South Atlantic Medical Group

New Provider Training

Revised November 2021

Welcome to South Atlantic Medical Group’s New Provider Training. The training is intended to provide you with an overview of Medi-Cal and Cal MediConnect programs and resources related to the successful management of your assigned Medi-Cal and Cal MediConnect members.

Topics Covered in this Training

- Medi-Cal Programs*
- Clinical Protocols & Evidence-Based Guidelines*^~
- Continuity of Care (COC) and Transition of Care (TOC)*^~
- Model of Care (MOC)^
- Advance Directives & Physician Orders for Life-Sustaining Treatment (POLST)*^~
- Member Rights & Responsibilities*
- Member Satisfaction Policy & Procedure*^~
- Cultural & Linguistic Sensitivity*^~
- HIPAA Privacy, Breach Notification and Compliance*^~
- Fraud, Waste & Abuse*^~
- General Compliance*^~
- OIG/SAM/Medi-Cal Exclusions*^~
- Critical Incidents^
- Sterilization Requirements*
- Documentation Requests & Modifications*^~

Legend

- ** - Medi-Cal*
- *^ - Cal MediConnect*
- *~ All other Lines of Business*

Medi-Cal Programs

California Department of Health Care Services (DHCS)

- All Programs and Services
- https://www.dhcs.ca.gov/services/Pages/AllServices.aspx
- Please click above link for DHCS Programs and Services

Medi-Cal Enrollment Process

- People who meet Medi-Cal eligibility requirements (Mandatory Enrollment and Voluntary Enrollment Aid Categories
- Health Care Options (HCO) is the organization that works with DHCS to manage the enrollment process. HCO helps people understand Medi-Cal benefits and the different managed care options available to them.
- Potential enrollees can call HCO Medi-Cal Managed Care toll-free at 1-800-430-4263 (TTY 1-800-430-7077) or HCO Coordinated Care Initiative toll-free at 1-844-580-7272 (TTY 1-800-430-7077) Monday through Friday, 8 a.m. to 6 p.m. PT, except holidays.
- If you want HCO to contact you, fill out the HCO Contact Form
- You can write to HCO at

  CA Department of Health Care Services
  Health Care Options
  P.O. Box 989009
  West Sacramento, CA 95798-9850
- To learn how to contact other DHCS Organizations, go to the Contact us page
- For additional information on HCO, go to: https://www.healthcareoptions.dhcs.ca.gov/learn

California Children's Services (CCS)

Program Informational Overview

What is California Children's Services (CCS)?

- California Children's Services (CCS) is a county-wide program that treats children (*under* 21 years of age) 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 and hospitals.
- The California Department of Health Care Services (DHCS) manages the CCS program and it is administered as a partnership between county health departments and the DHCS.
- CCS is the "payor of last resort". That means: if you have private insurance coverage, the insurer is responsible for paying for the services before CCS can pay.
- Providers are expected to refer a child to CCS if there is sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition.

Examples of CCS Qualifying Conditions

- Infectious Diseases
- Neoplasms
- Endocrine, Nutritional, Metabolic and Immune Disorders
- Mental Disorders and Mental Retardation
- Diseases of the Nervous System
- Medical Therapy Program
- Diseases of the Eye
- Diseases of the Ear and Mastoid Process
- Diseases of the Circulatory System
- Diseases of the Respiratory System
- Diseases of the Digestive System
- Diseases of the Genitourinary System
- Diseases of the Skin and Subcutaneous Tissues
- Diseases of the Musculoskeletal System and Connective Tissues
- Congenital Anomalies
- Accidents, Poisonings, Violence and Immunization Reactions

CCS Referrals

- Referrals to CCS can be made by anyone:
  - Hospital
  - Physician
  - School Nurse
  - Family
- Referrals are sent to the appropriate county office where the child resides.

What are CCS Benefits?

- If member has a special health problem that is a CCS covered benefit, then CCS will pay or assist if eligible with the following:
  - Doctor visits and care, hospital stay, surgery, physical therapy, occupational therapy, laboratory tests, X-rays, pharmaceuticals, medical equipment and supplies.
  - Medical Case Management may assist members in finding a special doctor and/or refer to other agencies for example, public health nursing and regional centers.
  - Medical Therapy Program (MTP), which provides physical therapy and/or occupational therapy in public schools.

Carved Out Service

- The CCS eligible medical condition is “carved out” of Medi-Cal Managed care plans responsibility.

- The “carve out” means that Medi-Cal Managed Care plans are not capitated to provide services for a child’s CCS eligible condition.

Examples of CCS-Eligible Covered Services

- Diagnostic Services
- Treatment Services
  - Doctor visits, Emergency Room Care, Hospital Stays, Surgery, Medication, Special Equipment, Medical Therapy Program
- Special Care Centers (SCC)
  - A SCC is a clinic where a team of doctors and other professionals (like nurses, therapists, and social workers) work together with families to help provide treatment for the child.

What is a Services Authorization Request (SAR)?

- A SAR allows CCS to authorize payment for services for a child's CCS-eligible condition. This may include doctors, hospitals, Special Care Center (SCC) services, medication, or medical equipment and supplies.
- It may take 1-2 weeks to receive the SAR letter in the mail, after your Nurse Case Manager approves it.

CCS Qualification Cessation

- CCS services may end when:
  - A child no longer has a CCS-eligible condition because the condition has changed or treatment has been completed
  - A child is no longer financially eligible because the family's income has changed
  - A child turns 21 years old
  - A child moves outside the state of California

Additional Resources

- California Children's Services:
  https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
- For Overview of CCS Medical Eligibility, you may refer to:
  https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx
- California Children's Services Provider Lists:
  Approved Hospitals, Approved Special Care Centers (SCC), Paneled Non-PMF Providers, Paneled Providers
  https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx
- Hospitals and Special Care Centers:
  https://www.dhcs.ca.gov/services/ccs/scc/Pages/default.aspx
- County Offices for California Children's Services:
  https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx
- Medical Therapy Program:
  https://www.dhcs.ca.gov/services/ccs/Pages/MTP.aspx
- California Children's Services Information Notices:
  https://www.dhcs.ca.gov/services/ccs/Pages/CCSIN.aspx
- CCS Numbered Letters:
  https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

SAMG Contact Information

For Any CCS related questions and concerns, please contact:

CCS Supervisor: Luz Molina

Email: Lmolina@samg.org

Phone: 323-725-0167

Child Health and Disability Prevention Program (CHDP)

What Does CHDP Offer?

The CHDP program helps to prevent or find health problems through regular, no cost, health check-ups. A check-up includes:

- Health and developmental history
- Physical exam
- Needed shots
- Oral health screening and routine referral to a dentist starting by age 1
- Nutrition screening
- Behavioral screening
- Vision screening
- Hearing screening
- Health information
- Lab tests, which may include: anemia, lead, tuberculosis, and other problems, as needed
- Referral to Women, Infants, and Children (WIC) program for children up to age 5

Other Services

If further health services are needed, we will help you find them, including:

- Dentists that accept Denti-Cal for the care of your child's teeth
- Medical specialists, as needed
- Mental and behavioral health services, as needed

Diagnosis and treatment can be paid for as long as your child has Medi-Cal.

Information

For more information about CHDP, transportation options, or for help setting up an appointment, contact your local CHDP office.

You can find your local CHDP office by visiting the California Department of Health Care Services website at:
www.dhcs.ca.gov/services/chdp

Regular health check-ups keep your child healthy.
Health check-ups can also find and treat problems before they become serious.

Edmund G. Brown, Jr.
Governor, State of California

PUB 183 (English, 9/15)

English

Child Health and Disability Prevention (CHDP) Program

Medical and Dental Health Check-Ups

FREE

For Babies, Children, and Youth Under age 21 with Full Scope Medi-Cal or Under Age 19 with Low Family Income.

No Documentation Required

Why Get Health Check-Ups?

Health check-ups are important for all children and youth. Health check-ups are a time to:

- Find and address medical, dental, mental, and behavioral health problems
- Get needed shots
- Ask your doctor questions

Health check-ups can also be used for foster care, sports, camp, or school entry, as needed.

Who is Eligible?

Children and youth up to age 21 who are eligible for Medi-Cal. Children and youth under age 19 with family incomes less than or equal to 200% Federal Income Guidelines are also eligible. Proof of residence and income is not required.

Babies and Toddlers
Birth Through 3 Years

Regular check-ups can keep your baby happy and healthy. You can find out about your baby's growth, weight, and health, and needed shots are given. At 1 year and 2 years, your baby should be tested for lead. A test for anemia is also given. Your child should see a dentist at least once a year starting by age 1.

