for all.
SECTION 1: 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 for 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.

1.1: 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 the Provider on active status. Care1st will maintain documented receipt of all Provider Manuals distributed.

1.2: 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 thirty (30) calendar days of executing a contract with Care1st.

PPGs:
Care1st’s contracted PPGs are responsible for conducting provider training and orientation for its contracted providers within thirty (30) calendar days of contracting with the PPG regardless of their effective status with Care1st.

1.3: Joint Operation Committee Meetings for PPGs & 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.

Note: Update made, please refer to Care1st website.
1.4: Provider Affiliations

PCPs may become affiliated with Care1st through a contracted PPG. 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.

1.5: Provider Network Additions

PPGs are required to provide 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
- Ancillary Providers
- Hospitals

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. First and signature pages of the executed agreement for each provider
   b. A comprehensive profile sheet to include at a minimum:
      - Name
      - Professional Title
      - Office Address
      - Telephone & Fax Numbers
      - Office Hours
      - Provider Type (PCP/Specialist)Specialty with Board Certification Status or 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
      - Gender
      - Ethnicity
   c. Other Care1st required documentation for General Practitioners (GP) only:
      - Two letters of recommendation from other PCPs if the GP provider has not completed at least one (1) year of stateside primary care medicine training.

2. For Medicare Practitioners: A practitioner applying for primary care credentialing for the Medicare line of business must have completed at least three (3) years of either a Family Practice or Internal Medicine residency in the United States.
   - An OB/GYN requesting to participate as a PCP must complete at least one (1) year of stateside primary care medicine and sign the Care 1st Addendum E. If an OB/GYN has not completed the required stateside primary care training, he/she may substitute two (2) letters of recommendation from primary care physicians for the primary care training;
• 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. ABMS does not recognize Canadian/British Specialty Boards).
• For PCPs, receive a minimum passing score on the facility site review and medical record review.

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 does not satisfy the minimum criteria if there is a determined need and if there is sufficient credible evidence that the practitioner is capable of providing the services requested.

3. 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 the specialty providers that typically do not require admitting privileges, such as allergy/immunology, dermatology, ophthalmology, and podiatry.

4. Providers submitted without required documentation, information or staff privileges at a Care1st contracted hospital will be unable to participate in the Care1st network.

1.6: Provider Network Changes

Provider network changes include terminations, office relocations, leave of absences/vacation, enrollment status/restrictions, and changes in PPG affiliation.

PPGs:

In order to comply with the CMS 30-day prior notice to affected Members policy, a provider with a demographic change must provide a minimum ‘60-day’ advance written notification to your assigned Care1st Provider Network Administrator.

1.6.1: PCP Terminations

PPGs shall send written notification of all provider terminations to their appointed Care1st Provider Network Administrator as soon as the PPG is notified and at a minimum of 60 days in advance of the proposed date of the change. The change shall become effective the first of the next consecutive month from the date of receipt. If a 60-day notification is not received, the PCP/PPG is responsible for submitting a written coverage plan to Care1st and this plan shall be reviewed by the Care1st Medical Director. 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.
In all Member notification, the Members are given an option to select a new different PCP and/or PPG. Thus Care1st does not guarantee the assignment to remain with their current PCP/PPG.

Care1st retains the right to obligate the PCP/PPG to provide medical services for existing Members until the effective date of transfer.

PPGs:

1. If the terminating PCP practices in a Federally Qualified Health Center (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 follow 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.

When a PPG fails to designate an appropriate provider, Members will be reassigned according to Care1st policy 70.5.15.0.

1.6.2: Specialist Provider Terminations

PPG shall send written notification for all provider terminations to the appropriate Care1st Provider Network Administrator as soon as the group is notified and at a minimum of 60 days in advance of the proposed date of the change. The change shall become effective the first of the next consecutive month from the date of receipt in order to comply with the 30-day prior notification to affected Members. For continuity of care purposes, Care1st retains the right to obligate the PPG to provide medical services for existing Members until the effective date of termination according to the terms of its contract with the PPG. The PPG is responsible for transition of care for all Members of terminated providers.

1.6.3: Office Relocation

PPGs shall send written notification 60 days in advance for all office relocations to their appointed Provider Network Administrator. The PCP/PPG is responsible for submitting a coverage plan to Care1st, if necessary.

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.

1.6.4: 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.

1.6.5: Change in a Provider’s PPG Affiliation

PCPs may change their Care1st PPG affiliation by submitting written notification of their change request to the PPG that the PCP wishes to change from in accordance with their contractual agreement. A separate request is sent by the PCP 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 any covered services provided through the effective date of the transfer.

1.7: PPG Specialty Network Oversight

As part of Care1st’s pre-contractual process, a complete specialist network deemed by State and Federal regulatory 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.

1.8: 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 which include on-site audits, MSO’s policy and procedure for Claims, Credentialing, Health Education and Utilization Management functions. 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.

1.9: Provider Grievances

See Sub-Section 3.3.3: Provider Disputes under Member Appeals & Grievance Process

1.10: Provider Directory

The Care1st provider directory is printed on an annual basis. The directory is solely used as a Member handbook referencing participation of 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 to the best of its ability dependent on notification by the group.

1.11: 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 an immediate refund of such surcharge.

SECTION 2: CREDENTIALING

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 non-physician medical practitioners (PA, NP, CNS, and NMW) employed in these practitioners’ offices and who 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 who are 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
1. To ensure that all practitioners, including both direct-contracted and delegated, who are added to the network meet the minimum Care1st requirements.
2. Care1st practitioners are evaluated for, but not limited to, education, training, experience, claim history, sanction activity, and performance monitoring.
3. To ensure that network practitioners/providers maintain current and valid credentials.
4. To ensure that network practitioners are compliant with their respective state licensing agency and Medicare and Medicaid programs, and Care1st has a process to ensure that appropriate action is taken when sanction activity is identified.
5. To establish and maintain standards for credentialing and to identify opportunities for improving the quality of providers in the network.

2.1: Credentialing Policies & Procedures

Policies and procedures are reviewed annually and revised, as needed, to meet the needs
of Care1st, its practitioners, 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 for review and approval.

2.2: Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners contracted with Care1st Health Plan. The Chief Medical Officer serves as chairman of the Credentials Committee, which is comprised of a multi-specialty panel of practitioners in the Care1st network, the QI Director, the credentialing manager, and a range of 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 their 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 identified with sanction activities from the state licensing agency, OIG, and CMS;
- Ensure appropriate reports, including 805, National Practitioner Data Bank, etc. are submitted, as required; and
- Ensure Fair Hearings are offered and carried out in accordance to the established policies and procedures.

2.3: Minimum Credentials Criteria

All practitioners will be credentialed and recredentialed in accordance with 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 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, allergy & immunology, psychology, pathology, radiology, radiation oncology, dental surgery, physical therapy, audiology, chiropractic, acupuncture 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 Medicare 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:

a. Physicians (MD, DO) must be either:
   i. Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards.
   ii. Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board.
   iii. 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.
   iv. A practitioner applying for primary care credentialing in the Medicare-line of business must have completed at least three years of either a Family Practice or Internal Medicine residency program in the United States.

b. 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/GYNs applying for PCP status may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.

c. 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.

d. 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).

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

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

g. Oral Surgeons (DDS, DMD) are required to have completed a professional degree in dentistry.

h. Physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), and nurse mid-wives (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.

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

j. The HIV specialist must meet any one of the following four criteria:
   i. Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.
   ii. Board certified in Infectious Disease by the American Board of Internal
Medicine (ABIM) and meets the following qualifications:

- In the immediately preceding 12 months, has provided continuous and direct medical care to a minimum of 25 patients who are infected with HIV; and 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; or
- In the immediately preceding 24 months, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV, and 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.

k. 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 j 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 does not satisfy minimum criteria and if there is a determined need and if there is credible evidence that the practitioner is capable of providing the services requested.

2.4: Recredentialing

At least every three (3) years, a practitioner must complete recredentialing to maintain his/her Membership with Care1st. Approximately 30 months after the last credentialing date, the practitioner will be mailed a recredentialing application containing information from the credentialing database for review. The practitioner 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 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 practitioner who has not returned his/her application. A final follow-up will be sent to any practitioner who has not returned his/her applications after 60 days from the initial mailing. The Credentials Committee and the Contracting Department will be notified of the practitioner who is non-responsive to the recredentialing requests and will follow the procedures for action, including administrative termination for non-compliance.

2.5: Credentialing Time Limit

The credentialing and recredentialing approval must be within 180 calendar days of the application date. Work history and primary source verifications (except for training and education) must be no more than 180 calendar days old at the time of the credentialing approval by the Credentials Committee.

2.6: Credentials Process for Participating Provider Group (PPG)

PPGs that are delegated credentialing activities are required to credential and recredential practitioners, non-physician medical practitioners, and allied health professionals in accordance with the above Care1st policies and procedures, NCQA, CMS, and DMHC 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:

The Credentialing Department will conduct pre-contractual and annual onsite audits in accordance with the PPG Delegated Oversight Assessment and Scoring Policy and Procedure (P&P) (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 (See Appendix 1) will be used to conduct the audit. The PPG will be required to submit a credentialing roster, with credentialing and recredentialing dates, at least two (2) weeks prior to the scheduled audit date and the PPG will be provided with a list of files to be pulled for the audit at least one (1) week prior to the audit.

1. 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 recredentialed file review;
b. For PPGs 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; or
c. Care1st may also use, at its discretion, the Industry Collaboration Effort (ICE) Shared Credentialing Audit results that can be downloaded from the ICE website at www.iceforhealth.org. Care1st would only consider the use of the ICE audit results for PPGs that scored above 80% on the previous year’s audit and if the ICE audit is no more than 6 months old at the time the PPG is due for a Care1st audit. However, Care1st will still continue to review the PPG Credentialing P&P and minutes. After reviewing the downloaded ICE audit, Care1st will follow-up with the PPG for any issues that requires a corrective action plan (CAP). The ICE audit is not to be used in lieu of a pre-delegation audit.

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 if the PPG scores less than 95% 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 and sites and to terminate or suspend individual practitioners or sites.

6. Delegated PPGs are required to submit at least a quarterly report and roster of practitioners approved for credentialing, recredentialing, and terminated or resigned to the Credentialing Department.

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

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

2.7: Practitioners’ Rights

Practitioners 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. Be informed of the status of their application upon written request to the Credentialing Department.

5. Practitioners will be notified of their rights in the initial and recredentialing application
2.8: 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. Only authorized personnel will have access to credentials files. Practitioners 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.

2.9: Ongoing Monitoring

Care1st queries the National Practitioner Data Bank (NPDB), Health Integrity and Protection Data Bank (HIPDB), Office of Inspector General (OIG), Opt-Out Report, SAM Report and state licensing agencies at the time of initial credentialing and recredentialing to determine if there have been any sanctions placed against a practitioner/provider. Care1st monitors the Medical Board of California (MBC) and other licensing agencies for license and reviews the monthly updates of the OIG’s List of Excluded Individuals/Entities (LEIE) and Ineligible Provider List to determine if any sanctions have been placed against or lifted from any network practitioners. Practitioners identified on the OIG’s LEIE report and Opt-Out Report will not be contracted for the Medicare product. The monthly updates are reviewed within 30 days of its publication or at least every 6 months for those reports that are not published regularly. Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner is contracted directly with Care1st, then the practitioner 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 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.

Care1st also monitors the practitioner for license, DEA and malpractice insurance expiration dates. On a monthly basis, the Credentialing Department runs a report for the medical/professional license, DEA, and malpractice insurance due to expire within the following month. License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the National Technical Information Service (NTIS) or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

2.10: Medicare Opt-Out Report

The Credentialing Department will check the Medicare Opt-Out Report to verify whether the practitioner has chosen to opt-out of Medicare. The results of the findings will be documented in the credentialing file and applicants identified on the report will not be
credentialed for Medicare.

2.10.1: 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 Medicare program;
   c. The practitioner fails to maintain the minimum malpractice liability coverage.

3. Should a practitioner fail to meet the minimum credentialing criteria as described above, Care1st will allow the practitioner a chance to correct the deficiency before inactivating the practitioner. Upon knowing that a practitioner is noncompliant, the Credentialing Department will notify the practitioner 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 will be inactivated on the 1st day of the following month unless the practitioner is able to correct the deficiency prior to the monthly upload, usually occurring on the 13th day of each month. If Members are assigned to the affected practitioner, then the Members will be transferred to another practitioner 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 is able to correct the deficiency prior to the monthly upload, usually occurring on the 13th day of each month. If Members are assigned to the affected practitioner, the Members will be transferred to another practitioner by the effective date of said inactivation.

