Accreditation of Medi-Cal,
Medicare, L.A. Care *Covered*™

L.A. Care HEALTH PLAN®

The New Provider Orientation Handbook

LA1456 08/23

Dear L.A. Care Contracted Preferred Physician Group,

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

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

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

Additionally, if you need clarification on any of the information provided, please contact your PPG or your L.A. Care Provider Network Account Manager for further guidance.

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

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L.A. Care History

Established in 1997, L.A. Care is an independent local public agency created by the state of California to provide health coverage to low-income Los Angeles County residents. L.A. Care is the nation's largest publicly operated health plan. Serving more than 2.7 million members, our mission is to ensure our members get the right care at the right place at the right time. For more history and information on L.A. Care, please visit **lacare.org.**

L.A. Care's Delegated Model

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

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

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

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

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

To determine who is financially responsible for the claim, please contact the members assigned PPG or reference your PPG contract for more information.

Timely Filing Deadline

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

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 form for facility services. L.A. Care accepts EDI submissions, please reference **Submitting a Claim | L.A. Care Health Plan (lacare.org)**

Claims Adjudication

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

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

Provider Portal Claims Verification

The L.A. Care Provider Portal is the preferred method for contracted providers to check claims status. Please see information on how to access the L.A. Care Provider Portal in the Provider Portal section of this handbook.

The secondary method to check claims status is by calling **1.866.LA-CARE6.**

Balanced Billing

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

Provider Disputes

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

Provider disputes must be submitted to:

L.A. Care Health Plan Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

Services That Do Not Require Prior Authorization

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

Services That Always Require Prior Authorization

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

- Non-emergency out of area care (outside of L.A. County)
- Out of network care, services not provided by a contracted network doctor
- Inpatient admissions, post-stabilization/non-emergency/elective
- Inpatient admission to skilled nursing facility or nursing home
- Outpatient hospital services/surgery
- Outpatient, non-hospital , such as surgeries or sleep studies
- Outpatient diagnostic services, minimally invasive or invasive such as CT Scans, MRIs, colonoscopy, endoscopy, flexible sigmoidoscopy, and cardiac catheterization
- Durable Medical Equipment, standard or customized; rented or purchased
- Medical Supplies
- Prosthetics and Orthotics
- Home Health Care, including: nurse aide, therapies, and social worker
- Hospice
- Transportation (excluding emergency medical transportation)
- Experimental or Investigation Services
- Cancer Clinical Trials

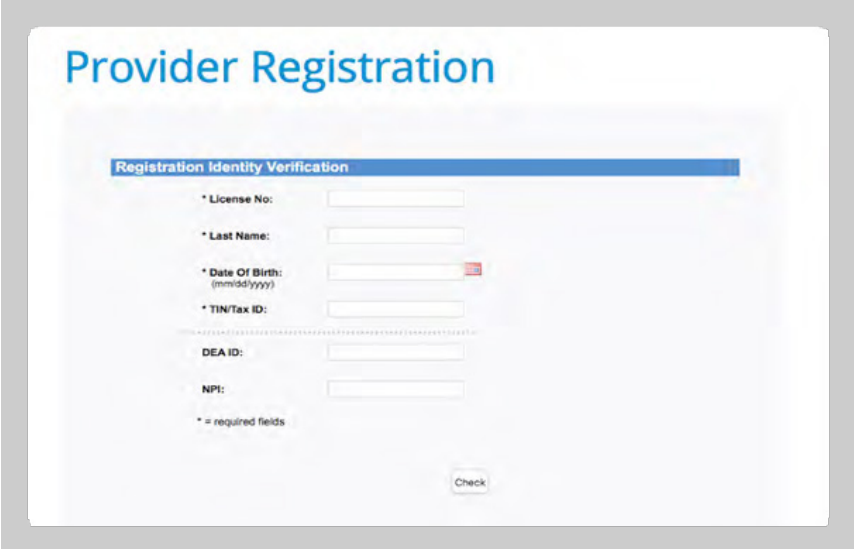
Hospital and Ancillary Provider Network
L.A. Care maintains a network of contracted hospitals and ancillary providers. Please contact your PPG/ MSO for the most recent list to be utilized for services provided to L.A. Care Direct members.

Provider Portal: Registering a New Provider

All contracted physicians and specialist may self-register at
www.lacare.org/providers/provider-central/la-care-provider-central

All information marked with an asterisk is required in order for your request to be processed. See Figure 1.

Figure 1.



All other medical and administrative staff have to submit a request for registration for the Provider Portal. This request can be submitted via email to **providerrelations@lacare.org.** The required information that needs to be specified is listed below:

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

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

Once you receive access to the Provider Portal you will be notified via email to confirm your registration. You will have 24 hours to activate your account with the link provided to you by email.