School Children
4 Through 12 Years

It is important to make sure your child is healthy and ready for school. State laws require children to be up to date on their shots and get a health check-up.

School children will also get vision and hearing screenings. If your child has not had a lead test before, he/she should have one by age 6 or before. Your child should see a dentist at least once a year.

Teens and Young Adults
13 Through 20 Years

Teens need health check-ups tool This is a chance to make sure your teen is growing and developing well. It is also a time for you or your teen to ask the doctor any questions. Extra health check-ups can be given for sports and camp physicals. Your child should see a dentist at least once a year.

Dental

Please contact your local CHDP office for assistance to find a Dentist who accepts Denti-Cal. CHDP may also assist with appointment scheduling and transportation if necessary.

Vision & Hearing

The local CHDP office can provide assistance to obtain vision and hearing services if medically necessary.

Mental Health, Autism and Behavioral Services

Contact the local CHDP office for assistance to access these services.

Comprehensive Perinatal Services Program (CPSP)

What is the CPSP Program?

- CPSP is a The Comprehensive Perinatal Services Program (CPSP) is a voluntary program that seeks to improve the health of low-income pregnant women and to give their babies a healthy start in life by providing enhanced Medi-Cal reimbursements to CPSP-certified obstetrical providers who implement CPSP protocols in their practices.
- The goals of CPSP are to encourage early and continuous prenatal care, decrease incidences of low-birth weight infants, improve outcomes of every pregnancy, and lower health care costs by preventing catastrophic and chronic illness in infants and children.

What are CPSP Services?

- CPSP services include comprehensive prenatal care, health education, nutritional assessment and education services, and psychosocial assessment and referral support for up to 60 days after delivery.
- CPSP services also include client orientation, assessment and follow-up services, individual case coordination, prenatal vitamin and mineral supplementation, and prenatal and postpartum parenting education.
- Participation in the program is voluntary.

Who can become a CPSP Provider?

- Any of the following can be a CPSP provider, as long as they are an active Medi-Cal provider and have an active National Provider Identifier (NPI) number, and are in good standing with their licensure board:
  - Physician (obstetrician/gynecologist, family practitioner, general practitioner, or pediatrician)
  - Medical Group, any of whose members is one of the above physicians
  - Certified Nurse Midwife
  - Nurse Practitioner (family or pediatric)
  - Preferred Provider Organization (PPO)
  - Clinic (hospital, community, county)
  - Alternative Birth Center

CPSP Application Process

- Contact the CPSP Perinatal Services Coordinator (PSC) at your local health department for an application. Please go to the CPSP web page at https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Sites.aspx#local_directory for the name and phone number of the PSC in your county.
- The completed application will be reviewed by the local CPSP coordinator and submitted to the California Department of Public Health (CDPH) for final certification.
- The application approval process may take up to 60 days from the date that CDPH receives a completed application.

Additional Resources

- CDPH - Comprehensive Perinatal Services Program (CPSP)
  https://www.cdph.ca.gov/programs/cfh/dmcah/cpsp/pages/default.aspx

Early Periodic Screening Diagnostic Treatment (EPSDT)

EPSDT Overview

- Consistent with state and federal law and regulations for EPSDT, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illnesses or conditions. This includes, but is not limited to:
  - physician, nurse practitioner and hospital services
  - physical, speech/language, and occupational therapies
  - home health services, including medical equipment, supplies, and appliances
  - treatment for mental health and substance use disorders
  - treatment for vision, hearing, and dental diseases and disorders.
- All of these services are at no-cost to individuals under age 21 who have full-scope Medi-Cal.
- EPSDT services are key to ensuring that infants, children, and youth receive age-appropriate preventive services, including screening for medical, dental, vision, hearing, and mental health, and for substance use disorders, as well as receiving developmental and specialty services.

EPSDT Covered Services

- **Early:** Assessing and identifying problems early.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals.
- **Screening:** Medi-Cal provides or arranges for screening services for medical, dental, vision, hearing, and mental health, and for substance use disorders, as well as developmental and specialty services. EPSDT screening and preventive services cover a broad range of services, including but not limited to:
  - Services assigned a grade “A” or “B” recommended by the United States Preventive Services Task Force (USPSTF).
  - Advisory Committee on Immunization Practices (ACIP) recommended vaccines.
  - Preventive care and screening for infants and children recommended by Health Resources and Services Administration’s (HRSA’s)/AAP’s Bright Futures periodicity schedule and anticipatory guidance
- **Diagnostic:** When a screening indicates the need for further evaluation and follow-up, EPSDT covers diagnostic services. Necessary referrals should be made without delay and with necessary follow-up to ensure a complete diagnostic evaluation is received whenever potential risk is identified.
- **Treatment:** Any necessary health care services to control, correct, or improve health problems discovered by any screening and diagnostic procedures are provided.

Additional Resources

- DHCS - Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) https://www.dhcs.ca.gov/services/Pages/EPSDT.aspx

Serving Seniors and Persons with Disabilities & Chronic Conditions

Overview

- Starting June 2011, the California Department of Health Care Services (DHCS) requires Medical Groups to conduct competency and sensitivity training for network providers and their staff who come in contact with members identified as Seniors and Persons with disabilities and chronic conditions (SPD).
- **Our goal and commitment is to:**
  - Serve all of its members with compassion and respect.
  - Ensure that communications, physical spaces, services and programs are accessible to people with special needs, including visual, hearing, cognitive and physical disabilities.
  - Be the member's partner in health care.

Disability and Functional Limitations

- Disability may be physical, cognitive, mental, sensory, emotional, developmental or some combination of these. A disability may be present from birth or occur during a person's lifetime.
- Functional limitations are difficulties completing a variety of basic or complex activities that are associated with a health problem. For example, vision loss, hearing loss, and inability to move one's legs are functional limitations.

SPD Members

- Members who are Seniors and Persons with Disabilities (SPD) are defined as Medi-Cal beneficiaries who are eligible for benefits through blindness, age, or disability.
- When checking eligibility, SPD Aid Codes are:

Aged / Blind / disabled Aid Codes
10, 13, 14, 16, 17, 20, 23, 24, 26, 27, 36, **53**, 60, 63, 64, 65, 66, 67, 1E, 1H, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y

Barriers to Access and Care

- **Physical Access** – The ability to get into a building or the area where health care services are offered; and the ability to get onto the equipment needed for procedures and testing.
- **Communication Access** – The ability of the provider and member to communicate and understand the information asked and directions given.
- **Program Access** – The ability to fully take part in health educations, prevention, treatment and other programs offered by the health plan.
- **Be aware that the most difficult barrier to overcome are attitudes toward people with disabilities. Focus on an individual's ability rather than on their disability.**

Reasons for Accommodations

- Functional limitations may create a need for accommodations, such as:
  - Physical accessibility
  - Changes to provider office policies
  - Accessible exam or medical equipment
  - Effective communication
  - Health education materials in alternate formats
- Physical disabilities may seem to be the most obvious, but unseen mobility issues are more common.
  - For example, a member may experience an issue with his/her physical ability to move around or walk a distance due to hip or knee problems, breathing issues, weakness, etc.
- **Never assume you know the member's disability**

Types of Accommodations

Physical accessibility may include access to:	Changes to provider office policies may include:
Building entrances, doors, doorways and hallways	Flexible and longer appointment times
Restrooms, elevators and parking lots	Allowing service animals
Waiting areas and reception desk	Providing support to fill out forms
Drinking fountains and water coolers	Providing lift assistance
Forms and documents	Providing printed material in alternate formats
Exam and medical equipment for those with limited mobility	

- Members who are blind or have low vision may use:
  - A white cane
  - A service dog
  - A sighted guide (a person used to sight guide)
- **These members may or may not need assistance.**
- **DO:** Identify Yourself, Ask before you try to help, Use sighted guide technique only when asked
- **DON'T:** Shout, Move someone's cane without asking and tell them where it is

Communication Tips

- When talking about disability, avoid negative language and use people-first language

Avoid Negative Language	Use People-First Language
Handicapped Person	Person with a disability
Deaf Person	Person who is deaf
Wheel-chair bound	Person who uses a wheelchair
Mentally retarded	Personal with an intellectual disability

- To help you better communicate with members who are deaf or hard-of-hearing, learn about available technology resources or services, such as:
  - Assistive Listening Devices/Amplification Technologies
  - Augmentative and Alternative Communication Devices
  - Audio Recordings
  - Captioning
  - Qualified American Sign Language (ASL) Interpreters
  - Qualified Readers
  - Relay Service
  - Speech Reading
  - Video Relay

Communication Tips (Cont'd)

- Speech disabilities may be developmental or a result of illness or injury. Members with speech disabilities may use:
  - Their own voice
  - Letter board
  - Pen and paper
  - Augmentative and Alternative Communication Devices
- People who are deaf, hard-of-hearing, deaf-blind or have a speech disability may use California Relay Service to communicate by telephone.
  - A TTY is a special device that lets people who are deaf, hard-of-hearing or have a speech disability use the telephone to communicate by typing messages.
  - A TTY is required at both ends of the conversation
- To conduct a relay call:
  1. Dial 711
  2. Speak slowly
  3. Speak directly to the caller.