4. Any information regarding an adverse event will be forwarded to the Quality Improvement (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. Any summary suspension or restriction of a practitioner's privileges based on a medical disciplinary action for a period of 14 days or more will be reported to the Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California through the 805 reporting process and to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank in accordance to Care1st policy. The California Business and Professions Code Section 805 define medical disciplinary cause or reason as “that aspect of a licentiate’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care”.

2.11 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 free standing surgical centers to ensure they have appropriate structures and mechanisms in place to render quality care and services. The evaluation process includes confirmation within 180 calendar days of the following:
   a. In good standing with the state and federal regulatory bodies, including verification from the OIG.
   b. Current accreditation by a Care1st recognized accrediting bodies.
   c. If not accredited, the HDO has been reviewed and approved by CMS or DHCS or had an onsite review by Care1st.
2. Care1st will not contract with HDOs that have not been approved by a recognized accrediting body or passed a CMS or DHCS site review and not willing to submit to a Care1st audit.

SECTION 3: MEMBER SERVICES

3.1: Covered Benefits

The benefit designs associated with the Care1st Medicare Advantage plans are described in the Summary of Benefits and the Evidence of Coverage. Electronic copies of these documents are available on the Care1st website, www.care1st.com. To request printed copies of the publications, please contact the Care1st Provider Network Operations Department at 1-323-889-6638.

3.2: Member Rights & Responsibilities

Care1st Health Plan is committed to providing quality health care and to communicate the Member’s Rights and Responsibilities to its Members, providers, and staff.

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 Newsletters.

Care1st Health Plan informs each Member of these Rights and Responsibilities in the 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.
- Know and receive information about Care1st Health Plan
- Know and receive your rights and responsibilities
- Know about our services, doctors, and specialists and be informed when your doctor is no longer contracted with Care1st Health Plan
- Know about all our other caregivers
- Be able to see your medical records. You have to follow the State and Federal laws that apply

You have the right to be treated well.
- Always be treated with respect and recognition of your dignity
- Have your privacy kept safe by everyone in our health plan
- Know that we keep all your information private

You have the right to be in charge of your health care.
- Choose your primary care doctor
- Say no to care from your primary care doctor or other caregivers
- Be able to make choices and to participate with your provider about your health care
- Make a living will (also called an Advance Directive)
- Have an honest talk with your doctor about all treatment options for your condition, regardless of cost or benefit coverage
- 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.
- Get family planning services
- Get preventative health care services
- Get minor consent services
- Be treated for sexually transmitted diseases (STDs)
- Get emergency care outside of our network
- Get health care from a Federally Qualified Health Center (FQHC)
- Get health care at an Indian Health Center
- Get a second opinion
- Get interpreter services at no cost. This includes services for the hearing-impaired
- Get informing information materials in alternative formats and large size print upon request

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

• 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
• Understand your health problems and participate in developing a mutually agreed-upon treatment goal(s), to the degree possible
• 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

3.3: Member Appeals & Grievances

3.3.1: Member Appeals

Different CMS terminologies are used in the appeals process:

Definitions:

Organization Determination - Any initial decision made by the managed care organization regarding a service or benefit, including payment or refusal to pay for medical care or services.

Coverage Determination – initial decisions regarding Part D drugs

Reconsideration – first step in the appeal process after an adverse organization determination of Medical Care or Services (Part C)

Redetermination - appeal of an adverse coverage determination under Prescriptions Drug (Part D)

All redetermination and reconsideration decisions made by Care1st may be appealed to MAXIMUS Center for Health Dispute Resolution (CHDR), an independent review entity (IRE).
Level 1 – Health Plan Appeal

A Medicare Member or representative may file a standard appeal. To ask for a standard appeal, written appeal request must be sent to Care1st Appeals and Grievances Dept. A fast appeal may be requested by calling, faxing, or writing to Care1st. If the physician provides a written or oral supporting statement explaining that the Member needs a fast appeal, then it is automatically granted to the member. If the Member or representative asks for a fast appeal without support from the physician, Care1st will decide if Member’s health requires a fast decision. If a request for fast appeal is denied, the standard appeal will apply.

For Medicare Managed Care appeals, contracted providers do not have standard appeal rights, but may request an expedited reconsideration for the member. Thus, without being a member’s appointed representative, a physician is prohibited from requesting a standard reconsideration (appeal), but may expedite a member’s appeal.

For Part D appeals, a prescribing physician may request an expedited redetermination without being the member’s appointed representative. However, this is the only appeal that a member’s prescribing physician may request on a member’s behalf unless he or she is the Member appointed representative. Thus, without being the member appointed representative a member’s physician is prohibited from requesting a standard redetermination (appeal).

Level 2 – Independent Review Entity (IRE)

Unfavorable appeal decisions made by Care1st regarding a Medicare Managed Care service that is not related to Part D are auto forwarded to the IRE for “reconsideration”. A request by the appealing person is not necessary for managed care.

Part D unfavorable Member decisions made by Care1st are not auto forwarded. An appeal request from Care1st to the IRE is necessary for Part D. Care1st will comply with CMS’s Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Manual and Chapter 18 - Part D Enrollee Grievances, Coverage Determinations, and Appeals Manual. The timeframes for filings and resolutions will be adhered to. Appeals should be filed within sixty (60) calendar days from the date of the initial determination. Appeals on behalf of the member must be in writing and state with specificity the action being appealed and what resolution is being requested. The provider should provide documentation supporting the Member’s position. Providers are encouraged to exhaust all other available means of resolving an issue before filing a dispute.

Decisions will be issued in writing within the time frame allowed for the kind of appeal requested and approved by the health plan. Standard decision for a Part D drug that has been paid for and received is within 7 calendar days of receiving the appeal request; expedited decision for Part D that has been received is rendered within 72 hours after the appeal request is received, or sooner if health condition requires. Any decisions not given within these required timeframes automatically go to Level 2.

For Part C medical care or services, requests for payment of services already received are made within 60 days. For a standard decision for Part C that has not been received, the decision is given within 30 days, plus additional 14 days if an extension is requested. For expedited appeals for Part C for services not yet received, a decision is rendered within 72 hours or sooner if the health condition requires. If an extension is requested, an additional
14 days is given to make the decision. If no decision is rendered during the required timeframe or at the end of extended time period, the appeal automatically goes to Level 2.

If a provider disagrees with the resolution of a matter, CMS guidelines for appeals of health plan redeterminations and reconsiderations will be adhered to. Appeal rights will be provided as appropriate with health plan decisions.

### 3.3.2: 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 PPG/PCP regarding any questions or concerns they may have. Members may also communicate their concerns directly to Care1st Member Services by telephone at 1-800-544-0088 (TTY 1- 800-735-2929), in writing, by e-mail, or in person.

Grievances can be filed by telephone, in writing, or in person no later than 60 calendar day after the event. Care1st will acknowledge receipt of all written formal grievances within five (5) business days. Care1st will resolve grievances within 30 days and/or as expeditiously as the enrollee’s health status requires but no later than 30 calendar days from the date the oral or written request is received unless as extension is made and documented in the best interest of the enrollee and provides prompt notification to the enrollee when a 14 day calendar extension is taken. Care1st will provide a resolution letter in writing to the Member. Providers and PPGs 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.

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 responsible for establishing and administering grievance procedures. The PPG and/or the PCP must participate with Care1st by providing assistance and information. Grievance forms shall be made available to Members at each PCP site. Additionally, providers are given the opportunity to review all member concerns and respond to the issues identified.
**Expedited 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 file a “fast complaint” with the health plan’s refusal to expedite an appeal as the member feels that the appeal meets criteria to be expedited.

Care 1st responds to an enrollee's expedited grievance request within 24 hours when Care 1st invokes an extension relating to an organization determination or reconsideration or the complaint involves a refusal by Care 1st to grant an expedited organization determination or reconsideration.

The complaint involves an MA organization's decision to invoke an extension relating to an organization determination or reconsideration. The complaint involves an MA organization's refusal to grant an enrollee's request for an expedited organization determination under CMS Managed Care Manual Chapter 13, Sections; §422.570 or reconsideration under §422.584

### 3.3.3: Provider Disputes

**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 AB 1455 regulation.

#### 3.3.3.1 Provider Questions, Concerns and Disputes

Providers can communicate questions and issues to the Care1st Provider Network Operations (PNO) Department or Grievance and Appeals 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 logged as a dispute. Examples of disputes are issues relating to non-compliant Members, non-payment of claims by Medical Groups/PPGs or access issues. All disputes entered in the provider dispute log will be investigated and a response will be provided in writing. They will be acknowledged within 15 working days and a final letter will be sent within 45 working days.

#### 3.3.3.2: Reconsiderations

A provider will have the ability to furnish the Care1st Provider Appeals 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:
323-889-6219.
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 Appeal and Grievance Department.

3.3.3.3: Provider Disputes Policy and Procedure

Providers may submit a written dispute to the Care1st Grievance and Appeals Department. Disputes may pertain to such issues as authorization or denial of a service; processing, payment or nonpayment of a claim; capitation issues; or others. 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 log. An acknowledgement letter will be sent to the provider within 15 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 by physical or electronic means.

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

3.3.3.4: 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 its findings and recommendations to the Chief Medical Officer for approval.

The Care1st Health Plan Appeals and Grievance Unit 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 to pursue the dispute. Care1st shall retain all documentation related to the clinical review for a minimum of (5) five years.

SECTION 4: ELIGIBILITY AND ENROLLMENT
In order to be eligible for enrollment at Care1st, the applicant must be entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date. In addition, enrollees in the Care1st Dual Special Needs Plan must be eligible for Medicare Parts A, B & D and Medicaid. Care1st does not discriminate against enrollees based on their health status. Each application received will be reviewed and processed according to CMS (Center for Medicare and Medicaid Services) regulations and guidelines.

Enrollees must reside within the CMS approved service area (defined by zip code) for Care1st. Enrollees who reside outside the approved service area will be denied enrollment. While a P.O. Box may be used for a mailing address, the enrollees must reside within the Care1st service area. In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

Enrollees with End-Stage Renal Disease (ESRD) would not be eligible unless they have received a transplant that restored kidney function and they no longer require a regular course of dialysis to maintain life (they would not be considered to have ESRD for purposes of Medicare Advantage (MA) eligibility). Such an individual may elect coverage in an MA plan if the individual makes an election during an election period, and submits proper documentation from their physician that the individual has received a kidney transplant and no longer requires a regular course of dialysis to maintain life.

4.1: Provider Selection

The Enrollment Specialist will verify the provider and PPG chosen on the application. In general, if the Primary Care Physician (PCP) is confirmed as active in the system and accepting new members, then the chosen provider will honored. The patient provider relationship is very important so in any circumstance where the chosen PCP and/or PPG cannot be met, then the enrollee will be contacted by Care1st’s Member Services Department to review further options.

If for example, the PCP is not active or not accepting new Members, the enrollee is contacted to inform him/her that the PCP chosen is inactive and with the PCP, then asked to make another choice. If the application does not list a PCP, the enrollee is contacted to choose a PCP.

4.2: Change of Primary Care Physician

4.2.1 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 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.

4.2.2: PCP Initiated Change

Occasionally, 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.

4.3: Eligibility List

Each Care1st PPG is given an eligibility roster listing all of 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. Sex
13. Special Remarks

4.4: Identification Cards

Care1st will furnish each new Member an Identification Card within the first seven (7) days of enrollment.

The member identification card is for identification purposes only, and does not guarantee eligibility for Care1st providers. You should always refer to your Eligibility List for current eligibility information, log on to Care1st e-link to verify eligibility. If necessary, you may contact your Provider Network Administrator or call Care1st Member Services for eligibility verification.

4.5: Disenrollment

Disenrollment refers to the termination of a Member’s enrollment with Care1st. It does not refer to a Member transferring from one primary care physician to another.

Typically, Medicare Advantage members may disenroll from Care1st only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Disenrollment Period from January 1 through February 14 of each year. Following this date, Members are "locked-in" throughout the benefit period.

For individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program, CMS allows individuals to enroll in, or disenroll from, an MA plan, on a continuous basis. This includes both “full benefit” dual eligible individuals as well as individuals often referred to as “partial duals” who receive cost sharing assistance under Medicaid.

Under certain circumstances it may be mandatory to disenroll a Member from Care1st. Some circumstances include but are not limited to:

- The member loses entitlement to either Medicare Part A or Part B.
- The SNP enrollee loses special needs status and does not reestablish SNP eligibility within the CMS allowable timeframe.
- Relocation of the Member outside of Care1st’s service areas.