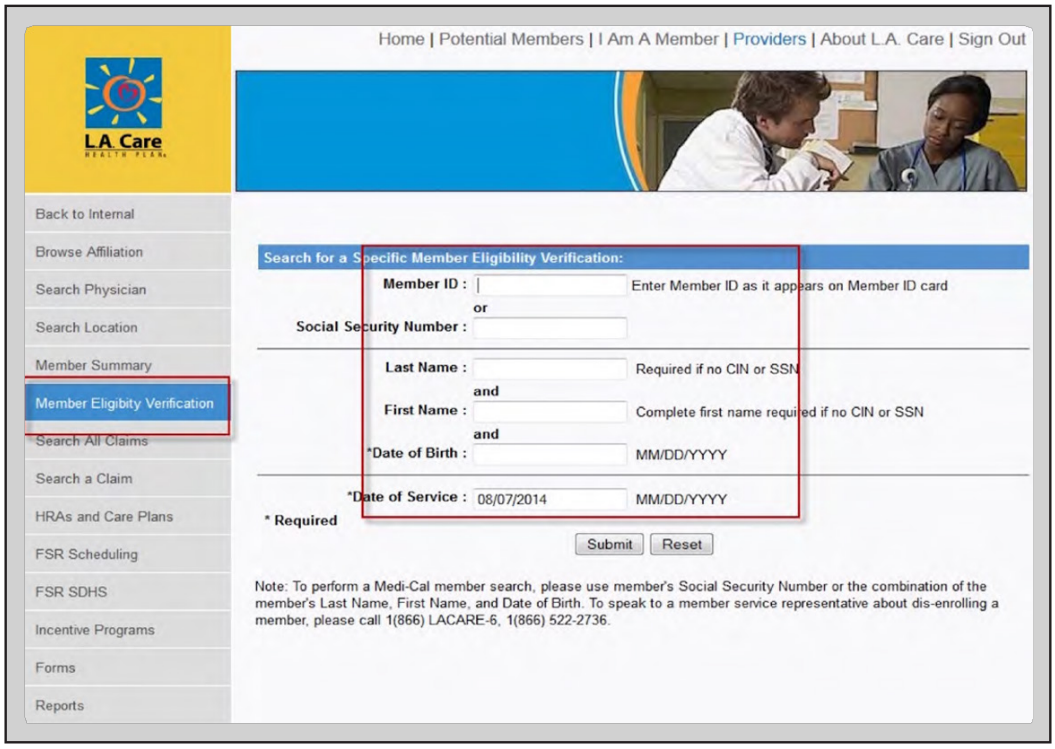
If you do not activate your account within the 72-hour period you will have to contact the Provider Relations department at **providerrelations@lacare.org** to receive a new activation email for your account.

Checking Member Eligibility

1 Log on to the Provider Portal then select *"Member Eligibility Verification."*
L.A. Care Provider Central | L.A. Care Health Plan (lacare.org)

2 Please fill out all fields with as much information as possible to get the best results. Click "submit when finished. See Figure 2.

Figure 2.



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

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

Physical Access

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

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

Reasonable Modifications

The Americans with Disabilities Act (ADA) provides protection from discrimination for people with all types of disabilities, including people with physical, cognitive, communication and mental health disabilities.

Health care providers must make reasonable modifications in policies, practices and procedures when necessary to avoid discrimination on the basis of disability, unless the provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.

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

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

Procedures for Providing Accommodations

Health care providers must:

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

Initial Health Appointment

The Initial Health Appointment (IHA) is a comprehensive assessment that is completed during a Member's initial encounter within a primary care setting (usually the assigned PCP), and must be provided in culturally and linguistically appropriate manner and documented in the Member's medical record.

The components may be provided in person or virtually, though all components cannot be provided virtually. The IHA enables the Member's PCP to assess and manage the acute, chronic, and preventative health needs of the Member.

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

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

Annual Cognitive Health Assessment (ACHA)

The Annual Cognitive Health Assessment (ACHA) is a component of the Evaluation & Management (E&M) visit for Medi-Cal members 65 years and older who do not have Medicare coverage. The ACHA is used to identify if a member has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN).

In order to facilitate the ACHA, providers must first complete the Department of Health Care Services (DHCS)' Dementia Care Aware cognitive health assessment training. Providers should use validated ACHA screening tools and complete necessary follow-up services based on the assessment findings, such as additional assessments and appropriate referrals.

Staying Healthy Assessments

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

Provider Toolkits

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

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

The medical and mental health toolkits are available at
www.lacare.org/providers/provider-resources/tools-toolkits/toolkits

The CHDP Program

Provides health assessments for the early detection and prevention of disease and disabilities for low-income children and youth.

CHDP health assessments screenings should consist of the following:

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for children to receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

EPSDT services include all services covered by Medi-Cal. A beneficiary under the age of 21 may receive additional medically necessary services.

EPSDT Screening Services

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

- a comprehensive health and developmental history (including assessment of both physical and mental health development)
- a comprehensive unclothed physical exam
- appropriate immunizations according to the required schedule according and to age and health history
- laboratory tests (including blood lead level assessment appropriate for age and risk factors)
- health education (including anticipatory guidance)

EPSDT Diagnostic Services

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

ESPDT Treatment Services

Mental Health and Substance Use Services:

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

  See "Carelon Behavioral Health Section" below for more information.