Support for SPD Members

- Any provider, member or caregiver can request assistance. South Atlantic Medical Group's Care Management team
  can assist with specific health conditions and provide support resources, such as:
  - Pre-natal education and service directories
  - Member education (disease specific, prescription compliance, etc.)
  - Referrals for housing, food or other needs
  - Assistance to coordinate referrals, transportation, ancillary support services (Durable Medical Equipment, Home Health, etc.)
  - Coordinate needs for frequent Inpatient or Emergency Dept patients
- Providers can submit Complex/Chronic Case Management (CCM) referrals via:
  - Name: Email: Ereyes@samg.org
- Members can request assistance directly by calling 323-725-0167

Additional Resources

- Interpreter Services
  - No-Cost telephone or face-to-face interpreter services are available
- Educational Materials
  - Members may request health education materials in alternative formats, such as Braille, digital, audio or large print.

Clinical Practice Protocols – All Lines of Business

Clinical Practice Protocols

- All Clinical Practice Protocols are available via the South Atlantic Medical Group's website https://www. https://www.southatlanticmedicalgroupipa.com//provider-resources/
  - Click on Clinical Practice Protocols to access the following documents:
    - Chronic Conditions
    - Diabetes Management
    - Diagnostics and Screenings
    - Imaging
    - Immunizations
    - Orthopedic
    - Scope of Primary care
    - Specialty Referrals

Evidence-Based Clinical Guidelines

South Atlantic Medical Group utilizes the below Plan-Specific Clinical Guidelines to provide the necessary services to the Health Plan-assigned members.

- Anthem Blue Cross – ABC Clinical Practice Guidelines ABC Preventive Health Guidelines
- Blue Shield Promise – BSCPHP Clinical Practice Guidelines
- Health Net – Clinical Practice Guidelines & Preventive Health Guidelines
- LA Care – LAC Clinical Practice and Preventive Health Guidelines
- Molina Healthcare – MHC Clinical Practice and Preventive Health Guidelines

Clinical Guidelines & Practice Protocols for Non-Contracted Providers

Non-Contracted and Out-of-Network Providers who do not receive South Atlantic Medical Group utilizes the below Plan-Specific Clinical Guidelines to provide the necessary services to the Health Plan-assigned members.

- Anthem Blue Cross – ABC Clinical Practice Guidelines ABC Preventive Health Guidelines
- Blue Shield Promise – BSCPHP Clinical Practice Guidelines
- Health Net – Clinical Practice Guidelines & Preventive Health Guidelines
- LA Care – LAC Clinical Practice and Preventive Health Guidelines
- Molina Healthcare – MHC Clinical Practice and Preventive Health Guidelines
- Network Provider training may request Health-Plan specific evidence-based clinical guidelines and SAMG clinical protocols by contacting 323-25-0167by phone or email at compliance@samg.org

Monitoring of Continuity of Care (COC) & Transition of Care (TOC) – All Lines of Business

SAMG General Procedures

Introduction

Purpose

To provide an overview of the Continuity of Care (COC) and Transition of Care (TOC) process, enabling the ability to:

- Comply with accreditation and contractual requirements
- Comply with accuracy and consistency in reporting
- Develop common understanding of data
- Reduce need for delegates to correct submitted data
- Introduce Semi-Annual Monitoring Case Reviews

COC vs TOC

- The difference between COC and TOC is:
  - COC focuses on the impact a **terminated provider** may have on the member
  - TOC focuses on the impact the **change in the insurance benefit** may have on the member as the result of benefit exhaustion

COC Definition

- There are five (5) types of Continuity of Care (COC) we typically process in managed care. For the purposes of the COC portion of the report, the focus is only on **members whose provider has terminated, per NCQA requirements**.
    1. COC for any newly enrolled member (applies to all members) ref: CA H&S Code 1373.96
    2. COC for any member whose provider has termed (applies to all members) ref: NCQA & CA H&S Code 1373.96
    3. COC for all newly enrolled members (applies to Medi-Cal members), per DHCS contract and regulatory requirements
    4. COC for all newly enrolled Medi-Cal members enrolled as the result of a denial from DHCS of their medical exemption request (MER), per DHCS contract and regulatory requirements
    5. COC for all newly enrolled Cal MediConnect (CMC) members, per 3 way CMS-DHCS- South Atlantic Medical Group contract and regulatory requirements

NCQA Net Standards 2021

- NET 4 Continued Access to Care
  - The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.
- NET 4 Element A: Notification of Termination
  - The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.
- NET 4 Element B: Continued Access to Practitioners
  - If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:

1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

NCQA NET 4B Explanation

- All practitioner specialties are included in factor 1.
  - The organization has a process for identifying members seen by practitioners and practice groups in its network, and notifies members about the opportunity for continued access. Even if no contracts were discontinued, the organization must have a process for allowing members to have access to care and treatment.
- The organization works with practitioners who are no longer under contract to develop a reasonable transition plan for each member in **active treatment** or **postpartum period.**
  - **Active course of treatment**: member has regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).
  - **Postpartum period**: begins immediately after childbirth and extends for approximately six weeks. This element applies if the practitioner agrees to:
    - Continue treatment for an appropriate period of time (based on transition plan goals).
    - Share information about the treatment plan with the organization.
    - Continue to follow the organization's UM policies and procedures.
    - Charge only the required copayment.

NCQA NET 4B Explanation (Cont'd)

- The organization is not required to provide continued access if:
  - The practitioner is unwilling to continue to treat the member or accept the organization's payment or other terms.
  - The member is assigned to a practitioner group, rather than to an individual practitioner, and has continued access to practitioners in the contracted group.
  - The organization discontinued a contract based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.).

TOC Definition

- Transition of Care (TOC) applies to members who require assistance when their benefits end/exhaust, per the NCQA standards below:

QI 3D 2021 The organization helps with members' transition to other care when their benefit ends, if necessary.	**Explanation: Exhausted benefits** If covered benefits are exhausted while a member continues to need care, the organization notifies the member about alternatives and resources for continuing care and how to obtain it, as appropriate. *The organization is not required to develop alternative resources.*	**Examples:** **Identifying members whose benefit ended** The organization identifies qualified individuals using daily case manager reports or requests for extension of needed services that were denied due to benefit limitations.
QI 5 Delegation of QI (of QI3D above) The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated QI activities.	**QI 5, Element C3:** Review of QI Program For arrangements in effect for 12 months or longer, the organization: 3. **Semiannually evaluates regular reports**, as specified in Element A.	

TOC Requirements

- The Delegate is required to notify members about healthcare alternatives, resources for continued access to care and how to obtain them. The Delegate will need to assist the member to transition to a resource that will meet their needs, as possible.
- Delegates report on the following:
  - How TOC members are identified (e.g., UM reports)
    - Members close to maxing out their benefits
- The process once identified members need assistance.
- Communicate with the member
  - Notify members within the established timeframe

TOC Report

- Examples of methods Delegates may use to identify members in need of TOC assistance include:
- **Benefit Exhaustion**:
  - During the UM authorization or case management process, identifying members who are receiving therapy services and/or skilled nursing facility benefits and are close to exhausting their benefit.
  - The organization may identify qualified individuals using daily case manager reports or requests for extension of needed services that were denied due to benefit limitations.
- TOC Reporting:
  - Number of members identified as having their benefit exhausting, such as exhausting their SNF or therapy benefits
  - Analysis of need of TOC assistance
  - Actions taken to assist in transition
- TOC Log:
  - Identifying members requiring TOC assistance, must accompany TOC report

Clinical Monitoring Team - COC-TOC Assessments

- Clinical Monitoring Nurses will assess the quarterly COC-TOC reports for timeliness and completeness and provide feedback with findings and any opportunities for improvement.
- *Semi-Annually*, Nurses will select up to five (5) cases each for COC and TOC for validation checks against member files as listed in COC-TOC reports and logs.
- Delegates will be requested to provide:
  - COC: Screen shots of authorization or copy of treatment authorization requests (TAR) and all member/provider notices and UM notes showing approval of continued access, as applicable.
  - COC: Letters or screen shot of provider termination notification which provides the date the physician has terminated and date the member was notified.
  - TOC: Screen shots, UM, CM Notes and Member/Provider Letters of notification of benefit exhaustion and alternatives and resources for continuing care and how to obtain them, as appropriate. The organization is not required to develop alternative resources.