SECTION 5: UTILIZATION MANAGEMENT
5.1: Utilization Management Program

The role of the Utilization Management (UM) Department is to ensure consistent delivery of high quality health care services to our Members through Care1st affiliated providers. Health care services are provided through full and shared risk networks structured to provide a continuum of care. The UM Department functions include authorization of the facility component for inpatient and outpatient procedures, home health, inpatient concurrent reviews, discharge planning, and retrospective reviews. Referrals for specialty care, diagnostic testing and other ancillary providers are reviewed by the PPG. If you have any questions regarding to whom you should submit a referral request, please contact your PPG.

Care1st Health Plan makes Utilization Management (UM) decisions only on appropriateness of care and service, based on the current Evidence of Coverage and the community standard of care. Care1st does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives that would encourage UM decision makers to make decisions that would result in underutilization of services.

The UM Department uses clinically sound, nationally developed and accepted criteria for making medical necessity decisions. The following includes, but is not limited to, a listing of the clinical criteria and resources used:

- MCG Guidelines
- Apollo Managed Care Guidelines
- The United States Preventative Services Task Force Standards
- The Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections
- CMS State and Federal Determination Guidelines
- Care1st-approved Clinical Practice Guidelines

These criteria alone cannot ensure consistent UM decision making across the organization. Care1st Health Plan recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan’s review process. The UM review criteria are available for disclosure to providers, Members, and the public upon request either in writing or by contacting the Care1st UM Department at 1-800-544-0888.

Care1st Health Plan uses nationally recognized clinical criteria in order to make UM decisions. These criteria are available to you upon request, by contacting 1-800-544-0888.

5.2: Authorization and Review Process

5.2.1: Authorization Timeframes

Inpatient and outpatient referral requests received from primary care and specialty care physicians shall be processed by the PPG according to the following designated time frames:

- **Standard** – decision within 14 calendar days from the date of request; notification within 14 calendar days after the receipt of request.

- **Expedited (no extension)** – decision within 72 hours from the date of the request (including weekends and holidays); notification within 72 hours after receipt of request.
Termination from Home Health Agency (HHA), Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF) – decision and Notice Of Medicare Non-Coverage delivery no later than 2 calendar days or 2 visits before coverage ends.

NOTE: Clean referrals are those referrals that contain adequate documentation and/or information to medically support the request, such as patient history to date, current symptoms, proposed treatments etc. If the information submitted is not adequate, the determination will be based upon the available information and/or lack of medical information. To expedite the process and to ensure appropriateness of the decision, it is very important that relevant clinical information be submitted with the request.

Request for Extensions:
Care1st may extend the decision time frame up to 14 calendar days. This extension is allowed if the enrollee requests the extension or if the provider or organization can justify a need for additional information and documents how the delay is in the best interest of the enrollee (for example, the receipt of additional medical evidence from non-contracted providers may change Care1st’s decision to deny). There are no extensions for collecting existing information from contracted providers.

Expedited Initial Organization Determination (EIOD):
When processing EIODs, it is necessary to determine if the expedited request is deemed to be expedited:

a) If expedited criteria are not met – the standard determination timeframe applies; give Member oral notice of the denial of expedited status and explains that the request will be processed using the 14-day timeframe. Follow the notification with written notice within 3 calendar days of the oral notice. The UM Department staff notifies the Member orally, then sends the standard denial letter informing the Member that the request did not qualify for expedited request and therefore, will be processed using 14 day-timeframe.

b) If no extension – decision within 72 hours of receipt after receipt of request (includes weekends and holidays); notification within 72 hours after receipt of request.

c) If extension requested – decision may extend up to 14 calendar days; written notification within 72 hours of receipt of request.

The physician reviewer rendering the determination will be available to discuss the decision with the requesting providers. The reviewer is available by calling (800) 468-9935.

Care1st provides written notification to Members and practitioners a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.

Care1st notifies Members of the reason for the denial in clear and understandable language.

5.2.1.a: Appeal Rights

When health care service is denied, the practitioners are notified of the appeal process. It includes the following:
1. Description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal;
2. Explanation of the appeal process, including the right to Member representation and time frames for deciding appeals;
3. Description of the expedited appeal process for urgent pre-service or urgent concurrent denials
   (Please see section 3.3 – Member Appeals and Grievances)

Please see Appendix 3 for the Utilization Management Timeliness Standards

5.2.2: Authorization Validity

Authorizations are generally approved for 30 days with a disclaimer stating that authorizations are valid only if the Member is eligible on the actual date of service. 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 1-800-544-0888.

Providers are responsible for re-verify eligibility and obtaining an updated authorization once the authorization has expired.

5.2.3: Specialty Referrals

PCPs are responsible for providing all routine health care services, including preventive care, to their enrolled Members. However, Care1st recognizes that in many circumstances 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.

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. This log must be completed by indicating the date when the consultation report was received, and whether the Member made it to the appointment or not. The office must have a process for recalling patients if the Member missed the appointment.

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.

5.2.4: 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 Member’s assigned PPG’s UM Department for review and authorization. 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.

5.2.5: **Outpatient Services**

Ambulatory services and outpatient surgery procedures require authorization by the Member’s assigned PPG’s UM Department.

5.2.6: **Elective Admission Requests**

All elective inpatient admissions require an authorization by the Care1st UM Department. Requests for elective inpatient admissions should be submitted to the Member’s assigned PPG’s UM Department. These requests will then be forwarded to the Care1st UM Department for final authorization.

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

5.3: **Emergency Services & Admissions Review**

An “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.

5.3.1: **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.

5.3.2: **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.

5.3.3: **Business Hours**

Care1st UM Department is available via telephone from 9:00 a.m. to 6:00 p.m., Monday through 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.
5.3.4: 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.

5.3.5: 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.

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 Member’s post emergency care.
- Facilitate Member transfers from emergency departments to contracted hospitals.
- 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 Chief Medical Officer (CMO), 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.

Nurse Advice Line

Care1st Medicare Members can access the Nurse Advice Line to receive fast and free medical advice over the phone. Registered nurses are available 24 hours a day – 7 days a week, including weekends and holidays. Members can call the nurse advice line at 1-800-544-0888.

5.3.6: Urgent / Emergent Admissions

Prior authorization is not required for emergency admissions (see Emergency Services for
definition of “Emergency Medical Condition”). 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.

**Plan Notification**

All contracted per-diem hospitals must notify the Care1st UM Department of 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. The hospital admission sheet comes from 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 concurrent and/or retrospective review procedures.

**5.3.7: 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, on a day to day basis thereafter, contingent on the condition that the inpatient care day has been determined to satisfy criteria for that level of care for 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 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 CMO.

**5.3.8: 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
The goal of the discharge planning process is to follow 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, 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

### 5.3.9: 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 does not receive sufficient information to meet the criteria (MCG Guidelines). When this occurs the case will be pended for a full medical record review to the CMO or designated physician reviewer.

All retrospective review referrals are to be turned around within 30 business days after 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.

### 5.4: Direct Access to Women’s Health Services

Care1st provides for direct access to women’s health services for routine and preventive health care services such as annual well woman exams,

These services must be provided by a Gynecologist within the PPG network. These services do not require prior authorization. Any treatments, procedures or surgeries that are recommended as a result of this evaluation will require prior authorization from the PPG.

### 5.5: Advance Directive

Care1st implements policies and procedures on advance directives for its Members and allows a Member’s representative to facilitate care or treatment decisions for a Member who is unable to do so. Care1st allows a Member or Member’s representative to be involved in decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.
5.6: Care Coordination and Integration

Care1st facilitates access to care for Members with specific care needs which includes arrangements with community and social services programs. This includes transition to and coordination of care by contracted and non-contracted providers. Care1st Case Managers implement procedures to ensure that services are appropriately coordinated.

Care1st educates providers about coordinated Medicare benefits for which Members are eligible and about Members’ special needs.

5.7: Non-discrimination in Healthcare Delivery

Care1st ensures that Members are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

5.8: Clinical Practice Guidelines

Care1st Health Plan, in collaboration with the Care1st Medical Services Committee, approves clinical practice guidelines that are available for physician reference. Please contact the Care1st Quality Management Department if you would like to receive these guidelines.

The current set of clinical practice guidelines include:
- Cardiac Care Guideline
- COPD Care Guideline
- Asthma Management Guideline
- Diabetes Management Guideline
- Attention Deficit Hyperactivity Disorder (ADHD) Guideline
- Major Depressive Disorder Guideline
- Major Depressive Disorders Unique to Women Guideline
- Schizophrenia Guideline

Clinical Practice Guidelines

Clinical Practice guidelines provide evidence-based recommendations for the assessment and treatment of various disorders. Additionally, the Clinical Practice Guidelines are reviewed and approved every two (2) years through our Medical Services Committee.

All guidelines used for the Care 1st CARES Disease Management Program are nationally recognized and represent appropriate standard of care for each condition.

Disease Management Program

Care1st Health Plan’s Disease Management Program, referred to as Care1st CARES, is to oversee and manage a defined Member population with chronic conditions by the consistent application of approved guidelines and criteria to achieve optimum Member outcomes with a focus on Member self-care efforts.

The intent of Care1st CARES Disease Management is to enhance quality of life and
activities of daily living, improve the disease pathway, to reduce health care service usage and costs associated with avoidable complications, such as emergency room visits and hospitalizations.

A focus of the program is to ensure a standardized approach in providing an educational pathway to assist Members with management of their chronic condition(s).

**Care1st CARES** Disease Management establishes on-going dialog and one-to-one communication with Members to assist in setting goals, developing actionable care plans, motivating the Member to succeed by achieving benchmarks in their care and encouraging Members to make the right choices regarding lifestyle changes. This Program is designed to inspire Members to participate actively in the management of their chronic conditions and focuses on improving the Member’s health and quality of life. Optimal care implementation can lead to measurable reduction in costs and improved outcomes.

**Care1st CARES** Disease Management is considered a multidisciplinary, continuum-based approach to the delivery of health care, proactively identifying distinct populations with a chronic condition considered high-risk. It reinforces the Member-practitioner relationship, prescribed plan of care with a focus on Member self-management, prevention of condition exacerbation, understanding signs and symptoms, various lifestyle choices, medication management, and minimizing complications through the application of evidence-based practice guidelines within a structured program. The **Care1st CARES** Disease Management Program continuously assesses the Member’s clinical condition, and reinforces a Member empowerment approach to improve overall health status.

The **Care1st CARES** Disease Management Program content addresses the following for each disease condition:

- **Condition monitoring:**
  - Includes Member reminders for self-monitoring tests or practitioner office testing
  - Initial and ongoing assessments by the Case Manager to assess how well the high risk Member is managing their care
  - Quality of life/functional status questions included in assessment
  - Symptom monitoring
- **Adherence to treatment plans:**
  - Includes adherence to self-monitoring activities, medication adherence and scheduled practitioner visits
  - Telephonic calls to Member by the Case Manager to assess:
    - Adherence to medications
    - Preventative care
    - Disease specific education
      - Action plan
      - Daily treatment plan
    - Recognize signs and symptoms of worsening condition
    - Keeping appointments with providers
    - Community education classes
      - Educational mailings
    - Enhance communication between Member and providers
- **Consideration of other health conditions:**
  - Assessing co-morbidities, cognitive/functional status
- **Lifestyle issues**
  - Addresses factors effecting chronic condition(s)
Targeted mailings and telephonic interventions including:

- Smoking cessation
- Nutrition
- Triggers
- Medication compliance
- Obesity
- Lack of exercise
- Alcohol/drug abuse

**Care 1st CARES** Disease Management Program interaction with Members is conducted either telephonically and/or via written correspondence.

**Medicare:** CHF & COPD  
**Medi-Cal:** Asthma & CHF

Please feel free to contact the Utilization Management Department if you have additional questions at 877-702-5566 or you can visit our website at [https://www.care1st.com/ca/providers/quality-improvement/care1st-cares/providers.asp](https://www.care1st.com/ca/providers/quality-improvement/care1st-cares/providers.asp)

**Care1st Care Transitions Program**

It is clearly established that hospital readmissions contribute significantly to the health care costs for the Medicare program. The most vulnerable Members affected by this problem are our Special Needs Plan (SNP) Members. CMS requires that all SNP Plans have a Care Transition Program in place.

Care1st’s Care Transition Program has been developed to meet all CMS requirements and deliver high quality care to our SNP Members during transition of care episodes. A care transition is defined as any time a Member moves from one care setting to another. Anytime a Member is admitted from home to the hospital, or discharged from the hospital to the Skilled Nursing Facility and eventually back home they are experiencing a care transition.