Medically Necessary Personal Care Services

- Are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility, or institution for mental disease, that are:
- Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State), otherwise authorized for the individual in accordance with a service plan approved by the State
- Provided by an individual who is qualified to provide such services and is not a member of the individual's family
- Furnished in a home or in another location

Oral Health and Dental Services:

- EPSDT requires that dental services are provided at internals which meet reasonable standards of dental practice as determined in consultation with medical experts, and at other internals as medically necessary to determine the existence of a suspected illness or condition.
- At a minimum, dental services must include relief of pain and infections, restoration of teeth, and maintenances of dental health.
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.
- Medi-Cal Dental Care and Treatment Services are a carved out benefit for Medi-Cal members through the Medi-Cal Denti-Cal Program. Members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made for Members no later than 12 months of age or when referral is indicated based on assessment.
- Primary Care Providers are expected to perform dental screenings on all Medi-Cal members as part of the IHA, periodic, and other preventive health care visits and provide referrals to the Medi-Ca Denti-Cal
  Program for treatment. For children, Denti-Cal uses the periodicity schedule recommended by American Academy of Pediatric Dentistry (AAPD). Also some Dental benefits for adults 21 and older have been recently restored. To find a dentist, Medi-Cal members should be advised to call Denti-Cal at 1.800.322.6384 or visit **www.denti-cal.ca.gov**.
- For members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made no later than 12 months of age or when referral is indicated based on assessment.
- Fluoride varnish and oral fluoride supplementation assessment and provision must be consistent with the AAP/Bright Futures periodicity schedule and anticipatory guidance.

Additionally, L.A. Care will cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures. Dental providers are able to reach out to the dental liaison or Utilization Management to assist with referrals these services.

Vision and Hearing Services

- EPSDT requires that vision services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.
- Glasses to replace those that are lost, broken, or stolen also must be covered.
- Medi-Cal vision benefits are covered by L.A. Care.
- L.A. Care has contracted with Vision Service Plan (VSP) to coordinate Medi-Cal vision care and lenses.
- To find out more about eye exams or vision care coverage for Medi-Cal members, call VSP at 1.800.877.7195 [TTY/TDD 1-800-428-4833].
- To find out more about eye exams or vision care coverage, you can also call L.A. Care Member Services at the toll free number **1.888.839.9909** [TTY/TDD **1.866.522.2731**].
- EPSDT requires that hearing services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Vaccines for Children (VFC)

The Vaccines for Children Program, established by an act of Congress in 1993, helps families by providing free vaccines to doctors who serve eligible childre 0 through 18 years of age.

The VFC program is administered at the national level by the United States Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers are able to order vaccine through their state VFC program and receive routine vaccines at no cost. This allows routine immunizations to eligible children without high out-of-pocket costs.

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

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

www.cdph.ca.gov/programs/immunize/ Pages/HealthProfessionals.aspx

https://eziz.org/vfc/overview/

California Children Services (CCS)

CCS is a statewide program that treats children under the age of 21 with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists.

The California Department of Health Services manages the CCS program. Providers are required to refer children with certain physical limitations and chronic health conditions or diseases to a CCS paneled provider or CCS Specialty Care Center for care. A full description of the program and potential CCS conditions is located at:

www.publichealth.lacounty.gov/cms
or
www.lacare.org/providers/provider-resources/provider-faqs/ccs
L.A. Care Health Plan maintains current processes for identifying, diagnosing, and referring members with California Children Service (CCS) eligible conditions, and coordinating their care with the local CCS office. Upon adequate diagnostic evidence that a Medi-Cal member under 21 years of age may have a CCS eligible condition, L.A. Care will refer the member to the local CCS office for determination of eligibility. L.A. Care will continue to provide all medically necessary covered services to the member until CCS eligibility is determined.

Once eligibility for the CCS Program is established for a Member, L.A. Care will continue to provide all medically necessary covered services that are not authorized by CCS, and will ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

Services for the Developmentally Disabled

The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment that begins before an

individual reaches adulthood. These disabilities include mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation or requiring similar treatment.

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

Early Intervention/Early Start

A child with or at risk of developmental delay or disability is eligible for the "Early Start" program in the State of California. The Early Start program ensures that early intervention services for infants and toddlers with disabilities up to age 3 and their families are provided in a coordinated, family-centered system of services.

The Early Start program can be accessed through local regional centers, county offices of education, local education agencies, health or social service agencies, and a network of local family resource centers (FRCs) throughout the state.

L.A. Care will identify eligible members under the age of three 3 years with or at risk for developmental disabilities and refer them to Early Start/Early Intervention Services and work with local Regional Centers in locating programs through Local Education Agencies and Family Resource Centers and ensuring medical and health assessment information is provided/processed in a timely manner.