COC-TOC Reporting

- If you do not have any metric data to report, indicate this by the use of a zero (0).
- If you do report members, submit the associated member COC & TOC logs, associated with a health problem such as asthma, diabetes, etc.
- If the metric data requested does not apply then use “not applicable” (N/A).
- Complete the analysis /actions portion of the report. Leaving this portion of the report blank will result in the report being considered “incomplete.”
    - For instance, limited exercise tolerance and significant activity limitation and fatigue are functional limitations associated with congestive heart failure.

Cal MediConnect – Model of Care (MOC) Training for Contracted Network Providers

Content

- Overall Goals of Model of Care
- Model of Care (MOC) and SNP/MMP Population
- 2 Types of SNPs
- SNP Population and Vulnerable Population
- Care Coordination
- Case Management Process
- Care Transition Process
- HRA – Health Risk Assessment
- ICP – Individual Care Plans
- ICT – Interdisciplinary Care Team
- Grievances and Appeals
- Member Rights & Assistance Responsibilities
- Training Requirements and FAQs

Overall Goals of the Model of Care (MOC)

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care, long-term supports and services (LTSS) and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, provider and health services
- Assuring appropriate utilization of services

Improve Health Status

- Improving patient health outcomes

MOC Description

What is Model of Care (MOC)?

- The Model of Care (MOC) is the comprehensive plan for delivering our integrated care management program for patients with special needs
- It is the architecture for promoting quality, care management policy and procedures and operational systems.

MOC – Special Needs Plan (SNP)/Medicare-Medicaid Plan (MMP) Population

- The MOC includes characteristics of the patients that South Atlantic Medical Group and providers serve including social factors, cognitive factors, environmental factors, living conditions and co-morbidities
- The MOC also includes:
  - Determining and tracking eligibility
  - Specially tailored services for patients
  - Working with community partners

SNP Types

- SNP is a special need plan. Medicare Advantage (MA) plan designs special and unique benefit package to meet the needs of our most vulnerable members
- 2 SNP types in 2021
  - Dual eligible SNPs (D-SNPs) for patients that are dually eligible for Medicare and Medicaid
  - Chronic SNPs (C-SNPs) for patients with chronic and disabling disorders; one or more of the following chronic diseases is required depending on the specific plan:
    - Diabetes
    - Chronic Heart Failure
    - Cardiovascular Disorders:
      - Cardiac Arrhythmias
      - Coronary Artery Disease
      - Peripheral Vascular Disease
      - Chronic Venous Thromboembolic Disorder

MMP

Medicare-Medicaid Plan (MMP) is referred to as Cal MediConnect (CMC).

- The MMP is a “demonstration plan” that combines Medicare and Medicaid. It’s a three-way contract between CMS, Medicaid and Health Plans as defined in Section 2602 of the Affordable Care Act.
- The goal of an MMP plan is to improve quality, reduce costs and improve the patient experience. This is accomplished by:
  - Ensuring dually eligible patients have full access to the services they are entitled
  - Improving coordination between the federal government and state requirements
  - Developing innovative care coordination and integration models
  - Eliminating financial misalignments that lead to poor quality and cost shifting

MMP Overview

- Eligibility rules can vary from state to state.
- General eligibility guidelines are that patients are eligible for Medicare
- and Medicaid and have no private insurance
- MMP patients have full Medicare and Medicaid rights and benefits
- The Medicare and Medicaid benefits are integrated as one benefit
- SNPs and MMPs follow a team based MOC, however, individual States may establish additional regulations and requirements for MMPs

Vulnerable Sub-Populations

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- **Complex and multiple chronic conditions** – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- **Disabled** – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- **Frail** – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- **Dementia** – patients at risk due to moderate/severe memory loss or forgetfulness
- **End-of-life** – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

Coordinate Medicare/Medicaid

Medicare and Medicaid benefits for D-SNPs and MMPs should be coordinated:

- Patients informed of benefits offered by both programs
- Patients assisted to maintain Medicaid eligibility
- Patient access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when health plan is contractually responsible
- Patients informed of rights to pursue appeals and grievances through both programs
- Patients assisted to access providers that accept Medicare and Medicaid

Benefits to Meet Specialized Needs

- **Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with patient and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP/MMP and region
- Additional benefits vary by region and type of SNP/MMP but may include **Dental, Vision, Podiatry, Gym Membership, Hearing Aides** or lower costs for items such as **Diabetic Monitoring supplies, Cardiac Rehabilitation**

Language/Communication Needs

SNP/MMP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication with negative impact on health outcomes. Services to meet these needs include;

- Office interpretation services – in-person and sign-language with minimum of 3-5 days notice
- Health Literacy – training materials and in-person training available
- Cultural Engagement – training materials and in-person training available
- Translation of vital documents
- 711 relay number for hearing impaired

Communication Systems

Integrated communication systems are necessary to implement the SNP/MMP care coordination requirements:

- An **Electronic Medical Management System** for documentation of care management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with eligibility and coordination of benefit questions and able to meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate HRA results and new patient information to SNP/MMP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online

What is Care Coordination?

Case Management services for members with increased needs:

- Episodic
- Increased resources
- Multiple services along the continuum
- May be accessing MLTSS services
- Additional designated care coordinator, appropriate specialty providers, and additional service providers.

The goal is to have seamless service coordination.

Primary Care and Specialty Care providers play an important role in Care Coordination.

Care Coordination

Care Coordination Standards

- Five elements of a person-centered approach:
  - Individualized service planning and delivery
  - Participation of the person and, as appropriate, family members and others chosen by the person in service planning and delivery
  - Consideration of the person's values, culture, traditions, experiences and preferences in the definition of quality
- Recognition and support of a person's self-care capabilities
- Integration of formal and informal supports

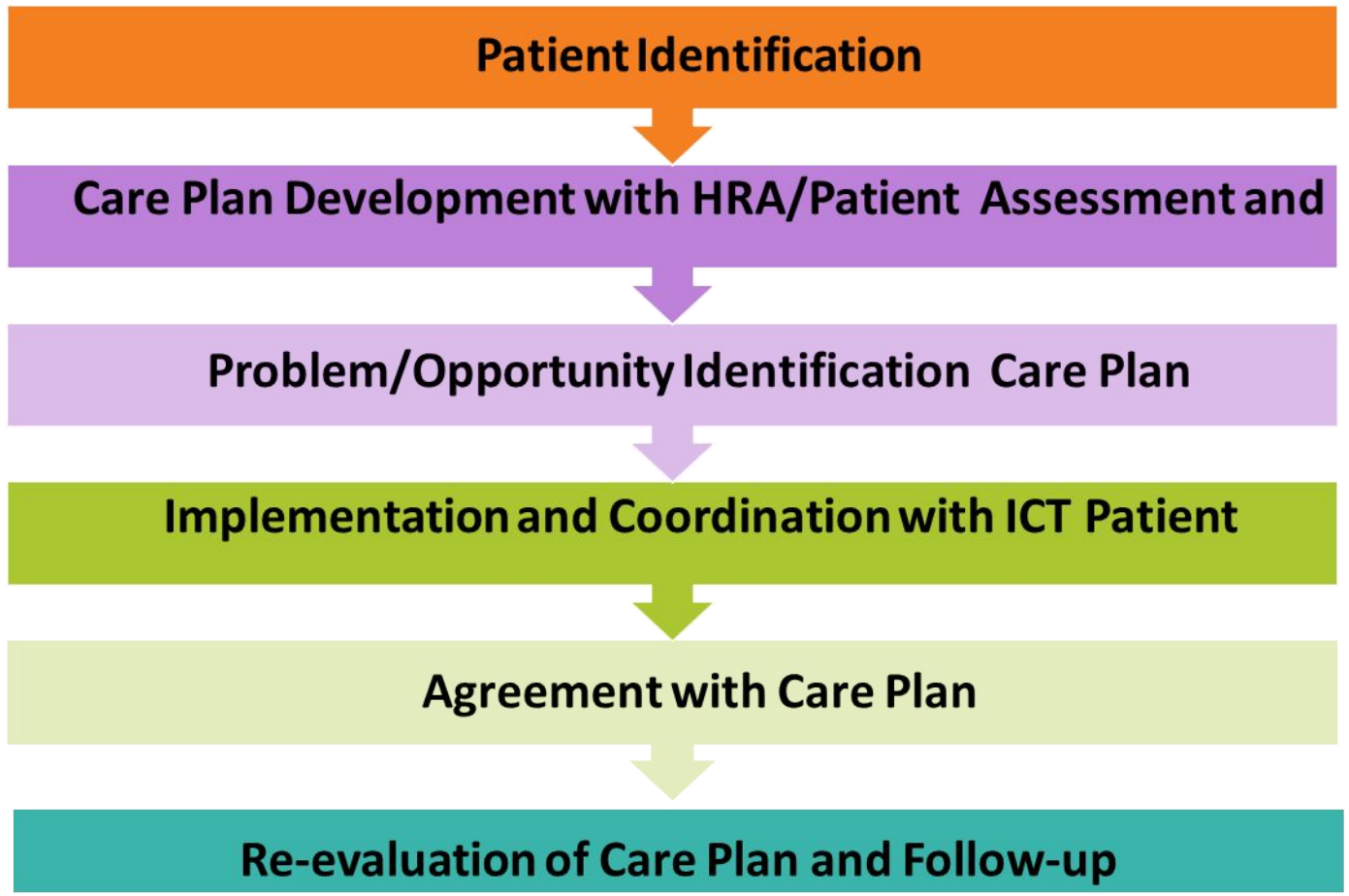
Care Coordination Processes

- Targeted assessment of identified member needs
- Creation of individualized care plan
- Facilitation of identified referrals
- Facilitation of Continuity of Care with non-contracted providers
- Development of short term goals
- Follow up communications
- Discussion of ICP with ICT

What is a Case/Care Manager?