Care1st's Care Transition Team is comprised of Case Managers, Social Workers, Pharmacists, Physicians and Care Transition Coordinators. This team will work closely with the Member and/or caregivers to assist them through each and every care transition concurrently. Every time a care transition occurs, the PCP will be notified in writing. Once the Member transitions to their home, the Care Transition Specialist (CTS), who is a nurse, will call the Member and perform a comprehensive hospital discharge assessment and medication reconciliation. The CTS will also assist the Member with making an appointment to see the PCP and or any specialists needed. Copies of both the Hospital Discharge Assessment and a Medication Reconciliation Form will be mailed to the PCP.

We are confident that this program will be successful in lowering our readmission rates and improving the quality of care our SNP Members receive.

Please visit our website at [https://www.care1st.com/ca/providers/transition-program.asp](https://www.care1st.com/ca/providers/transition-program.asp) so you may review the various forms and documents both our Members and physicians will be receiving.

**Model of Care – Special Needs Plan**

The Centers for Medicare & Medicaid issued final regulations on the Medicare
Improvements for Patients and Providers Act of 2008, also known as MIPPA. As part of this regulation, the Special Needs Plan Model of Care has been implemented as of January 1, 2010.

The SNP Model of Care requires that all SNP Members receive an initial Health Risk Assessment (HRA) within 90 days of enrollment, and that an Individualized Care Plan (ICP) be created for each Member. The ICP will be developed and shared with the Member, the PCP and any other parties involved in managing the Member’s care such as PPG case managers or social workers. The purpose is to encourage the early identification of the Member’s health status, and allow coordinated care to improve their overall health.

HRA Process:

Care1st Health Plan has created a standardized HRA that evaluates the physical, psychosocial, cognitive, and functional needs of the SNP Member. Care1st Health Plan has contracted with a vendor to perform the telephonic HRA. The process is as follows:

- All HRAs will be conducted telephonically from vendor’s centralized call center.
- All successful and unsuccessful attempts will be documented and reported to Care1st on a weekly basis.

Care Plan Process:

Depending on the answers to specific HRA questions an Individualized Care Plan is generated. The Care Plan is comprised of problems, interventions and goals. The problem is specific to the identified issue based on the Member’s answer to the particular question. The intervention is targeted to address the associated problem and either a short term or long term goal is triggered.

The Member and Member’s PCP receive a cover letter explaining the HRA process and the Individual Care Plan. The PCP also receives a summary of the Member’s responses to the HRA. The Care1st HRA is available on the Care1st website at: https://www.care1st.com/ca/providers/snp-model-of-care.asp

SECTION 6: PHARMACEUTICAL MANAGEMENT

6.1: Medication Therapy Management (MTM) Program

The Medication Therapy Management (MTM) Program, will ensure optimum therapeutic outcomes for targeted beneficiaries (multiple chronic medical conditions, taking many prescription medications, minimum medication cost threshold) through improved medication use. The goal of the program is to reduce the risk of adverse events, including adverse drug interactions and improve the quality and cost effectiveness of the pharmacy benefit. The Care1st MTM program is offered at no additional cost. By assisting in the reduction of both over and underutilization, this program helps us make sure that our Members are using the appropriate drugs to treat their medical conditions and to identify possible medication problems. This is a voluntary program.
6.2: Pharmaceutical Quality Assurance

Care1st established measures and systems to conduct drug utilization reviews for all of our Members to make sure that they are getting safe and appropriate care. The programs include real-time and historic review of prescriptions claims to reduce medications errors and adverse drug interactions. These reviews are especially important for Members who have more than one doctor who prescribe their medications, use more than one drug, or have more than one pharmacy.

Care1st conducts drug utilization reviews when the pharmacy fills a prescription at the point-of-sale. The claim may be electronically reviewed for the following:
- Screen for duplicate drugs that are unnecessary because Member is taking another drug to treat the same medical condition.
- Age-related contraindications
- Gender-related contraindications
- Drug-Drug interactions
- Incorrect drug dosage
- Drug-Disease contraindications
- Drug-Pregnancy precautions
- Clinical abuse or misuse

In addition, retrospective drug utilization reviews identify inappropriate or medically unnecessary care. We perform ongoing, periodic review of claims data to evaluate prescribing patterns and drug utilization that may suggest potentially inappropriate use.

6.3: Pharmaceutical Utilization Management

This program incorporates utilization management tools to encourage appropriate and cost-effective use of Part D medications. The Care1st Pharmacy & Therapeutics Committee developed these requirements and limits to help us provide quality coverage to our Members. These tools include, but are not limited to: prior authorization, clinical edits, quantity limits and step therapy.
- Age Limits: Some drugs may require a prior authorization if the patient’s age does not meet the manufacturer, FDA, and clinical practice guidelines.
- Quantity Limits: For certain drugs, we limit the amount of the drug we will cover per prescription or for a defined period of time. Similar to the age limit, the quantity limit threshold is based on manufacturer, FDA, and clinical practice guidelines.
- Prior Authorization: Prior authorization is required for certain drugs. Typically, a prior authorization is established to ensure appropriate utilization.
- 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.
- Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically dispense the generic version, unless the prescription indicates “brand only”. If an FDA-approved generic alternative is available on the Care1st formulary, the prescribing physician will need to submit medical justification for the use of the brand product.
The Care1st formulary is available on the Care1st website (www.care1st.com). 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.

6.3.1: 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 4).

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 manager’s (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 communication to the provider. For medications requiring immediate 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.

6.4: Member Coverage Determination, Exceptions, and Appeals

Care1st Health Plan will follow the policy and procedures set forth in the Care1st Beneficiary Coverage Determination, Exceptions (Prior Authorization) P&P to administer and comply with the Medicare Part D requirements for performing these functions.

Providers may access the Pharmacy Prior Authorization request on the Care1st website (www.care1st.com) or by calling the Care1st Pharmacy Department. Verbal requests are accepted from medical providers.
Section 7: QUALITY IMPROVEMENT

7.1: Quality Improvement Program

Mission Statement

Care1st's Quality Improvement (QI) Department's mission 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, and 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, DHCS, 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 Quality Improvement Program is to monitor care and identify opportunities for improvement of care and services to both our Members and practitioners. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. This Quality Improvement Program covers all Medicare Members. Behavioral Health Care is a covered benefit for our Medicare line of business. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include but not limited to:

- Practitioner accessibility and availability
- Member satisfaction/grievances
- Member Safety
- Continuity and coordination of care
- Clinical measurement and improvement monitoring
- Chronic Care Improvement Program (CCIP)
- Credentialing and Recredentialing
- Peer Review
- IPA/MSO oversight
- Clinical practice guidelines
- Under and over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility site reviews
- Practitioner satisfaction
- Timeliness of handling claims
- High risk and high volume services
- Meet regulatory requirements and reporting
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.

**7.1.1 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/Pee Review, Pharmacy & Therapeutics, QIA Steering, and delegated oversight committees. Responsibilities of the CMO also include but are not limited to:
• Ensure that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative responsibilities.
• Ensure that the medical care provided meets the standards for acceptable medical practice.
• Ensure that medical protocols and rules of conduct for Plan medical personnel are followed.
• Develop and implementing medical policy.
• Resolve medical related grievances.
• Actively participate in the functioning of the Plan grievance procedures.
• Provide support and clinical guidance to the program and to all physicians in the network.
• Ensure that the QI and UM Departments interface appropriately to maximize opportunity for PQI improvement activities.
• Direct the implementation of the quality improvement process.
• Oversee the formulation of comprehensive policies and procedures to support the Quality Improvement operations.
• Analyze data.
• Review all clinical complaints, grievances, PQIs, QCIs; assigning severity levels; and directing actions to be taken, including peer review, if required.
• Review QI Program, work plan, annual evaluation and quarterly reports.
• Direct Health Education and Credentialing activities.
• Assist with the development, conduct, review and analysis of focused review, HEDIS, QIAs and QISMC studies.
• Collaborate as needed with the Utilization Management Department with Disease Management and preventive service programs and activities.

**Quality Improvement Medical Director**

The Quality Improvement (QI) Medical Director oversees the operations of the QI Department and is responsible for the execution and coordination of all quality improvement activities. The QI Medical Director reports to the CMO. The QI Medical Director helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI program and all QI policies and procedures. It is the QI Medical Director’s responsibility to interface with other departments on quality improvement issues. The QI Medical Director reports any areas of concern to the CMO and/or the Medical Services Committee. Additional responsibilities include but 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
 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 who 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.

**7.1.2: 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

Established thresholds and targets are:
• 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.

7.1.3 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.

**7.1.4: 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.

### 7.2: Policies & Procedures

#### 7.2.1: 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 an 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.

7.2.2: 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.

7.2.3: 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:
     - Regulatory agencies
     - Practitioner/Provider offices
     - 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 or the QI Medical Director 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 and or the QI Medical Director for recommendations. The CMO and or the QI Medical Director will identify a quality of care (QOC) description code, outcome code, and 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 and or the QI Medical Director 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 and or the QI Medical Director, 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 and or the QI Medical Director documents his rationale for action in the action section of the case review summary.
   d. If the CMO and or the QI Medical Director determines a quality of care issue exists, one or more of the following actions will be taken by the CMO: and or the QI Medical Director
      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 and or the QI Medical Director 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 and or the QI Medical Director 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 and or the QI Medical Director 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 and or the QI Medical Director.
c. The QI nurse specialist will modify the database to reflect any changes as a result of re-evaluation.
d. 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.

7.2.4: 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:

   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.

### 7.2.5: 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.

7.2.6: 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>
<th>Code</th>
<th>Event Description</th>
<th>Code</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Mortality</td>
<td>015</td>
<td>Retired</td>
</tr>
<tr>
<td>001</td>
<td>Unexpected Death</td>
<td>016</td>
<td>More than 2 ER visits/month</td>
</tr>
<tr>
<td>002</td>
<td>Asthma Admission</td>
<td>017</td>
<td>Sepsis</td>
</tr>
<tr>
<td>003</td>
<td>Breast Malignancy</td>
<td>018</td>
<td>Retired</td>
</tr>
<tr>
<td>004</td>
<td>Pregnancy Induced Hypertension</td>
<td>019</td>
<td>Prescription Drug Related Admission</td>
</tr>
<tr>
<td>005</td>
<td>Pulmonary Emboli</td>
<td>020</td>
<td>Over and Under Utilization</td>
</tr>
<tr>
<td>006</td>
<td>Diabetic Admission</td>
<td>021</td>
<td>Continuity and Coordination of Care</td>
</tr>
<tr>
<td>007</td>
<td>Low Birth Weight Infant</td>
<td>022</td>
<td>Cultural and Linguistic Issues</td>
</tr>
<tr>
<td>008</td>
<td>GI Catastrophe</td>
<td>023</td>
<td>Access Issues</td>
</tr>
<tr>
<td>009</td>
<td>Readmission with 30 days</td>
<td>024</td>
<td>Admission for CVA</td>
</tr>
<tr>
<td>010</td>
<td>Medical Management Issue</td>
<td>025</td>
<td>Admission for COPD</td>
</tr>
<tr>
<td>011</td>
<td>Surgical Management Issue</td>
<td>026</td>
<td>Admission for CHF</td>
</tr>
<tr>
<td>012</td>
<td>Hypertensive Admission</td>
<td>027</td>
<td>Hip Fracture</td>
</tr>
<tr>
<td>013</td>
<td>Cervical Malignancy</td>
<td>028</td>
<td>Admission for CAD/MI</td>
</tr>
<tr>
<td>014</td>
<td>Delay in Service or Authorization</td>
<td>015</td>
<td>Retired</td>
</tr>
</tbody>
</table>
7.2.7: 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 noncompliant 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: 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.

### 7.3.3: 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
7.4: 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.

7.5: 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.

7.6: Health Risk Assessment (“HRA”)

Purpose

To ensure that all Medicare Members have timely access to a Health Risk Assessment (“HRA”) within 90 days of enrollment. The HRA is to evaluate all new Medicare Members and to establish a process for identifying Members’ medical needs and status. The risk assessment consists of a health history, assessment of needs and initiates the process for Members getting needed care and services. Care1st utilizes a vendor to contact and complete these assessments and the Members are also encouraged to schedule an appointment with their primary care provider (PCP) to establish care and complete a full risk assessment, which consists of a comprehensive health history, assessment of health education needs, physical assessment, and specific evaluations, tests, immunizations, counseling, follow-up, behavioral assessment, and treatments.

Policy

Care1st or contracted vendor will contact all newly enrolled Members to complete a risk assessment and assist the Member in arranging an Initial Health Risk Assessment (IHRA). As referenced in Title XVII, the United States Preventive Services Task Force (“USPSTF”) Members are entitled to and should receive timely access to an IHRA or, alternatively, should have documentation in the patient’s medical record that a comparable assessment has recently been performed. Care1st Health Plan (“Care1st”) will assist providers in identifying Members who need an IHRA and educate Members and providers about the importance of an IHRA. Care1st will utilize an Interactive Voice Response (IVR) phone system to contact all new enrollees to assist them in scheduling their IHRA.