PCPs or specialists can refer children who meet the eligibility criteria to Early Start/Early Intervention programs either using the L.A. Care referral process, or refer the member directly to Early Start/Early Intervention programs. PCPs will assure:

- Participation/cooperation in the development of the member's Regional Center individual service plan.
- Provision of available medical reports, as requested.
- Follow up and coordination of treatment plans between other specialists and Early Start Programs.
- Consultations and ongoing responsibilities for preventive care and all medically necessary services are specified by the specialty care, diagnostic and treatment services, therapies and durable medical equipment.

For more information, please refer to the section below; *"Primary Care Responsibilities for Care Coordination with Linked and Carved out Services."*

Eligibility Criteria

For additional information on Early Intervention and Early Start, please see L.A. Care's website at **www.dds.ca.gov/services/early-start/what-is-early-start/**

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

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

Care Managers at L.A. Care or the PPG are available to assist members, who may need or who are receiving services from out of plan providers and/or programs. This service is available to ensure coordinated service delivery and effective joint case management.

Providersare responsible for ensuring L.A. Care has updated contact information such as telephone number(s), address with correct suite number, and names of contracted providers at the location. It is the providers' responsibility to ensure member's demographics are current; Providers should capture accurate demographic information at time of members' engagement. In addition, any consultative provider participating in the members care should have current demographic information on file. Providers should practice auditing for accuracy of demographics for Members and consultative providers associated with coordinating Members care.

The coordination of care and services remains the responsibility of each member's PCP. PPG's and the member's PCP will monitor the following:

- Member referral to and/or utilization of special programs and services
- Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- Routine medical care, including providing the necessary preventive medical care and services

- Provision of Initial Health Assessments including the Staying Healthy Assessment (SHA)

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

Have established risk conditions of known etiology, with a high probability resulting in delayed development

- Are at high risk of having a substantial developmental disability due to a combination of risk factors

For additional information on Early Intervention and Early Start, please see L.A. Care's website at **www.dds.ca.gov/services/early-start/what-is-early-start/**

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

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

Medi-Cal Linked and Carve Out Services

Linked and Carve Out Program	Medi-Cal
California Children Services (CCS)	X
School Linked Child Health Disability Prevention (Chdp) Services	X
Tb/Dot	X
WIC, Nutritional Program	X
Developmental Disabilities Services (Dds)	X
Early Intervention/Early Start	X
Specialty Mental Health	X
Substance use Disorder Treatment	X
Local Education Agency	X

HIV / Aids Home and Community Based Waiver Programs	X
Dental Services	X
Vision	X
Targeted Case Management	X
Early Periodic Screening, Diagnosis And Treatment - Supplemental Services	X

Care Managers at L.A. Care or the PPG are available to assist members, who may need or who are receiving services from out of plan providers and/or programs. This service is available to ensure coordinated service delivery and effective joint case management.

The coordination of care and services remains the responsibility of each member's PCP. PPG's and the member's PCP will monitor the following:

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

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

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

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

Facility Site Review

State law requires L.A. Care to have adequate facilities, service at site locations, and Providers available to meet contractual requirements for the delivery of primary care within their service areas. All Primary Care Physician (PCP) sites must have the capacity to support the safe and effective provision of primary care services. To ensure compliance, L.A. Care is required to perform initial and subsequent site reviews, consisting of a Facility Site Review (FSR) and a Medical Record Review (MRR), using the DHCS tools and standards.

The FSR confirms the Provider site operates in compliance with all applicable local, state, and federal laws and regulations. MRRs are conducted to review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the Member received care. Incomplete records or lack of documentation implies the Provider did not deliver quality, timely, or appropriate medical care.

FSR will validate that the current office hours are posted within the office or readily available upon request. When a Provider is not on site during regular office hours, personnel should be able to contact the Provider (or covering physician) at all times by telephone, cell phone, pager, etc.

For more information, on the Facility Site Review and Medical Record Review surveys and how to prepare for the on-site survey, please visit: **www.lacare.org/providers/provider-resources/tools-toolkits/toolkits**

Behavioral Health Services

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

- Individual, and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication and treatment
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation
- Family therapy and dyadic care
- For non-specialty mental health services, please contact:
  - Carelon Behavioral Health
  - Phone Line: **1.877.344.2858**

County Specialty Mental Health and Substance Use Services

Specialty Mental Health services provided by Los Angeles County Department of Mental Health (DMH) and Substance Use Disorder Treatment is provided by the Department of Public Health (DPH).