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the patient to navigate the healthcare system and collaborating with providers, their social support system, their Community and other professionals associated with their care.

Case Management Process Overview



Case Management of Transitions

Patients are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health).

- Patients experiencing inpatient transition identified/managed (pre- authorization, facility notification, inpatient census)
- Important elements (diagnoses, medication reconciliation, treatments, providers and contacts) of care plan transferred between care settings before, during and after a transition
- Patient is able to communicate their health information to healthcare providers in different settings
- Patient educated on health status and self-management skills: discharge needs, meds, follow-up care, and how to recognize and respond to issues (discharge instructions, post-discharge calls)

MOC CM Requirements

CMS requires all **SNP and MMP** members to have the following:

HRA Health Risk Assessment

ICP Individualized Care Plan

ICT Interdisciplinary Care Team

Health Risk Assessment (HRA)

- A health questionnaire that provides an overview of patient's health risks and quality of life
- Health plans attempt to complete the HRA within 90 days of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the patient's provider
- Clinical review of the HRA must be completed by a licensed staff member*
- Patients have the right to refuse to complete the HRA

* Licensed person includes RN, LCSW or MD/DO

What Does the HRA Assess?

The HRA is a Medicare requirement for all SNP and MMP members. The HRA screens for:

- Health status, chronic health conditions/health care needs
- Clinical history
- Mental health and cognitive status Activities of daily living (ADLs)/Instrumental activities of daily living (IADLs)
- Depression
- Medication review
- Cultural and linguistic needs, preferences or limitations
- Evaluate visual and health needs, preferences or limitations
- Quality of Life
- Life planning activities
- Caregiver support
- Available benefits
- Continuity of care needs
- Fall prevention
- Managed Long Term Services and Supports, including HCBS

This tool, along with other resources, is used to develop the Individualized Care Plan (ICP)

HRA Utilization

1

Encourage patients to complete HRA over telephone or by mail

2

Explain the information helps the Care Manager and ICT to meet their healthcare needs

3

Register for and check the provider portal regularly for new HRAs

4

Use the HRA responses to stratify patient outreach

What is a Care Plan?

Case Management Society of America defines a Care Plan as:

- “A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; measurable goals to demonstrate resolution based upon the problem/need, timeframe, the resources available, and the desires/motivation of the client/family.”

Building Individualized Care Plans (ICP)

Individualized care plans include, but are not limited to, the following:

- Establishing patient prioritized goals: what is important **TO** the patient and **FOR** the patient
- Identifying resources that might benefit the patient, including recommendations for the appropriate level of care
- Planning for continuity of care, including assisting the patient in making the transition from one care setting to another.
- Collaborative approaches to health and care management which can including the PCP, family or patient representative.
- Established timeframes for ongoing evaluation of patient's goals

Building ICP (Cont'd)

Person Centered Care Plan

Problems	Goals	Barriers	Interventions
Communicated by the patient regarding their life, health, worries and behaviors	What the patient hopes to achieve regarding their health	Lack of transportation, finances, housing, treatment side effects	Actions to support problem resolution and support goal decrease stress

ICP Problems

- Medical conditions not being well managed
- Ineffective pain management
- Cognitive deficits (dementia, brain injury)
- Unable to meet financial obligations (rent, utilities, food)
- Unsafe housing, lack of social support
- Lack of knowledge to self-manage health
- Lack of caregiver or family support
- Communication needs: language or sensory deficits
- Cultural or other beliefs interfere with prescribed treatment

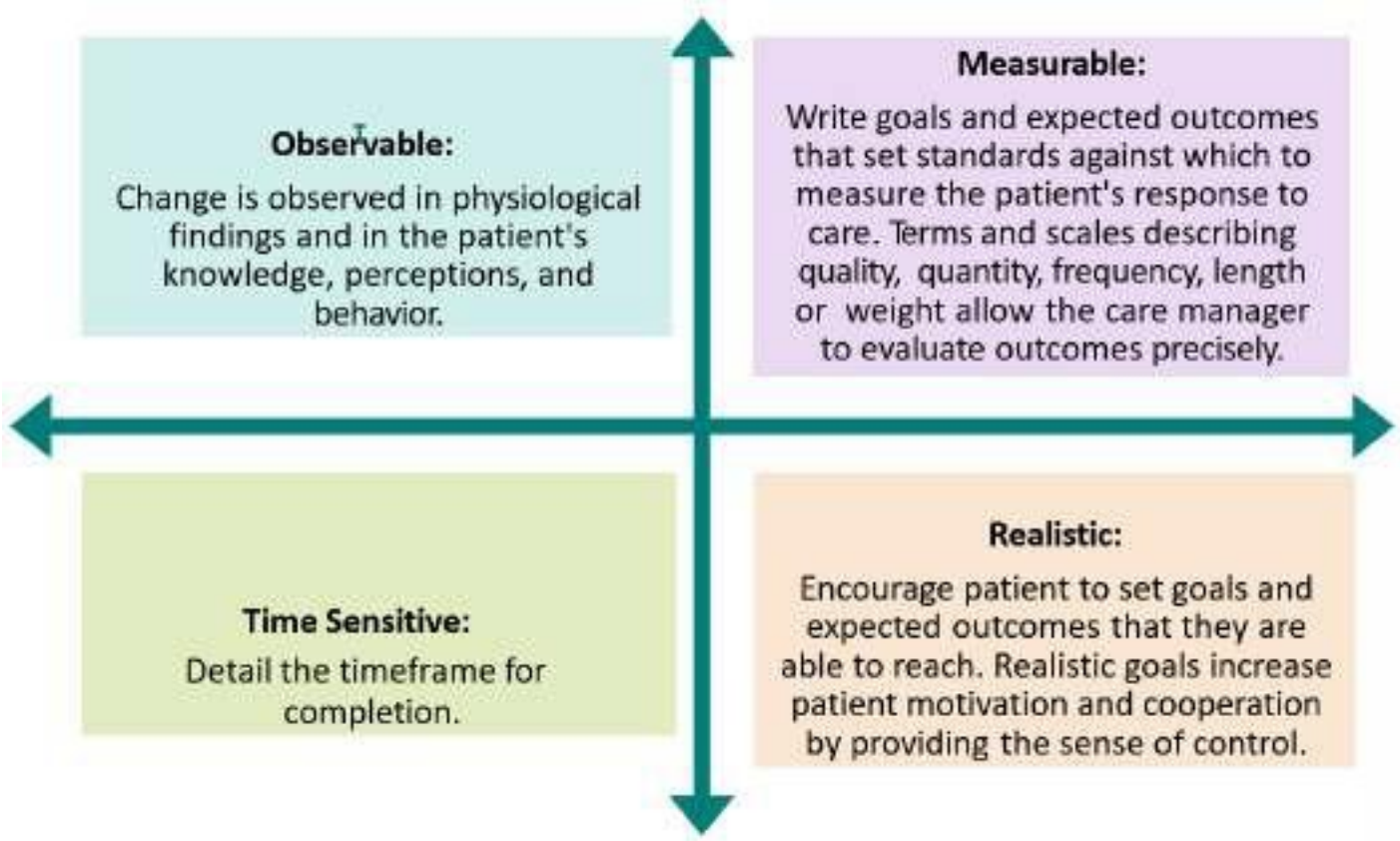
ICP Problems (Cont'd)

Review, Prioritize and Set Problems

Member Centered Goals

- **Measurable goals** provide a clear description for the patient and care manager on how and when the goals have been achieved, patient behavior and improvement in health outcomes.
- **Goals and outcomes** reflect patient behaviors and responses expected as a result of nursing interventions. Write a goal or outcome to reflect a **patient's** specific behavior, not to reflect the **care manager's** goals or interventions.
- Each goal should address only **one behavior or response**. The outcome should be **measurable** and **evidence-based**.
- **Goals** can be short term or long term.