Risk Assessment Process:

1. Identification of newly enrolled Medicare Members:
   - Newly enrolled Medicare Members are identified by our Informatics Department and a monthly listing is supplied to our vendor for contact calls.
   - The Members identified through Informatics will have a HRA packet produced and mailed to the PCP. The packet includes a three page Health Risk Assessment progress note, summary of all conditions we have identified and a pharmacy profile.
   - All Medicare Members are re-identified for this assessment annually thereafter.
2. **Initial Health Risk Assessment (IHRA) Contact Process:**
   - The Informatics Data Analyst will provide the newly enrolled and identified Medicare Members to the HRA vendor.
   - The HRA Vendor will have a Nurse contact the Member to complete the HRA survey over the phone with an effort to schedule them for a physical assessment with the PCP.
   - The HRA Nurse will evaluate the Members’ medical needs such as medical equipment, diagnosis history, living situation and behavioral concerns.
   - The HRA Nurse will also try to schedule the Member for an initial health assessment and make sure the physician has the risk assessment form when conducting the initial visit.
   - All information is submitted to Care1st and housed in the Risk Assessment tracking database including scheduled appointments. This information is used to produce the Member individualized care plan.

**Initial and Annual Health Risk Assessments:**
- When a new Member or existing Member is due for an annual HRA they are identified and an HRA packet is produced. The packet consists of the three page progress note (with functional assessment, pain assessment, mental assessment, health history and full comprehensive physical assessment), diagnosis history, and a pharmacy profile.
- The packet is mailed out to the current PCP and instructions given to schedule the Member for this assessment.
- The providers are paid an incentive to complete the comprehensive physical assessment with instruction to submit the claim form with a copy of the progress note for review.
- The progress note is reviewed to assure a comprehensive assessment was completed before payment is approved.
- A monthly meeting will be held that includes QI, CMO, UM and Pharmacy to review and identify any Case Management or Disease Management needs.

**Health Assessments for Medicare Members must include, at minimum:**
- Care1st requires providers to complete a Staying Healthy Assessment form/IHEBA with this visit
- Full functional assessment
- Pain assessment
- Discussion of Advance Directives
- Complete history and physical examination that includes inspection of ears, nose, mouth, throat, teeth and gums
- Blood Pressure, pulse, resp., BMI, weight and height
- Cholesterol
- Clinical breast exam for women over 40 years of age
- Mammogram within 2 years for women over 40 years of age and within 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 pas smears; 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 Diphtheria/Tetanus (Td) at least every 10 years
• Influenza vaccine every year after age 65; and
• Pneumococcal vaccine; and
• Individual Health Education Behavioral Assessment.

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 IHRA. 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 IHRA.

2. Care1st Provider Relations representatives educate contracted practitioners/providers on the 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 IHRA.

4. Upon receiving updated eligibility lists, PCP offices, in cooperation with Care1st, shall contact new Members by mail and/or telephone to assess the current need for an IHRA 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.

5. 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.

6. If a Member refuses an IHRA, the refusal must be documented in the medical record.

7.7: Facility Site Review (“FSR”)

Purpose

The facility site review (FSR) is a comprehensive evaluation of your facility to ensure it meets and maintains contracted minimum requirements. This Review meets the Medicare Facility Site Review Policy requiring a comprehensive evaluation of Primary Care Physician’s and Obstetrics and Gynecology facilities that function as Primary Care Facilities. This ensures that each facility meets the Centers for Medicare and Medicaid Services expectations including physical accessibility status. Each Primary Care Physician’s site will be evaluated at the time of entry into the Care1st Network and every three (3) years by Care1st, or its designated vendor. Care1st does participate in the Site Review Collaborative in the County where your site(s) is/are located and will accept reviews completed by Certified Reviewers from other contracted Health Plans in the county and sometimes bordering counties. A complete facility and physical accessibility review tool is included at the end of this section.
7.7.1: Site and Physical Accessibility 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.

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.

7.7.2: Facility Review Tool

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.

7.7.3: 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.

7.7.4: 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
   • Freezer temperature is maintained between 2 and 8 degrees F (or –14
   • 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

7.7.5: 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.
7.7.6: 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.

7.7.7: 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.

**7.8: Medical Records**

**7.8.1 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.

7.8.2: 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.

7.8.3: 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. 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.
5. Entries must be legible to someone other than the author.
6. 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.
7. All entries must be dated and timed.
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 (in 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)
- Patient information sheet. This form should always be on top of all other forms in this section
- 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
- Authorization for release of medical records
- Letters to and from the patient and/or his or her agent
- Special cultural and linguistic needs

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

**Section 3. Laboratory**
- Laboratory reports are to be filed in reverse chronological order with the most current data on the top
- 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. XRAY and EKG**
- File in reverse chronological order filing with EKG results segregated from each other

**Section 5. Consult / Referral**
- Referral information such as correspondence directed to an outside agency, physician, health facility, etc. regarding the medical information contained in his/her particular patient’s medical record
• 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.
• Copy of medical records from previous medical practitioners/providers.
• Hospital discharge summaries
• Emergency room records

Section 6. Miscellaneous
• Correspondence with insurance companies or health plans
• Back to work forms
• 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 forward to 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
• All information contained in the medical record shall remain confidential. This includes medical, personal, social and financial information.
• Only authorized personnel (i.e., physicians, nurses, social workers, and authorized clerks) may have access to the contents of the medical record.
• Patient information in the medical record shall only be discussed over the telephone to facilitate patient care and only between qualified medical professionals directly involved in the patient’s care or health maintenance.
• Patient information in the medical record shall only be discussed by appropriate personnel and only in a location that assures confidentiality.
• 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.
• 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 medical record after presenting a signed 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.
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.

- 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.

- 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.

- 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

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

**Mental Health Care Records**

- 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.

- 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.

- 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

- 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.
- 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.
- 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.

7.9: Access to Care

7.9.1: 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 7). 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 15 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 noncompliance 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.

7.9.2: 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.
7.10: Broken/Failed Appointments

7.10.1: 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: ________________________________
   PRACTITIONER/PROVIDER SIGNATURE: ________________________________
   COMPLETED BY: ________________________________

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 missed 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/failed 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.

### 7.11: 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.

### 7.12: 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.

7.13: 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).

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>1. Adult BMI Assessment</td>
<td>Care1st will audit Members records age 18–74, and have been continuously enrolled for two years and determine if a BMI was done during that timeframe.</td>
<td>The Member should have a documented BMI within the past two years</td>
</tr>
<tr>
<td>2. Breast Cancer Screening</td>
<td>Care1st will audit Members that are age 40–69 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year.</td>
<td>The Member must have at least one (1) bilateral mammogram screen for breast cancer within the past two years.</td>
</tr>
<tr>
<td>3. Colorectal Cancer Screening</td>
<td>Care1st will audit Members that are age 50–80 during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>The Member must have at least one (1) of the following: 〈 Fecal Occult Blood Test (FBOT) during the last year, OR 〈 Colonoscopy within the past ten years, OR 〈 Sigmoidoscopy with the last five years, OR 〈 Double Contrast Barium Enema (DCBE) or air contrast barium enema during the last five years</td>
</tr>
<tr>
<td>4. Glaucoma Screening</td>
<td>Care1st will audit Members that are age 65 and older during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>The Member must have at least one (1) glaucoma screening with an eye care professional within the past two years.</td>
</tr>
<tr>
<td>5. Care for Older Adults</td>
<td>Care1st will audit Members that are age 65 and older during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>The Member must have each of the following during the measurement year: 〈 Advanced Care Planning 〈 Medication Review 〈 Functional Status Assessment 〈 Pain Screening</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
<td>Criteria</td>
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<tr>
<td>6. Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>Care1st will audit Members that are age 40 and older during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>Members that have a new diagnosis OR newly active chronic obstructive pulmonary disease (COPD) must have a spirometry test to confirm the diagnosis.</td>
</tr>
</tbody>
</table>
| 7. Pharmaco-Therapy management of COPD Exacerbation | Care1st will audit Members that are age 40 and older during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year. | Members that had an acute inpatient discharge OR ED encounter for exacerbation of COPD will be measured for the following:  
① Dispensed a systemic corticosteroid within 14 days of the event  
② Dispensed a bronchodilator within 30 days of event |
| 8. Cholesterol Management for Patients with Cardiovascular Conditions | Care1st will audit Members that are age 18-75 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) LDL screening within the past year which will also be measured for the percentage of results are below 100 mg/dL. |
| 9. Controlling High Blood Pressure | Care1st will audit Members that are age 18-85 during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year. | Members with a diagnosis of hypertension whose blood pressure was adequately controlled below 140/90 during the past year (the last BP reading on record in the calendar year is used) |
| 10. Persistence of Beta-Blocker Treatment After a Heart Attack | Care1st will audit Members that are age 18 and older during the measurement year who were hospitalized for an acute myocardial infarction (AMI). There must not be more than a one-month gap in enrollment during the measurement year. | Members who were hospitalized for an acute myocardial infarction (AMI) must have received persistent beta-blocker treatment for six months after discharge from the hospital. |
| 11. Comprehensive Diabetes Care | Care1st will audit Diabetic Members that are age 18-75 years of age during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year. | Diabetic Members must have the following done during the past year:  
① Hemoglobin A1C Screen  
② LDL Screen  
③ Retinal Eye Exam  
④ Medical Attention for Nephropathy  
These measures will also have rates for:  
① Rate of hemoglobin A1C <7  
② Rate of hemoglobin A1C <8  
③ Rate of Hemoglobin A1C >9  
④ Rate of LDL <100  
⑤ BP control <130/80  
⑥ BP control <140/90 |
<table>
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<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Disease Modifying Anti- Rheumatic Drug Therapy in Rheumatoid Arthritis</td>
<td>Care1st will audit Members who were diagnosed with rheumatoid arthritis. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>Members who were diagnosed with rheumatoid arthritis must have been dispensed at least one prescription for a disease modifying antirheumatic drug (DMARD) during the past year.</td>
</tr>
<tr>
<td>13. Osteoporosis Management in Women who had a Fracture</td>
<td>Care1st will audit female Members that are age 67 and older during the measurement year and suffered a fracture. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>Female Members who suffered a fracture must have had either a bone mineral density (BMD) test or prescribed a drug to treat or prevent osteoporosis within six months after the fracture.</td>
</tr>
<tr>
<td>14. Antidepressant Medication Management</td>
<td>Care1st will audit Members that are 18 years of age or older who were diagnosed with depression. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>Members who were diagnosed with depression who were treated with antidepressant medication and remained on medication treatment.</td>
</tr>
<tr>
<td>15. Follow-up After Hospitalization for Mental Illness</td>
<td>Care1st will audit Members that are 6 years of age or older who were hospitalized for mental illness. There must not be more than a one-month gap in enrollment during the measurement year.</td>
<td>Members that were hospitalized for mental illness must have a follow-up visit within 7 days of discharge.</td>
</tr>
</tbody>
</table>
| 16. Annual Monitoring for Patients on Persistent Medication | Care1st will audit Members that are age 18 and older who are on a select therapeutic agent. There must not be more than a one-month gap in enrollment during the measurement year. | Members that are on specific therapeutic agent must have the following:  
- Members on ACE Inhibitors or ARBs must have an annual serum potassium (K+), creatinine (SCr) and blood urea nitrogen (BUN).  
- Members on Digoxin must have an annual serum potassium (K+), creatinine (SCr) and blood urea nitrogen (BUN).  
- Members on Diuretics must have an annual serum potassium (K+), creatinine (SCr) and blood urea nitrogen (BUN).  
- Members on Anticonvulsants must have an annual drug serum concentration level. |
| 17. Medication Reconciliation Post-Discharge | Care1st will audit records to assure Member who are discharged from an acute care setting are having a medication reconciliations with their PCP of all discharge medications within 30 days of discharge. | Members that are discharged from an acute care setting will have a full Pharmacy Profile Report generated that includes all discharge medications sent to the PCP for review. |
SECTION 8: ENCOUNTER DATA

8.1: Encounter Data - Medicare

Policy

IPAs/Medical Groups shall submit encounter data at least once monthly. This shall include complete and accurate data that meets the volume, standard and timeframe as established by Care1st Health Plan.

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

COMPLIANCE GUIDELINES

Volume of the data
The Centers for Medicare and Medicaid Services’ (CMS) payment methodology is a risk-adjusted payment rate based on the reporting open counter data. Therefore, it is important to comply with encounter submission requirements and to report all services appropriately.