- For Specialty Mental Health services, please contact:
  - L.A. County Department of Mental Health (DMH)
  - Phone Line: **1.855.854.7771**
- For Specialty Substance Use Disorder treatment, please contact:
  - L.A. County Department of Public Health (DPH)
  - Phone Line: **1.800.804.7500**

L.A. Care's Behavioral Health Department

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

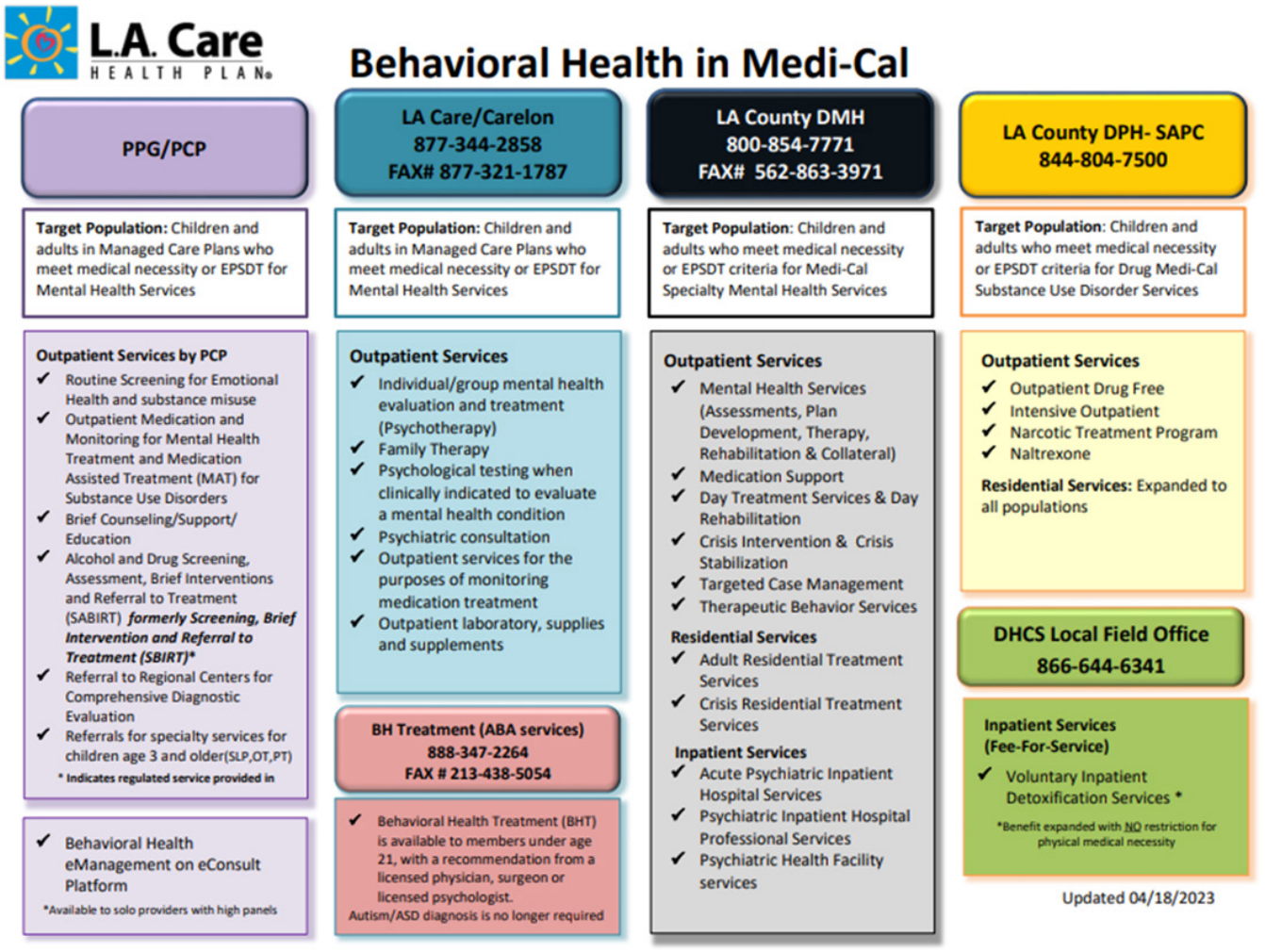
- Resolve behavioral health service access issues
- Ensure appropriate clinical transfer in behavioral health system of care

- Assist with service system coordination provided by the Carelon network
- Facilitate Care Coordination between Care Management and PPG Case Managers for behavioral health services
- Educate and train providers and the community
- Support members with behavioral health grievances, appeals and advocacy

The Behavioral Health Department is available Monday to Friday from 8 a.m. to 5 p.m. You can reach us by phone at **1.844.858.9940** or via email at **behavioralhealth@lacare.org.** Please note that protected health information (PHI) must be sent secured.

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

See figure 3



Population Health Management (PHM) Program, Department of Health Care Services (DHCS), California Advancing and Innovating Medi-Cal (CalAIM)

The Department of Health Care Services (DHCS) is innovating and transforming the Medi-Cal delivery system. California Advancing and Innovating Medi-Cal (CalAIM) is moving Medi-Cal toward a population health approach that prioritizes prevention and whole-person care.

CalAIM's Population Health Management (PHM) program, which launched January 1, 2023, adopts the quadruple aim to enhance the patient experience, improve population health, reduce costs, and improve the work life of health care providers, including clinicians and staff.

CalAIM supports a unified approach for PHM across delivery systems to promote accountability and transparency, integrating national standards and evidence-based practices.