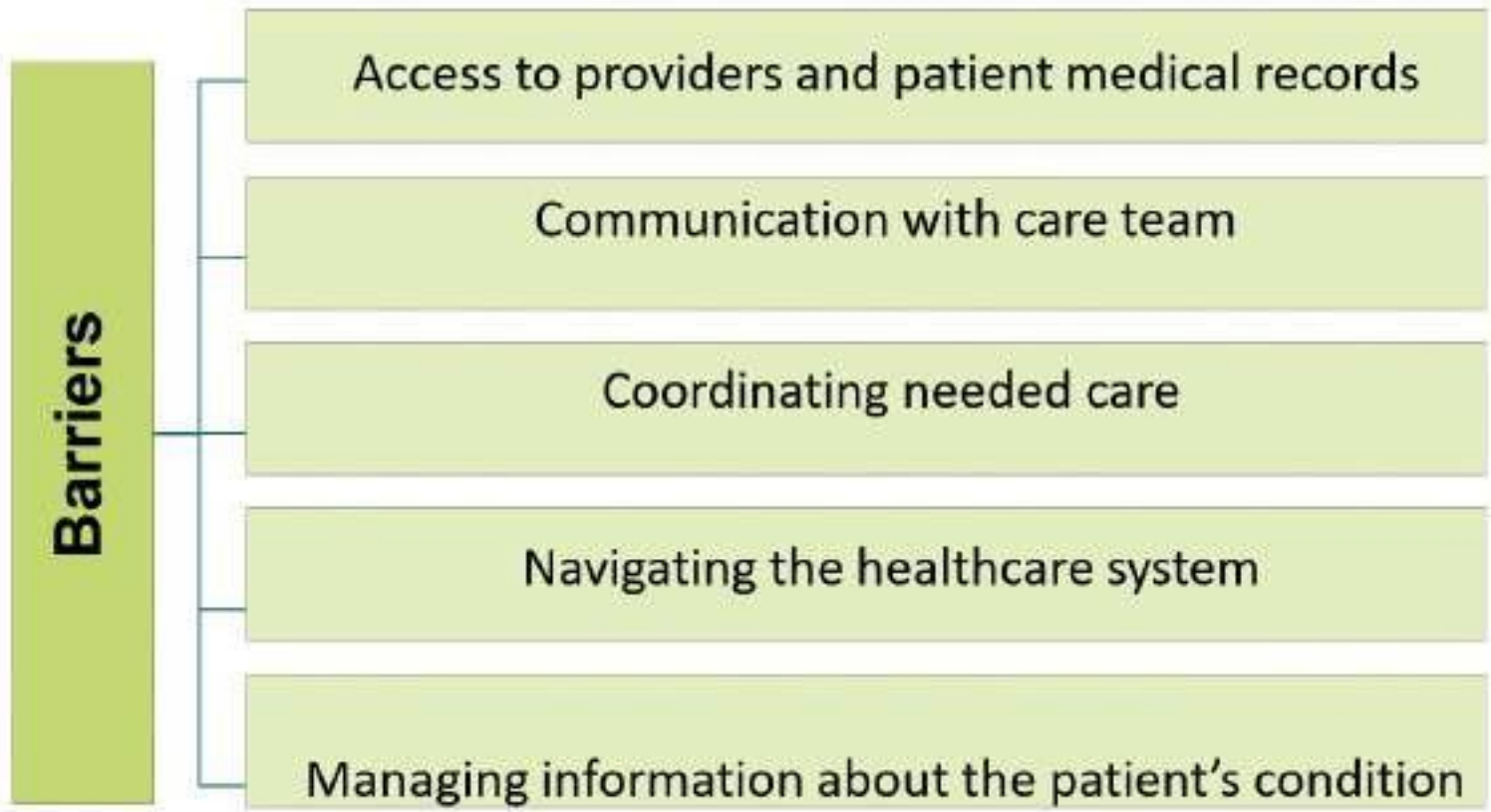
Member Centered Goals (Cont'd)



ICP Steps


1
Define care opportunities or care goals
2
Ensure goals are realistic, measurable and achievable
3
Address care gaps in goals
4
Identify any barriers that may hinder goal achievement
5
Confirm that the patient agrees with the goals

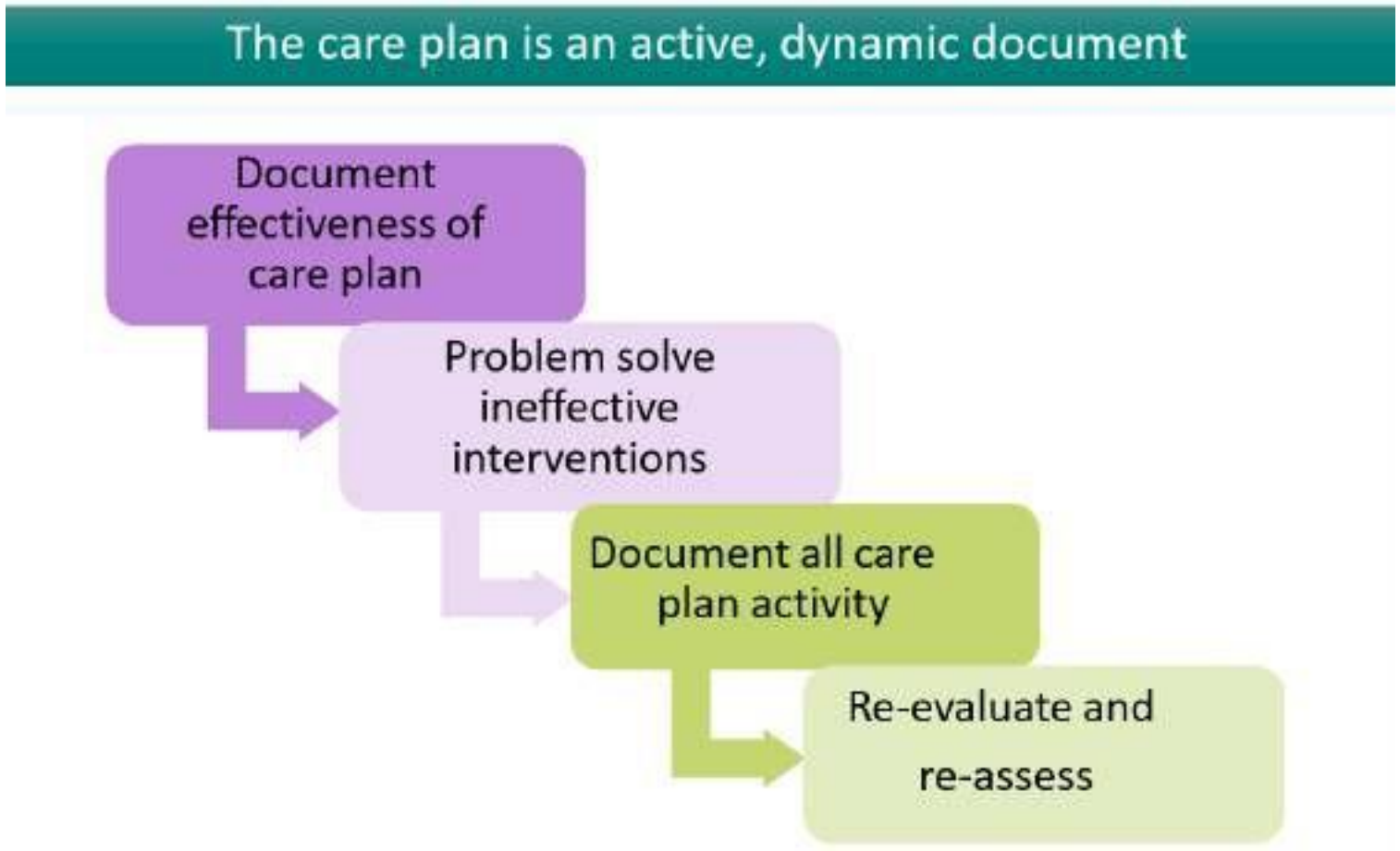
ICP Barriers



ICP Interventions

- An intervention is an action to help the patient achieve their goals (including overcoming barriers)