Quality of the data
The Care1st Health Plan collects information regarding the utilization of primary care, hospital inpatient and outpatient, specialty and ancillary services by its Members. Data acceptance rate shall not be less than 90% of all data submitted.

Timeliness of the data

Medicare:
Encounter records shall be submitted within 45 days of the end of the month in which the encounter occurred (date of service). Failure to submit encounter data on the 15th day following the 45 days’ timeframe, may constitute a material breach of contract and may result in sanctions.

Medi-Cal:
Encounter records shall be submitted within 10 days of the end of the month in which the encounter occurred (date of service). Failure to an encounter data file monthly submit encounter data monthly, may constitute a material breach of contract and may result in sanctions.

8.2: Encounter Data Submission

The submission of data from the appropriate risk adjustment sources and formats is critical for accurate risk adjusted payment. All Encounter data should be submitted or electronically in the format acceptable to Care1st. When necessary all Manual encounter forms must be submitted directly to Care1st Health Plan. Electronic Submissions to Care1st Health Plan.

Delegated IPAs may arrange to submit electronic encounter data by contacting the Care1st Encounter/MIS Department. Electronic data submissions are exchanged via FTP.
server and each IPA is assigned to a designated encounter folder with a private PGP key.

For questions regarding electronic uploading (FTP) & encryption (PGP) of Encounter files, contact Data Exchange at (323) 889-5254, or email: dataexchange@care1st.com. Electronic data must be submitted in ANSI X12/837 v5010

When necessary manual data must be submitted on one of the following forms:
• CMS-1500 for all professional encounters
• UB-04 for all institutional encounters

Encounter Data – Manual forms may be submitted to the following address:

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

Do Not Submit Claims Data to this address. Continue to submit Claims Data (i.e. Fees for Service Claims) to Care1st Health Plan Claims Department. For additional questions or information, please contact Sione Ayers, Manager of Encounter Data & Risk Management at (323) 889-6638 ext 3299.

8.3: Encounter Data Contact Requirement

• Provide primary and secondary contact information
  o Office Telephone #
  o Business Cell #
  o Fax #
  o Email

SECTION 9: CLAIMS

9.1: 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 clean and accurate. Clean claim mean a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

When submitting paper claims, all required/mandatory fields in the current CMS-1450 or UB format adopted by the National Uniform Billing Committee and CMS-1500 adopted by the National Uniform Claim Committee (NUCC).

When submitting claims electronically, claims must be HIPAA compliant and meet all requirements for EDI transactions.

C. Claim Filing Limits
Providers must submit clean claims to Care1st within one calendar year from the date of service.

9.2: Claims Processing Overview

A. Care1st makes every effort to ensure clean claims that are Care1st financial responsibility are processed (paid or denied) within 30 calendar days of receipt from non-contracted providers. All other claims are processed (paid or denied) within 60 calendar days of receipt.

B. Misdirected Claims
   a. Claims that are financial responsibility of the Participating Provider Group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.
   b. Billing Providers receive notices from Care1st identifying the responsible payers

C. Reimbursement Rates
   a. To be eligible for payment, the claim must be clean and accurate.
   b. Contracted providers are paid at contracted rate;
   c. Non-contracted providers are paid at Medi-Cal established rates

D. Interest payments are applied to clean claims from non-contracted providers that are not paid within 30 calendar days. Interest is paid for the period of the time that the payment is late. Interest rate is based on rate published by the Treasury Department.

E. Balance Billing
Beneficiaries are only responsible for plan allowed cost-sharing (copay/coinsurance). Members shall not be balance billed for any covered/authorized or approved services.

F. Overpayment Recovery
Care1st notifies provider of service in writing within three calendar year of the last claim payment when an overpayment is discovered. If the provider does not respond to the overpayment request within 41 calendar days from the first demand letter, 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. 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.

I. 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.

J. 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.

9.3: 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.

9.4: 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 10: ACCOUNTING

10.1: 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 of each PPG 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).

10.2: 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 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 Program

The Care1st Health Education 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. Members and providers may obtain more information about these programs and services by calling the Health Education Department.

11.2.1: Health Education Classes

The Health Education (HE) Department or the Utilization Management (UM) Department serves as resources for educational inquiries forwarded by the provider groups.

11.2.2: Community Outreach

The HE Department plans 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.

11.2.3: Health Education Materials

A variety of brochures and handouts are made available on the Care1st website (www.care1st.com). All materials are culturally sensitive and linguistically appropriate, and do not exceed the 6th grade reading level.

Care1st is highly committed to the delivery of quality health promotion and education activities. Before materials are purchased or created for the Member population, they are carefully reviewed to meet certain standards. The standards evaluate the content/style, layout/appearance, visuals/graphics, medical accuracy and readability of all materials.

For providers contracted with a PPG

Please contact the health education liaison at your affiliated PPG to order health education materials.

11.2.4: 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. Care1st offers a Living Well information line (1-800-544-0088) to answer Member questions on cholesterol, weight management, exercise, general nutrition guidelines, and diabetes.
11.2.5: Provider Education

The HE Department Health Educators are available to educate providers and their staff on health education services if the provider office requests this service. At this visit, the Health Educators distribute health education resources.

Care1st providers may contact the Health Education Department to request an in-service or more information on health education services.

11.3: Program Resources

11.3.1: 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 HE policies and procedures.
- Oversight of development, implementation, and evaluation of provider, Member and condition specific programs.
- Oversight of evaluation and distribution of culturally and linguistically appropriate Member education materials.
- Meeting the requirements of Centers for Medicaid and Medicare Services (CMS) 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 in addition to collaborating 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 for staff development in personal and Member health.

11.3.2: Departments in Collaboration with Health Education

Cultural and Linguistic Department
The HE Department collaborates with the Cultural and Linguistics Department to develop and implement training sessions for providers and PPG’s. These units also work together to ensure proper translation of the materials into threshold languages.
**Quality Management Department**
The HE Department collaborates with the Quality Management Department in the implementation of HE programs, and the development of disease state management programs.

**Member Services Department**
The Member Services Department serves as a liaison between the Member and the HE Department. The Member Services Department documents all common questions on health education related topics and distributes this to Health Education. Health Education uses this information for coordination of classes or materials distribution.

**Provider Relations Department**
The Provider Relations Department works with the HE Department to help identify health education needs of the provider.

**Marketing Department**
The Marketing Department works with the HE Department to help identify health education needs of the provider.

**Utilization Management Department**
The HE Department works in collaboration with the Utilization Management Department to direct appropriate health education services. The HE Department also assists the UM Department in educational services for Member education involving the appropriate use of the emergency room by researching, ordering, supplying and verifying appropriate reading levels of materials selected for use.

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**SECTION 12: 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 policies & procedures that are consistent with the National Standards (i.e. CMS) for CLAS. Contracts between Care1st and 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.

All providers must ensure that services are provided in a culturally competent manner to all members. This means you should provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical and mental disabilities.
12.1: Provider Responsibility in the Provision of CLAS

I. 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.

Care1st 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.

Definition: “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.

II. Access to 24 Hours & 7 Days Interpretation Services:

It is Care1st’s responsibility to provide 24 hours & 7 days language assistance necessary to afford Limited English Proficient (LEP) members meaningful access to health care services, free of charge.

Care1st and its providers 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 the 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, and 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.

**III. 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 is responsible for on-going distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural & Linguistic Department.

**IV. Cultural Competency Training:**

Care1st Health Plan values diversity as an integral component of our organization and will promote the achievement of a cultural 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).

**V. Translation of Member-Informing and Health Education Materials:**

Care1st Health Plan makes specific marketing materials available in any language that is the primary language of more than ten percent of its geographic service area. Such Marketing Materials may include but are not limited to:

- Summary of Benefits
- Annual Notice of Change
- Evidence of Coverage
- Appeals and Grievance letters
- Enrollment forms
- Enrollment Letters
- Advertising materials (brochures, flyers, and newspaper ads)

**VI. CLAS Related Grievances:**

Care1st Medicare Members have the right to file a grievance if their cultural and/or linguistics 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)
Care1st CLAS Department is available to provide further explanation on CLAS requirements as well as offer provider and staff education.

VII. **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.

**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 13: PROVIDER MEDICARE MARKETING GUIDELINES

13.1: Compliance with Laws and Regulations CMS-4131-F

Practitioners and providers and (your) subcontractors must agree to comply with rules and regulations that are applicable to federal contracts. These laws and regulations include Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the American Disabilities Act, and all other laws applicable to recipients of federal funds. This also includes the general rules that might apply and the policies, procedures and manual provisions, as well as other program requirements, issued by the Centers for Medicare & Medicaid Services (CMS). These also include Care1st’s policies and procedures.

13.2: Specific Guidance about Provider Promotional Activities

CMS is concerned with provider activities for the following reason:
- Providers may not be fully aware of all plan benefits and costs; and
• Providers may confuse the beneficiary if the provider is perceived as acting as agent of the Plan versus acting as the beneficiary’s provider.


13.3.1: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Marketing Reforms

The MIPPA became a law on July 15, 2008. Effective January 1, 2009, MIPPA included a number of prohibitions and limitations on sales and marketing activities by Medicare Advantage (MA) and Prescription Drug (PDP) Plan Sponsors and their agents, brokers or other third parties that represent them. Beginning September 18th, 2008 the prohibition on door to door solicitation has been extended to other instances of unsolicited contact that may occur outside of sales and education events.

Providers cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

Providers can refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, http://www.medicare.gov/, or 1-800-MEDICARE.

Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates.

13.3.2: Plan Activities and Materials in the Health Care Setting

While providers are prohibited from accepting enrollment applications in the health care setting, plans or plan agents may conduct sales presentations and distribute and accept enrollment applications in health care setting as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.

Prohibited Areas

Providers are prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

Provider Affiliation Information

Providers may announce new affiliations and repeat affiliation. Communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Provider affiliation banners, displays, brochures, and/or posters located
on the premises of the provider must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has as affiliation with certain plans and only lists plan names and/or contact information do not require CMS approval.

Special Needs Plan (SNP) Provider Affiliation Information

Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider’s affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and may include specific information about the SNP. This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

Comparative and Descriptive Plan Information

Providers may display benefit information for all contracted plans. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution.

CMS continues to hold the plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers may not conduct health screening or other like activities that could give the impression of “cherry picking” when distributing information to their patients, as health screening is a prohibited marketing activity.

Providers/Provider Group Websites

Providers may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

Providers’ Do’s and Don’ts

Providers should remain neutral parties in assisting plans with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accepting enrollment applications for Medicare Advantage (MA)/MA- Prescription Drug plans or PDPs.
- Directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mailing marketing materials on behalf of plans.
- Offering anything of value to induce plan enrollees to select them as their provider.
• Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
• Health screening and distributing information to patients, are prohibited marketing activities.
• Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.
• Providers contracted with plans (and their contractors) are permitted to do the following:
  • Provide the names of plans with which they contract and/or participate.
  • Provide information and assistance in applying for the Low Income Subsidy.
  • Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate.
CMS does not expect providers to proactively contract all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plans with which it participates. To that end, providers are permitted to:

  • Provide objective information on plans’ specific plan formularies, based on a particular patient’s medications and health care needs.
  • Provide objective information regarding plan sponsors’ plans, including information such as covered benefits, cost sharing, and utilization management tools.
  • Make available and/or distribute plan marketing materials including PDP enrollment applications, but not MA or MA-PD enrollment applications for all plans with which the provider participates.
• To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
• Refer their patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS’ website at http://www.medicare.gov/ or 1-800-MEDICARE.
• Print out and share information with patients from CMS’ website.

Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plans with which it participates.
The “Medicare and You” Handbook or “Medicare Options Compare” (from http://www.medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries.

**NOTE:** Plans may not use providers to distribute printed information comparing the benefits of different plans unless providers accept and display materials from all plans in the service area and contract with the provider.

**Important:** CMS conducts its regular marketing oversight and surveillance activities throughout the year. These oversight activities increase significantly during Annual Election and Disenrollment Periods. Care1st Health Plan is confident that the release of this information will help you implement CMS policies and procedures and comply with critical program requirements.

To contact the Care1st Medicare Marketing Department, please call 1-800-847-1222 or you may email us at www.Care1st.com

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**SECTION 14: REGULATORY, COMPLIANCE, AND ANTI-FRAUD**

**14.1: Overview**

All providers who render services to Care1st Health Plan Members must be informed of their responsibilities through their provider contract or through a provider manual or other provider communication. As a Medicare Advantage provider, you must comply with certain requirements as described in this section.