In tandem with the PHM Program rollout, DHCS is building a statewide PHM Service, which will launch July 2023 and is designed to collect and integrate disparate information to support DHCS' vision for PHM in myriad ways. Most notably, the PHM Service will:

- Provide Health Plans, providers, counties, health plan members, and other authorized users with access to comprehensive, historical data on members' health history, needs and risks;
- Include a single, statewide, open-source risk stratification and segmentation (RSS) methodolog with standardized risk tier criteria that will place all Medi-Cal members into high-risk, medium-rising-risk, and low-risk tiers

Population Health Management Requirements for L.A. Care Providers Basic Population Health Services:

In partnership with L.A. Care Health Plan, providers will be expected to offer basic population health services to every Medi-Cal member regardless of the member's risk tier. Below are highlights of the key requirements for providers as detailed in the PHM Program Guide.

Providers must ensure that members:

- Have a source of care that is appropriate, ongoing, and timely to meet the member's needs.
- Receive and have access to all needed preventive services, care coordination, navigation, and referral across all health and social services, including community supports, wellness and prevention programs, management and support for chronic diseases.

Lower risk members who do not meet the criteria for High Risk or Complex Case Management (CCM) or Enhanced Care Management (ECM) will receive care management and coordination of care services conducted by their provider/PPG

Given the rising incidence of mild to moderate physical and behavioral health conditions, Health Plans and providers will be required to ensure effective networks for treatment of these conditions and integration with physical health

interventions, ensure coordination of care and follow-up.

The transitional care service requirements may be subject to review and audit by L.A. Care Health Plan.

Transitional Care Services:

Participating Physician Groups (PPG) are responsible for knowing in a timely manner when their members are admitted, discharged, or transferred, and therefore experiencing a transition.

Providers conducting transitional care services must ensure that all members have:

- Transitional care services offered and are assigned a care manager upon transition from one level of care to another.
- The assigned care manager is the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.
- The assigned care manager will be engaged after notification of admission and is responsible for collaborating with the facility and knowing when member is transferred or discharged.
- The responsibilities of the care manager also include ensuring non-duplication of services provided by other team members (including facility or Primary Care Provider (PCP) based care managers); and collaboration, communication, and coordination with members and their family/support persons/ guardians, hospitals, emergency departments, Long Term Support Services (LTSS), physicians, nurses, social workers, discharge planners, and service providers.
- A core responsibility of the care manager is to ensure that a discharge risk assessment is complete and that a discharge planning document is created and shared with appropriate parties.
- A discharge risk assessment and discharge planning document should be completed by the discharging facility (and at minimum should be informed by discharging providers). However, it is the responsibility of the care manager assigned for transitional care services to ensure it is complete and accurate, coordinated, and shared with appropriate parties. It is also the responsibility of the care manager to ensure non-duplication so that members do not receive two different discharge documents (one from discharging facility and a separate one from care manager).
- The ability to transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- The support and coordination needed to have a safe and secure transition with the least burden on the member as possible and has the needed support and connections to services that make them successful in their new environment.

- Discharge planning until they have been successfully connected to all needed services and supports (regardless of acuity level).

Care Management

L.A. Care has a Case Management department with specially trained staff to help members with complex care needs or members at high risk for adverse outcomes. The care management program provides health education and care coordination, focusing on the delivery of quality, cost-effective, and appropriate health care services for L.A. Care members.

The goal of Care Management is to improve health outcomes, quality of care, and self-management for members with targeted conditions, high-risk and complex care needs by ensuring efficient and appropriate utilization of resources and treatment plans while reducing health care disparities.

The care management program provides health education and care coordination, focusing on the delivery of quality, cost-effective, and appropriate health care services for L.A. Care members. The goal of Care Management is to improve health outcomes, quality of care, and self-management for members with targeted conditions, high-risk and complex care needs by ensuring efficient and appropriate utilization of resources and treatment plans while reducing health care disparities.

Providers are encouraged to participate in Care Management's interdisciplinary Care Team (ICT) to contribute to their member's Individualized Care Plan (ICP) that aligns with the needs and preferences of the member.

In order to be eligible for the High Risk program, members must have multiple unmanaged chronic conditions and/or evidence of functional decline. Eligibility for the Complex Care Management program is reserved for the most at-risk members who display both medical severity and associated high-cost utilization.

Providers should refer members with complex needs to Care Management by:

- Completing the Care Management Referral Form which is available on the L.A. Care Provider Portal **https://www.lacare.org/sites/default/files/la4310_cm_referral_form_ 202212.pdf**

- Call the Care Management department during regular business hours at: **1.844.200.0104**

Enhanced Care Management

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit effective January 1, 2022.

ECM is intended for the highest risk, highest-cost Medi-Cal managed care members with the most complex medical and social needs.

ECM Providers deliver services in order to provide ECM-enrolled members with long-term help coordinating their services across delivery systems.

To be eligible for ECM, members must be enrolled in a Medi-Cal managed care health plan and meet criteria for at least one of the Populations of Focus.