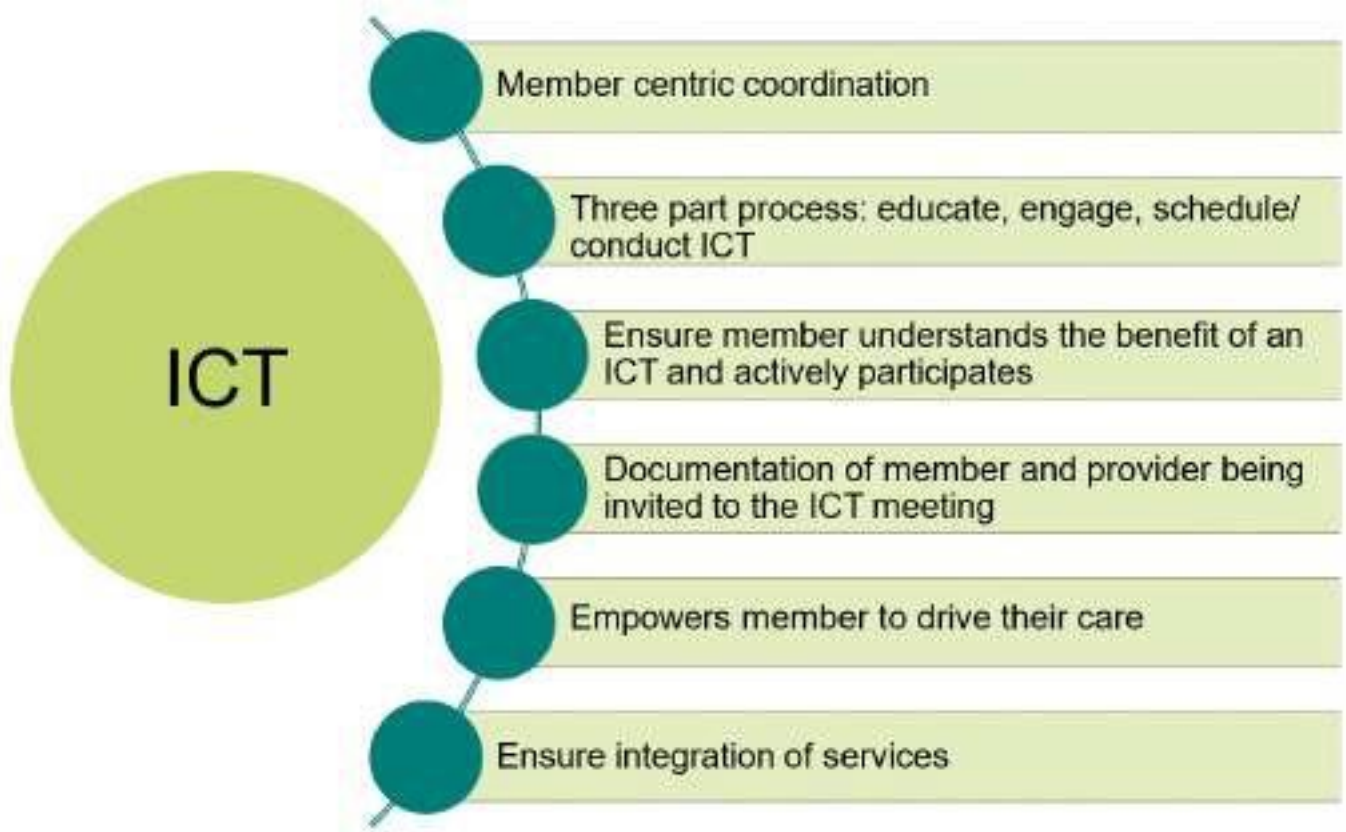
Monitoring the Care Plan



Updating the Care Plan

- Update the patient's care plan when changes in condition or transitions of care (TOC) occur
- Close problems, goals and interventions accurately using:
  - Claims data
  - Prescription drug event (PDE)
  - Lab, radiology etc.
- All updates are documented and communicated as needed

Interdisciplinary Care Team (ICT)



What is an ICT?

An (ICT) Interdisciplinary Care Team is a collaborative, multidisciplinary team who:

- Analyzes and incorporates the results of the initial and annual health risk assessment into the care plan.
- Develops a collaborative Individualized Care Plan (ICP) and annually update the member's ICP.
- Manages the medical, cognitive, psychosocial and functional needs of each member.
- Communicates the ICP to all caregivers for care coordination.
- Coordinates with and facilitates referrals to the appropriate resources, medical, behavioral health or home and community based providers, i.e. MLTSS

Membership

The Care Manager leads and determines ICT membership with the patient and can include:

- Patient/caregiver
- Medical Expertise*
- Social Services Expertise*
- Behavioral Health as indicated*
- Pharmacist
- LTSS Coordinator
- Nursing Facility Representative
- Discharge Planner
- PT/OT/ST
- Community agencies
- Other health care professionals

*Indicates minimum required

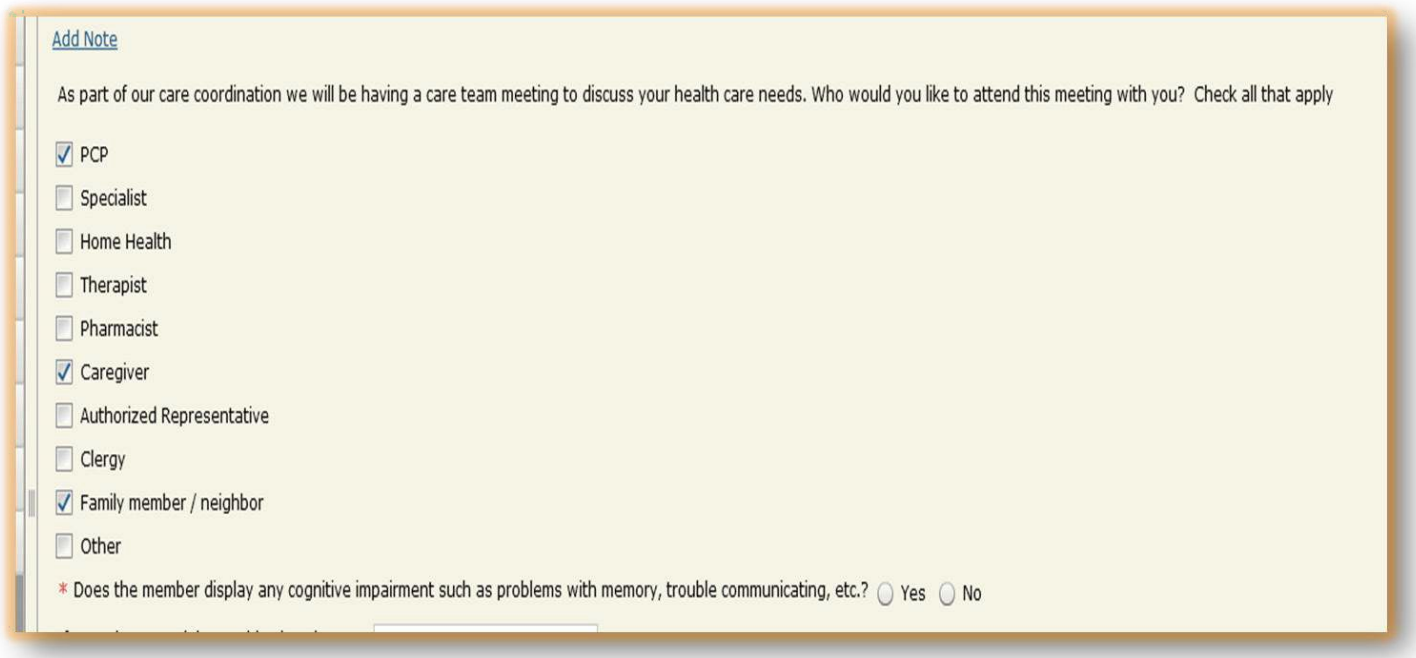
Regular Meetings

ICT meetings are conducted at least annually and more frequently based on the patient's needs. They can be in the form of:

- Virtual/Conference calls
- In-person meetings (Grand Rounds)
- Inpatient facility care conference