Care1st Health Plan is responsible for maintaining written agreements with practitioners and providers to provide adequate access to covered services.

Care1st Health Plan is also required to comply with National Coverage Determinations (NCD) issued by CMS. An NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a specific medical item or service. If the new NCD or legislative change in benefits meets the “significant costs” threshold, Care1st Health Plan is not required to assume the risk for the costs of the service until CMS has included the cost of the NCD in Care1st Health Plan capitation payment. Coverage of the services will be provided under the Medicare Fee-for-Service program. Medicare fiscal intermediaries and carriers will make payments on behalf of Medicare Advantage organization directly to providers and practitioners for costs associated with an NCD. Medicare Advantage enrollees may be liable for any applicable coinsurance amounts under Original Medicare. For more information on NCDs go the CMS web site at http://cms.hhs.gov/coverage/default.asp.
14.2: Medicare Part D

Beginning January 1, 2006, the new Medicare Prescription Drug Plan was available to all people with Medicare. Care1st’s Medicare Advantage Members were automatically enrolled in the Medicare Part D. These Members receive their medical care and prescription drug coverage from the Care1st Health Plan contracted Pharmacy network.

An important requirement of the Medicare Prescription Drug Improvement and Modernization Act (MMA) is the responsibility of the MA-PD to ensure the integrity of the prescription drug program. Care1st Health Plan works closely with CMS and CMS’ contractors to prevent fraud, waste and abuse of the prescription drug program. If you have questions or want to report suspected or potential fraud, waste and abuse problems, please call our Hotline at 1-877-837-6057 or you may contact Brooks Jones, CHC, Corporate Compliance Officer at (323) 889-6638 or e-mail to ComplianceSIU@care1st.com.

If you have any questions about Care1st Health Plan’s coverage of Medicare Part D, please call our Member Services Department at 1-800-544-0088

14.3: Compliance with Laws and Regulations

Providers and their subcontractors must agree to comply with all the rules and regulations that are applicable to federal contracts. These include all laws and regulations applicable to federal contracts including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of federal funds. This also includes general rules that might apply, and the policies, procedures and manual provisions, as well as other program requirements, issued by CMS. These also include Care1st Health Plan’s policies and procedures.

14.4: Compliance with Policies and Program

All practitioners and providers must comply with the medical policy and management program and quality assurance / quality improvement program. This includes reviewing and participating in the programs as required.

14.5: Prohibition against Contracting with Excluded Individuals and Entities and Opt-Out-Providers

Care1st Health Plan is prohibited from employing or contracting with practitioners and providers excluded from participation in federal health care programs or who have opted out of Medicare. Affiliated practitioners are also prohibited from employing or contracting with such providers. Contracts are terminable for these reasons. Affiliated practitioners and providers must certify to Care1st Health Plan that its contractors are eligible to participate in Medicare and/or provisions would be included in the written agreements. Monthly screening of employees, providers, and contracted entities against the Office of Inspector General (OIG) / List of Excluded Individuals and Entities (LEIE) and the General Service Administration (GSA) / System for Award Management (SAM) / Excluded Parties List Systems (EPLS) is essential to prevent inappropriate payment to providers and other individuals or contractors that may have been added to exclusion lists. The link for OIG/LEIE can be found at http://exclusions.oig.hhs.gov/ and the GSA/SAM/EPLS at https://www.sam.gov/.
14.6: Prompt Payment

The amount of payment and the period in which payment should be made must be set forth in the contract. Any subcontracts that you have with practitioners or provider to render services to Care1st Health Plan Medicare Advantage Members must likewise contain a prompt provision.

14.7: Disclosure of Information to CMS

Providers must provide Care1st Health Plan or CMS with all information that is necessary for CMS to administer and evaluate the Medicare Advantage program. Simultaneously, practitioners and providers must cooperate with Care1st Health Plan in providing CMS with the information CMS needs to establish and facilitate a process to enable current and potential beneficiaries to get the information they need to make informed decisions with respect to available choices for the Medicare coverage.

14.8: Maintenance and Audit of Record

The purpose of this requirement is to allow CMS to evaluate the quality, appropriateness and timeliness of services, the facilities used to deliver the services and other functions and transactions related to CMS requirements. It applies to all parties in relation to service performed, reconciliation of benefit liabilities and determination of amounts payable. All parties are required to have their records available for a 10-year period after Care1st Health Plan terminates its contract with CMS or the completion of an audit by the government, whichever is later (or longer in certain circumstances, if required by CMS). You must have books and records (including, but not limited to, financial, accounting, administrative and patient medical records and prescription drug files) available to support any activity with Care1st Health Plan.

14.9: Confidentiality

All providers must ensure the confidentiality and accuracy of the medical records or other health and enrollment information of Members and must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records or other health or Membership information. The provider shall not sell, release or otherwise disclose the name or address of any Member to any third party for any purpose, including scientific study.

Practitioners and providers must maintain records in accurate and timely manner and ensure timely access to Members who wish to examine their records. Confidential patient information that is protected against disclosure by federal or state laws and regulations may only be released to authorized individuals.

14.10: Fraud, Waste, and Abuse (FWA) Training Requirements

Employees and contractors who are involved in the administration or delivery of the Medicare benefits must, at a minimum, receive FWA training within 90 days of initial hiring (or contracting for contractors) and annually thereafter. Care1st Health Plan will provide training materials to assist in fulfilling this requirement.
Important Note: Providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the FWA training and education requirements. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or contractor is deemed.
### SECTION 15: APPENDICES

**Credentialing**  
Appendix 1: Standardized Audit Tool  

**Member Services**  
Appendix 2: Grievance Forms (go to [www.care1st.com](http://www.care1st.com) to see forms)

**Utilization Management**  
Appendix 3: Utilization Management Timeliness Standards

**Pharmaceutical Management**  
Appendix 4: Care1st Medication Prior Authorization Form

**Quality Improvement**  
Appendix 5: Sample: Authorization for Disclosure of Patient Healthcare Information  
Appendix 6: Practitioner/Provider Request to Terminate Patient/Provider Relationship Form  
Appendix 7: Access to Care Standards
# Standardized Audit Tool

## Medicare Facility Site Review Tool

### Reviewer Information:
- **Name**
- **Organization**
- **Contact For Questions About this Survey:**
  - **Name/Title**
  - **Phone**
  - **Email**

### Type of Facility:
- **Total number of on-site staff =**
- **Reviewer Information:**
  - **Name**

### Additional Information:
- **Address**
- **Physician**
- **NP**
- **RN**
- **PA**
- **LVN**
- **MA**
- **Clerical**
- **CNM**
- **MA**
- **Other**

### Group Practice (if applicable):
- **Name of Office Manager:**

### Visit Purpose
- **Initial Credentialing – Primary Location**
- **Initial Credentialing – Other Location**
- **CAP Follow-up 1 (date of this follow-up)**
- **CAP Follow-up 2 (date of this follow-up)**
- **CAP Follow-up 3 (date of this follow-up)**

### Corrective Action Plan
- Scores below 90% require a CAP
- Critical element deficiency requires CAP regardless of score.
- Scores below 70% will result in delay of credentialing until deficiency is corrected.

### Site Point Summary; Initial Visit
Enter total earned (yes) points and total available (yes + no) points for each section.

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<thead>
<tr>
<th></th>
<th>Earned</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Access/Safety</td>
<td>14</td>
</tr>
<tr>
<td>B.</td>
<td>Personnel</td>
<td>4</td>
</tr>
<tr>
<td>C.</td>
<td>Office Management</td>
<td>10</td>
</tr>
<tr>
<td>D.</td>
<td>Clinical Services</td>
<td>14</td>
</tr>
<tr>
<td>E.</td>
<td>Preventive Services</td>
<td>10</td>
</tr>
<tr>
<td>F.</td>
<td>Infection Control</td>
<td>12</td>
</tr>
</tbody>
</table>

### Site Score Summary; Initial Visit

<table>
<thead>
<tr>
<th></th>
<th>Total Points Earned:</th>
<th>Total Points Available:</th>
<th>Total Score:</th>
</tr>
</thead>
</table>

### CAP INFORMATION
- Next Follow-up Date: ________________
- Δ In-person visit
- Δ Documentation Req’d
- Δ Telephone follow-up

---

120
### A. Access/Safety Survey Criteria

#### Outside Building

1. Access to building is adequate, evidenced by reasonable parking and/or feasible public transportation within walking distance. Reviewer to consider regional site characteristics.

2. General appearance of exterior area is in good condition. ie litter free, good repair, adequate sign exposure.

3. Accommodations for persons with disabilities are available, evidenced by designated parking, loading zone, and/or public transportation within close proximity to the building. Reviewer to consider regional site characteristics.

#### Inside Building

4. Accommodations for persons with disabilities include all of the following:
   - a. external ramp (if applicable)
   - b. automatic entry option or alternative access method.
   - c. elevator for public use (if applicable).
   - d. restroom equipped with large stall and safety bars or other reasonable accommodation.

5. Exit signs are clearly visible.

6. An Evacuation plan is posted in a visible location.

7. Fire protection equipment (fire extinguisher, smoke detector, fire alarm, or sprinkler system) is accessible and in working order:

#### Inside Office

8. Emergency medications (injectable epinephrine, benadryl) are available on-site.

9. There is a procedure for the management of non-medical emergencies (i.e., earthquakes).

10. Adequate waiting and examination room space for the population served.

11. There is a procedure for handling medical emergencies appropriate to the patient population.

### B. Personnel Survey Criteria

1. There is evidence that staff receive orientation/training about policies and procedures relevant to their job description.

2. Appropriate licensure or certification is current and available (as applicable for RN, NP, LVN, PA, MA).
### B. Personnel Survey Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Standardized protocols are in place for all physician extenders (as applicable).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Staff signs Confidentiality Agreements at time of hire.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C. Office Management Survey Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Office hours are posted or are available on request.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. There is provision for 24 hour, 7 days per week coverage.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The average number of patients scheduled per day does not exceed 5 per hour.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. There is access to interpreter services for patients with limited English proficiency and those with hearing impairments.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. The average wait time is less than 30 minutes from the scheduled appointment time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Urgent visits are scheduled within 24 hours.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Non-urgent appointments are scheduled within 7 calendar days</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. Preventive exam appointments are scheduled within 30 days.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. There is a policy to follow-up on missed appointments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. There is a policy for compliance with HIPAA privacy regulations including evidence that the disclosure of privacy practices is signed by patient and posted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### D. Clinical Service Survey Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmaceutical Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The following are secured and inaccessible to patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Prescription pads</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Needles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Syringes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Medications (including sample drugs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## D. Clinical Service Survey Criteria

<table>
<thead>
<tr>
<th>Pharmaceutical Services</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Narcotics are stored in a secured locked cabinet accessible to only authorized licensed personnel.</td>
<td>YES</td>
</tr>
<tr>
<td>3. A current inventory is maintained for each controlled substance.</td>
<td>NO</td>
</tr>
<tr>
<td>4. Medications (including samples, emergency drugs and vaccines) are checked monthly for expiration dates and there are no expired medications on site.</td>
<td>N/A</td>
</tr>
<tr>
<td>5. There is a policy for disposal of expired medications.</td>
<td></td>
</tr>
<tr>
<td>6. Refrigerator thermometer temperature is maintained and documented daily at 35°-46° Fahrenheit.</td>
<td></td>
</tr>
<tr>
<td>7. Freezer thermometer temperature is maintained and documented daily at 5°Fahrenheit if varicella vaccine is present.</td>
<td></td>
</tr>
<tr>
<td>8. Drugs are stored in a separate refrigerator from food and drinks.</td>
<td></td>
</tr>
</tbody>
</table>

### Laboratory Services

9. CLIA certificate number or CLIA Waiver is current (if applicable).

   a. Indicate certificate number here: __________________________

   b. Indicate expiration date here: __________________________

### Radiology Services

10. X-ray technician license(s) is current.

   a. Indicate license number(s) and expiration dates here: ____________

11. X-Ray equipment maintenance documentation is current.
E. Preventive Services Survey Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exam rooms are neat and clean and have exam tables with protective barriers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. At least one exam room can accommodate physically challenged patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The office has age-appropriate equipment, including but not limited to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. weight scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. length/height measuring device</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. sphygmanomometer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. thermometer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. exam gowns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. eye chart</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Education

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Educational materials are:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. available for patients</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. language appropriate for the patient population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F. Infection Control Survey Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The following autoclave processes are documented (as applicable):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Follow written Policies &amp; Procedures for sterilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Routine maintenance (inspection dates, service results, calibration, repairs, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Monthly spore checks *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The following cold chemical sterilization processes are documented (as applicable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Containers dated and labeled with name of solution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Solutions used must kill HIV, HBV, TB (should be indicated on label)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Solutions used according to manufacturer’s guidelines. (note: test strips are used according to manufacturer’s guidelines)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Specimens requiring refrigeration are stored in sealed containers and separated from drugs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### F. Infection Control Survey Criteria Cont.