California's Department of Health Care Services (DHCS) has identified both adult and children/youth Populations of Focus for ECM.

To learn more or make a referral click here: Enhanced Care Management | L.A. Care Health Plan (**lacare.org**)

Providers will be invited to participate in Care Management's Interdisciplinary Care Team (ICT) to contribute to a multidisciplinary care plan that aligns with the needs and preferences of the member.

The care management program provides care coordination and health education for health condition management, as well as, identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals, in accordance with federal and state requirements and L.A. Care's MOC. Care management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members.

The care management program is designed to specifically identify and support those most vulnerable and provide Members with tools and services to manage their conditions within the least restrictive environment. Members receive a HRA upon initial enrollment and annually thereafter, or more frequently if a Member experiences a significant change in health status.

The HRA screens for physical health, behavioral health, medication management problems, and social determinants of health. The HRA stratifies Members into either complex, high or low risk levels in accordance with L.A. Care policy. Risk stratification helps target high-need Members who would benefit from more intensive support and education from a case manager. Additionally, functional, social support, and health literacy deficits are assessed, as well as safety concerns and caregiver needs. Upon completion of the risk stratification there is a division of responsibility between L.A. Care and the Delegated Entity's care management teams. Unless otherwise specified in the provider's contract, L.A. Care's care managers will be responsible for the care management of Members stratified as high or complex risk. Delegated Entity's Care Managers will be responsible for the care management of Members stratified as low risk. If there is a change in the risk stratification levels assessed, L.A. Care and the Delegated Entity will coordinate the transfer

of care management between the two (2) parties.

The role of the Care Manager includes:

- Coordination of quality services and timely interventions that increase efficiency and effectiveness of care and services provided to the Member
- Development and implementation of an ICP driven by the Member's clinical and behavioral conditions, social determinants of health and preferences. ICP is regularly updated as the Member's conditions, needs, and/or health status changes -160- Universal Provider Manual Serving Los Angeles County
- In case the Member is unable to be reached, the use of historical medical and pharmacy claims data will be utilized to develop the member's ICP
- Promotion of the health, independence, and optimal functioning of Members in the most proactive, effective, and least restrictive way
- Collaboration and communication with the PCP and/or specialists, and other health care Providers regarding completed clinical assessments and care plans
- Education and involvement of the Member and family in the coordination of services to promote self-management
- Coordination of access to Member benefits and appropriate services across the healthcare continuum
- Assistance with transitions between care settings and/or Providers including timely notification
- Facilitation of ICT meetings and updates to Member care plan goals and intervention based on ICT recommendations and Member health status progress
- Promotion of multidisciplinary care including clinical, behavioral, and rehabilitative services Referral to and coordination of appropriate resources and support services, including but not limited to Long-Term Services & Supports (LTSS):
    - Attention to Member preference and satisfaction
    - Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality
    - Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence
    - Protection of Member rights
- Promotion of Member responsibility and self-management Referral to Care Management can be made by the following entities:
    - Member or Member's designated representative(s)
    - Member's PCP
    - Specialists
    - PPGs
    - Hospital Staff
    - Home Health Staff
    - L.A. Care Staff

Care Management Contact Providers may direct Members in need of Intensive Care Management by calling **1.844.200.0104**

Managed Long-Term Services and Supports

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

In Home Supportive Services (IHSS)

Provides in home care for seniors and people with disabilities who need assistance with their activities of daily living (ADLs/IADLs). Eligible members can hire anyone they wish to help them with their daily needs. This includes assistance with home chores, personal care assistance, basic medical needs, getting to provider appointments and providing supervision for people with dementia or other mental impairments.

Multipurpose Senior Services Program (MSSP):

Provides intensive care management services in the home for seniors age 65 and older. An MSSP nurse and social worker team will provide eligible members with a full assessment of their health and social support needs. Additionally the MSSP team will identify, arrange and provide help with accessing resources, monitor the member's wellbeing, and purchase other needed services that may not be available through L.A. Care or other community based programs.

Community Based Adult Services (CBAS):

Provides professional nursing services, physical, occupational and speech therapies, socialization, mental health services, therapeutic activities, social services, nutrition and nutritional counseling for people ages 18 and older. CBAS is a day program formerly known as adult day health care . A meal and transportation to and from the CBAS center is provided.

Long Term Care (LTC)

Provides continuous skilled nursing care to eligible members at risk in the community with physical or mental conditions in a nursing home. The Medi-Cal LTC nursing facility benefit includes room and board and other medically necessary services.

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

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

To find MLTSS Referral forms, go to the L.A. Care website:

www.lacare.org/providers/forms-manuals

MLTSS Contact Information:

For Managed Long Term Services and Supports questions:

MLTSS Phone Line: **1.855.427.1223**

MLTSS Fax Line: **1.213.438.4866**

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

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

To find various community supports programs, these wraparound services are available to eligible members, go to the L.A. Care website:

www.lacare.org/members/member-support/community-supports

2023 Evidence of Coverage states/lists the following

- Managed long-term care services and supports (MLTSS). L.A. Care covers these managed long-term care benefits for members who qualify:
- Long-term care facility services as approved by L.A. Care
- Skilled nursing facility services as approved by L.A. Care
- Home and Community Based services as approved by L.A. Care
- Community Based Adult Services (CBAS)
- In-home Supportive Services (IHSS)
- Intermediate care facilities as approved by L.A. Care

If a member qualifies for long-term care services, L.A. Care will make sure they are placed in a health care facility that provides the level of care most appropriate to their medical needs.

If you have questions about managed long-term care services, call **1.855.427.1223** (TTY **711**).

Federal Statutes

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

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

www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance

State Statutes

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

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

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

Access to Care Quick Tips

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

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

next page >

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

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

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

V. 10/5/2015

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

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

- Members have the right to be treated with respect and dignity, giving due consideration to their right to privacy and the need to maintain confidentiality of their medical information.
- To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To receive fully translated written member information in their preferred language, including all grievance and appeals notices.
- To make recommendations about L.A. Care's member rights and responsibilities policy.
- To be able to choose a primary care provider within L.A. Care's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding their own healthcare, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care they received.
- To know the medical reason for L.A. Care's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting services for their language.
- To get free legal help at their local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing is a service or benefit is denied and they have already filed an appeal with L.A. Care and are still not happy with the decision, or if they did not get a decision on their appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll from L.A. Care and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (such as braille, large-size font, audio and accessible electronic formats) upon request in a timely fashion appropriate for the format being requested and in accordance with Welfare & Instructions Code Section 14182 (b) (12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatments options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of their medical records, and request that they amended or corrected, as specified in 45 Code of Federal Regulations § 164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how they are treated by L.A. Care, their providers, or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified

- Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside L.A. Care's network pursuant to the federal law.
- To receive free written plan materials in their preferred language or alternative format (such as audio, braille or large-print).

  *2023 MCLA Evidence of Coverage (Member Handbook).

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

- **Act courteously and respectfully:** Members are responsible for treating providers and staff with courtesy and respect. Members are responsible for being on time for their visits or calling your office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information:** Members are responsible for giving correct information and as much information as they can to all of their providers and L.A. Care. Members are responsible for getting regular check-ups and telling their provider about health problems before they become serious.
- **Members should follow their provider's advice and take part in their care:** Members are responsible for talking about their health care needs with their provider, developing and agreeing on goals, doing their best to understand their health problems following the treatment plans and instructions you both agree on.
- **Use the Emergency Room only in an emergency:** Members are responsible for using the emergency room in case of an emergency or as directed by their provider.
- **Report wrong doing:** If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste or abuse, it is your right to report it by calling the confidential toll-free number 800.822.6222 or submitting a complaint online at **www.dhcs.ca.gov/**.

L.A. Care Fraud and Abuse Hotline toll-free **1.800.400.4889**

To access the L.A. Care Member Rights section on the website go to **www.lacare.org/member-handbook/your-rights**

Cultural and Linguistic Service

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

Bilingual Staff/Interpreter Services

L.A. Care provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. Interpreter, linguistic and cultural services are available at no cost to you.

Help is available 24 hours a day, 7 days a week. For language help, call **1.888.839.9909** (TTY **711**). The call is toll-free

ATTENTION: If you need help in your language call **1.888.839.9909** (TTY **711**). Aids and sevices for people with disabilities, like documents in braille and large print, are also available. Call **1.888.839.9909** (TTY **711**) 24-hours a day, 7 days a week, including holidays. These services are free of charge

Please maintain the following documentation for your qualified bilingual staff:

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

Bilingual Language Skills Self-Assessment Tool

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

- To order the toolkits go to **http://healtheducation.chi.v6.pressero.com/login**
- To download the toolkits go to **https://www.lacare.org/providers/tools**

Key Things to Remember

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

Language Poster

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

To order the posters, go to **http://healtheducation.chi.v6.pressero.com/login**

Telephonic Interpreting Card

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

To order the telephonic card, go to **http://healtheducation.chi.v6.pressero.com/login**

Cultural and Linguistic Training

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

- Interpreting Services
- Cultural Competency
- Disability Awareness

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

Cultural and Linguistic Provider Toolkit

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

- To order the toolkits, go to **http://healtheducation.chi.v6.pressero.com/login**
- To download the toolkits, go to **https://www.lacare.org/providers/tools**

Online Resource Directory

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

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

Build rapport with the member

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

Make sure members know your role

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

Keep members' expectations realistic

- Inform members of delays or extended wait times

Work to build members trust

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

Determine if the member needs an interpreter for the visit

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

Give members the information they need

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

Make sure members know what to do

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

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

Styles of Speech

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

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

Eye Contact

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

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

from theme.

Body Language

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

Gently Guide Member Conversation

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

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

Facilitate member-centered communication

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

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

Produced by the L.A. Care.

LA4156 09/23