<table>
<thead>
<tr>
<th>Hazardous Waste/Sharps</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. There is a needle disposable system available.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Engineered Sharps Injury Prevention (ESIP) device and/or safety needles are available on site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. There is a policy for the handling of bio hazardous waste</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. There is a contract or written agreement for the secured disposal of bio hazardous waste.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Bio hazardous waste is stored in rigid leak resistant containers.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CRITICAL ELEMENT: FAILURE TO MEET THIS CRITERIA RESULTS IN CAP REGARDLESS OF OVERALL SCORE**

### Corrective Action Plan (CAP)

The Health Plans have collaborated in establishing a process to facilitate compliance while limiting the intrusion into your facility. Participating Health Plans agree to accept evaluation findings of the other Health Plans upon the physician’s signature of Disclosure and Release. The collaborative process does not supersede any contractual requirements and participation is voluntary.

### Disclosure and Release

I have received and reviewed copies of the above listed site’s evaluations and corrective action plans for the facility and medical record reviews (if applicable). I agree to correct each identified deficiency by implementing any corrective action that may be required. I understand that failure to correct any of the noted deficiencies within the required **30 calendar days** from the review date may result in the exclusion of this facility and the associated provider(s) from the roster. The completed CAP must include evidence of correction, date completed, and responsible person.

For assistance in completing the CAP, please call the Facility Site Review (FSR) Department, at 323-889-6638, ext. 6417.

I hereby authorize the above mentioned health plan and any government agencies that have authority over the health plans, and authorized county entities in the State of California, to furnish to each other these reviews and corrective action plans of this facility.

---

Print Name of Physician/Designee and Title __________________________ Signature of Physician/Designee __________________________ Date __________________________
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine (Non-urgent)</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. Member: None Specified.</td>
</tr>
<tr>
<td><strong>Pre-Service</strong></td>
<td></td>
<td>Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.</td>
</tr>
<tr>
<td><strong>Extension Needed</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. Member: None Specified.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member: None Specified.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practitioner: Within 2 working days of making the decision. Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practitioner: Within 2 working days of making the decision. Member: None Specified.</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification (Notification May Be Oral and/or Electronic)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Additional information received</strong></td>
<td></td>
<td>Practitioner: Within 24 hours of making the decision.</td>
</tr>
<tr>
<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>Member: None Specified.</td>
<td>Member: None Specified.</td>
</tr>
<tr>
<td><strong>Additional information incomplete or not received</strong></td>
<td></td>
<td>Practitioner: Within 24 hours of making the decision.</td>
</tr>
<tr>
<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>Member: None Specified.</td>
<td>Member: None Specified.</td>
</tr>
<tr>
<td><strong>Expedited Authorization (Pre-Service)</strong></td>
<td>Within 72 hours of receipt of the request.</td>
<td>Practitioner: Within 24 hours of making the decision.</td>
</tr>
<tr>
<td>• Requests where provider indicates or the Provider Group/Health Plan determines that the standard time-frames could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.</td>
<td></td>
<td>Member: None Specified.</td>
</tr>
<tr>
<td>• All necessary information received at time of initial request.</td>
<td></td>
<td>Member: None Specified.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service.</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Initial Notification (Notification May Be Oral and/or Electronic)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Expedited Authorization (Pre-Service) - Extension Needed</td>
<td>Additional clinical information required: Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and Member using the “delay” form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered.</td>
<td>Practitioner: Within 24 hours of making the decision. Member: None specified.</td>
</tr>
<tr>
<td></td>
<td>Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan 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></td>
</tr>
<tr>
<td>Additional information received</td>
<td>If requested information is received, decision must be made within 1 working day of receipt of information.</td>
<td></td>
</tr>
<tr>
<td>Additional information incomplete or not received</td>
<td>Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.</td>
<td></td>
</tr>
</tbody>
</table>

**Practitioner:** Within 24 hours of making the decision.

**Member:** None specified.

**Practitioner:** Within 2 working days of making the decision.

**Member:** Within 2 working days of making the decision.
<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>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.</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>In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.</td>
<td><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.</td>
<td>Member: None Specified.</td>
<td>Member: Within 2 working days of making the decision.</td>
</tr>
<tr>
<td>CA H&amp;SC 1367.01 (h)(3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification</th>
<th>Written/Electronic Notification of Denial and Modification to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent</td>
<td>Within 5 working days or less, consistent with urgency of Member’s medical condition.</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>Parallel</td>
<td>Within 2 working days of making the decision.</td>
<td>Member: Within 2 working days of making the decision.</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** 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.

CA H&SC 1367.01 (h)(2)
**Concurrent** review of treatment regimen already in place—(i.e., inpatient, ongoing/ambulatory services).

**OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.

<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>Post-Service / Retrospective Review</strong></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>
</tbody>
</table>

**Note:** 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.
<table>
<thead>
<tr>
<th>Post-Service - Extension Needed</th>
<th>Additional clinical information required (AKA: deferral).</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Additional clinical information required.</td>
<td>• 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.</td>
</tr>
<tr>
<td>Additional information received</td>
<td>Additional information received</td>
</tr>
<tr>
<td>• If requested information is received, decision must be made within 30 calendar days of receipt of information.</td>
<td>• If requested information is received, decision must be made within 30 calendar days of receipt of information.</td>
</tr>
<tr>
<td>Example: Total of X + 30 where X = number of days it takes to receive requested information.</td>
<td>Example: Total of X + 30 where X = number of days it takes to receive requested information.</td>
</tr>
<tr>
<td>Additional information incomplete or not received</td>
<td>Additional information incomplete or not received</td>
</tr>
<tr>
<td>• 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>• 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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice - Inpatient Care</th>
<th>Within 24 hours of receipt of request.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner: Within 24 hours of making the decision.</td>
<td>Practitioner: Within 24 hours of making the decision.</td>
</tr>
<tr>
<td>Member: None Specified.</td>
<td>Member: Within 2 working days of making the decision.</td>
</tr>
<tr>
<td>Practitioner: Within 2 working days of making the decision.</td>
<td>Member: Within 2 working days of making the decision.</td>
</tr>
</tbody>
</table>
# Medication Prior Authorization Form

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: <em>(required)</em></th>
<th>Patient ID#: <em>(required)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Phone Number:</td>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td></td>
<td>Sex: □ Male □ Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Name:</th>
<th>Pharmacy NABP Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Phone Number:</td>
<td>Pharmacy Fax Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescribing Physician’s Name: <em>(required)</em></th>
<th>Specialty: <em>(required)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>State NPI Number:</td>
<td>E-mail address: <em>(optional)</em></td>
</tr>
<tr>
<td>Phone Number: <em>(required)</em></td>
<td>Fax Number: <em>(required)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Requested: <em>(required)</em></th>
<th>Strength: <em>(required)</em></th>
<th>Formulation:</th>
<th>Quantity:</th>
<th>Days Supply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis: <em>(required)</em></td>
<td>Duration of Therapy:</td>
<td>Refills:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directions, sig or a copy of prescription: <em>(required)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Medications: <em>(required)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Medication(s) Tried and Failed: <em>(required)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Justification: <em>(required)</em></td>
</tr>
</tbody>
</table>

| Signature of Requestor: *(required)* | Request Date: |

---

**CONFIDENTIALITY NOTICE:** This document and any attachments are confidential and may be protected by legal privilege. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of this information or any attachment is prohibited. 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.
Authorization for Disclosure of Patient Healthcare Information

Provider/Clinic: ____________________________

Address: ______________________________________

Phone: _______________________________________

Patient’s Last Name __________ First Name __________ Middle Initial __________ Date of Birth __________ Former Name (if any) __________

Social Security # __________ Medical Record # __________

I authorize __________________________ to release records to __________________________

Information to be released:

☐ Entire Medical Record ☐ Only those records pertaining to:

☐ Alcoholism ☐ HIV (Aids) ☐ developmental disabilities ☐ drug abuse ☐ other – specify __________

Under California State Law, the office cannot release certain information unless you give us special permission to release it. I give specific permission to release records pertaining to the following:

Note: Requests for Mental Health information must be made in accordance with Section 56.10 of the California Civil Code.

Reason for Disclosure:

☐ Further medical care ☐ Payment of insurance claim ☐ legal investigation

☐ Applying for insurance ☐ vocational rehab evaluation ☐ other – specify: __________

☐ Disability determination ☐ personal __________

This authorization is valid for one time access to the medical records and expires 30 days from _______________ (date).

I authorize release of my medical records as specified above. I understand that the only way to cancel this request is to notify the provider/clinic in writing. I also hereby release the provider/clinic from all legal responsibility and liability that may arise from the release of the information authorized by this document.

Signature of patient: ____________________________ Date: __________

If signed by anyone other than the patient, state relationship and/or reason and legal authority to do so.

Patient is: ☐ Minor ☐ incompetent ☐ Disabled ☐ Diseased ☐ Legal guardian ☐ Next of kin to deceased

Signature of Witness: ____________________________ Date: __________

For Clinic Use Only:

Date Received: __________ I.D. Provided: __________

Date Released: __________ Processed By: __________
## PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name (First and Last):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th>License #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>IPA/Medical Group:</th>
</tr>
</thead>
</table>

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name (First and Last):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>SSN:</th>
</tr>
</thead>
</table>

Reasons for terminating patient/doctor relationship:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please give specific dates and instances of the issues you have had with this member:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs Defined as:</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>Emergency exam</td>
<td><strong>Immediately</strong></td>
</tr>
<tr>
<td></td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>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>Urgent PCP exam</td>
<td><strong>Within 48 hours if no authorization is required</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Within 96 hours if an authorization is required</strong></td>
</tr>
<tr>
<td></td>
<td>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>Sensitive Services</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:</td>
</tr>
<tr>
<td></td>
<td>- Sexual Assault</td>
</tr>
<tr>
<td></td>
<td>- Drug or alcohol abuse for children 12 years of age or older</td>
</tr>
<tr>
<td></td>
<td>- Pregnancy</td>
</tr>
<tr>
<td></td>
<td>- Family Planning</td>
</tr>
<tr>
<td></td>
<td>- Sexually Transmitted Diseases, for children 12 years of age or older</td>
</tr>
<tr>
<td></td>
<td>- 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.</td>
</tr>
<tr>
<td></td>
<td>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>Routine PCP, Non-urgent exam</td>
<td><strong>Within ten (10) business Days</strong></td>
</tr>
<tr>
<td></td>
<td>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>Initial prenatal visit to OB/GYN</td>
<td><strong>Within seven (7) Calendar Days</strong></td>
</tr>
<tr>
<td></td>
<td>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>
<tr>
<td>Well child visits (For child under 2 years of age)</td>
<td>Within fourteen (14) Calendar Days</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Preventive care and physical exam</td>
<td>Within thirty (30) Calendar Days</td>
</tr>
<tr>
<td>Initial Health Assessments and behavioral health screenings if not completed by the County Mental Health Plan or MBHO contracted Behavioral Health Practitioner previously.</td>
<td>Within thirty (30) calendar days upon request (must be completed within 90 calendar days from when member becomes eligible)</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Care1st requires that a Staying Healthy Assessment form is utilized during this visit.</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. 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.</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. 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.</td>
</tr>
<tr>
<td></td>
<td>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>Waiting Time when contacting Care1st</td>
<td>During normal business hours members will not wait more than 10 minutes to speak to a plan representative</td>
</tr>
<tr>
<td>Waiting Time in office</td>
<td>Thirty (30) minutes maximum after time of appointment</td>
</tr>
<tr>
<td>Access for Disabled Members</td>
<td>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.</td>
</tr>
<tr>
<td>Seldom Used Specialty Services</td>
<td>Care1st will arrange for the provision of seldom used specialty services from specialists outside the network when determined medically necessary.</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 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</td>
</tr>
</tbody>
</table>
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 required)</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td></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 required)</td>
<td>Within 96 hours</td>
</tr>
<tr>
<td></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-urgent exam</td>
<td>Within fifteen (15) Business Days</td>
</tr>
<tr>
<td>Routine Ancillary visit, Non-urgent exam</td>
<td>Within fifteen (15) Calendar Days</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 | During normal business hours members will not wait more than 10 minutes to speak to a plan representative |

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Time in office</td>
<td>Thirty (30) minutes maximum 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>
</tbody>
</table>
## Behavioral Health Access to Care Standards
### ATTACHMENT C

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<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 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>