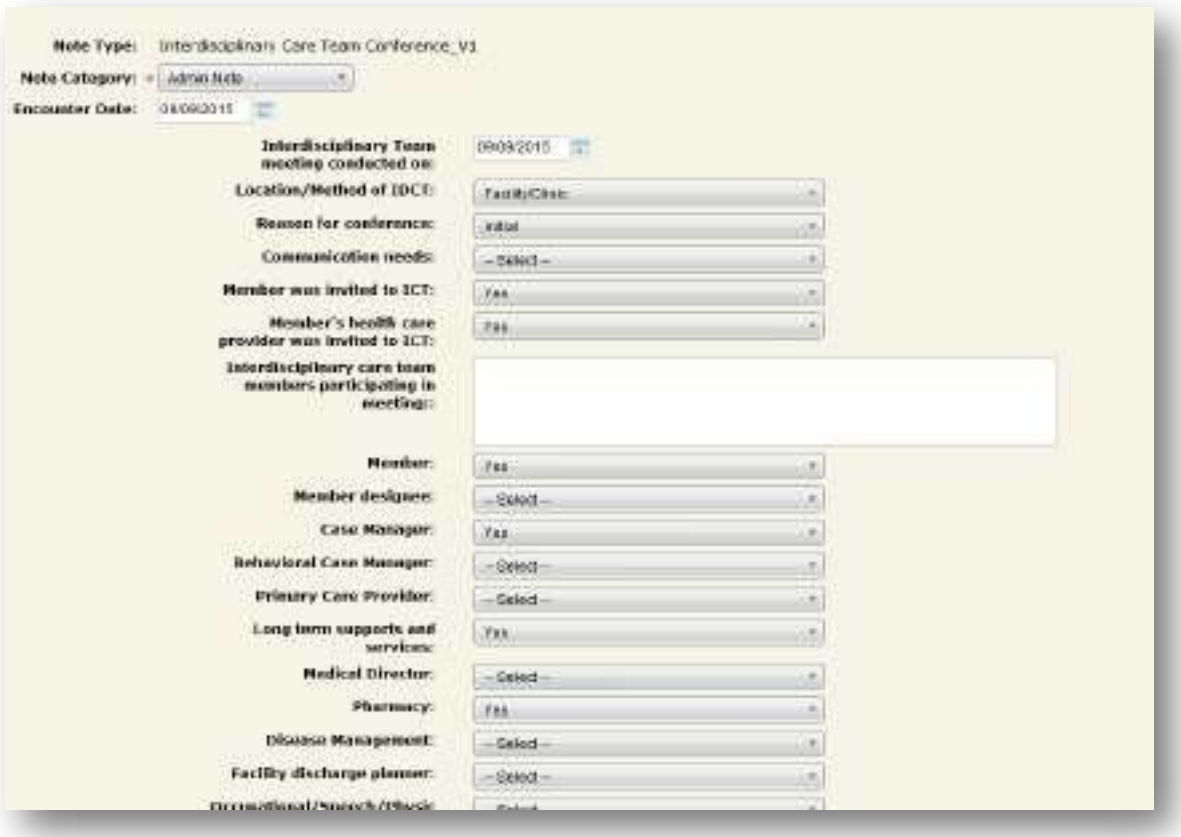
Patient Centered

The member is at the center of the care planning process and may choose to include clinical or non-clinical staff and/family or caregivers. **The member may also choose to exclude participants as part of their right to self-direct care**. The patient should attend or be kept informed of ICT meeting outcomes and identify preferences for ICT members. Example:



Documentation Required

Example: ICT Conference Note



MOC - Member Rights

- Members have specific rights about information, privacy, participation in their treatment, voicing complaints, choosing a PCP within the Contractor's Network, enrollment/disenrollment, and receiving emergency services.
- South Atlantic Medical Group does not discriminate against enrollees due to:
  - Age
  - Ancestry
  - Color
  - Disability (Physical or Mental)
  - Ethnic group identification
  - Evidence of insurability (including conditions arising out of acts of domestic violence)
  - Gender
  - Gender identity
  - Genetic information
  - Health status
  - Marital status
  - Medical condition
  - National origin
  - Race
  - Religion
  - Sex
  - Sexual orientation
  - Source of payment
  - Status as a parent

MOC - Member Rights (Cont'd)

- Members have the right to:
  - Receive information about South Atlantic Medical Group, its services, its
  - practitioners and providers.
  - Privacy and right to be treated with respect, dignity, and courtesy from South Atlantic Medical Group's providers and staff.
  - Participate with practitioners with any care their practitioner provides or recommends, discuss all treatment options, and participate in making decisions about their health care, presented in a manner appropriate to the enrollee's condition(s) and ability to understand.
  - Right to say "no" to treatment.
  - Talk candidly to their practitioner about inappropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Right to decide in advance how they want to be cared for in case they have a life-threatening illness or injury.

MOC - Member Assistance Responsibilities

- Access barriers and disability conditions: Efforts will be made to provide access to care in accordance with DMHC timelines.
- Referral to appropriate clinical staff: Providers will evaluate patient's clinical and functional needs through needs assessments and refer patients to appropriate clinical staff to further diagnose and treat patients.
- Grievances & Appeals: If dissatisfaction is expressed by the member or a representative on behalf of the member, member services representatives will warm transfer the member to the health plan to file a formal grievance or service appeal. Member services will also document the grievance and assist with requests for appropriate documents should this be requested by the health plan.

HRA/ICP/ICT Frequently Asked Questions

1. What if the HRA is not received timely?
   - *Initiate the ICP. Document that there was no HRA at time of completion of ICP.*
2. What if HRA arrives after I have completed the initial assessment?
   - *Review HRA and update ICP with any additional or clarified information.*
3. Do I need to monitor ICP once completed?
   - *Yes. All ICPs should be updated and monitored based on the patient's current status and changes.*
4. When should I initiate an ICT?
   - *Documentation and implementation of the ICT should start along with the ICP.*
5. What are requirements if a patient chooses to opt-out?
   - *The ICP and ICT must still be completed per MOC requirements. Best practice is to reach out to member at least annually and/or when there is a change or transition to offer case management services.*

Advance Directives – All Lines of Business (LOBs)

Introduction

Purpose

- Discuss advance directives and end-of-life care decisions
- Learn the different types of advance directives
  - Living Will
  - Durable Power of Attorney
- Physician Orders for Life-Sustaining Treatment (POLST)
- Recognize advantages and disadvantages of advance directives
- Identify resources that can help you complete your advance directives

What is an Advanced Directive?

- An advance directive is a document that indicates in writing:
  - Your choices about the treatments you want or do not want
  - Who will make healthcare decisions for you if you become incapacitated and cannot express your wishes
- Wishes examples:

Dialysis	Medicines
Feeding Tube	Blood and Water Transfusion
Breathing Machines or Ventilator	Surgery
Organ or Tissue Donation	Funeral or Burial Wishes
Cardiopulmonary Resuscitation (CPT)	Autopsy

Why have an Advanced Directive?

- An advance directive speaks for you when you are unable to do so. It tells others the care and treatments you do or do not want and/or who will make healthcare decisions for you when you cannot express your wishes. It may relieve your family from the burden of guessing what you would want. Providing such guidance may also prevent painful family arguments about how you would want to be treated.
- There are two kinds of Advance Directives
  - **Living Will** - Indicates what kind of treatments you would want, and what treatments you wouldn't want
  - **Durable Power of Attorney** - Names a person of your choosing to make decisions for you

Living Will

- A living will is a written statement in which you specify what kind of healthcare you do or do not want to receive. It can act as a guide for those who may need to make your medical decisions. A living will allows you to make decisions regarding treatment or machines that keep your heart, lungs or kidneys functioning when they are unable to function on their own.
- Although you may write your living will on your own, it is best to inform your family, close friends and physician of your wishes

Durable Power of Attorney in Health Care

- The power of attorney for healthcare is a form that allows you to appoint another person (a "healthcare agent") to make healthcare decisions for you if you are not capable of making them for yourself. When you complete this form, you give authority to your healthcare agent to make a wide range of decisions for you, such as:
  - Whether or not you should have an operation,
  - Receive certain medications
  - Be placed on life support
- In some areas of healthcare, your healthcare agent is not allowed to make decisions for you unless you give him or her specific authority in these areas when you complete the form. These areas are listed on the form.
- You can also include specific instructions about the type of treatments you want or do not want (such as surgery or tube feedings) when you complete the form. A power of attorney for healthcare goes in effect only when two physicians, or a physician and a psychologist, agree in writing that you can no longer understand your treatment options or express your wishes to others.

Physician Orders for Life-Sustaining Treatment (POLST)

- This form is used to direct paramedics, physicians and other health care professionals on what life sustaining measures are required.
  - The POLST **does not** replace an Advance Directive. This form should be reviewed in conjunction with the Advance Directive, to ensure that there is no conflict.
- It is a doctor's order that is recognized throughout the medical system.
- It is a portable document that transfers with the patient from one care setting to another.
- It is easily distinguished by its bright pink color.
- It is a standardized form for the whole state.
- Allows individuals to choose medical treatments they want to receive, and identify those they do not want.
- Provides direction for healthcare providers during serious illness.

POLST vs Advance Healthcare Directive (AHCD)

POLST	AHCD
For Seriously ill/frail, at any age	For anyone 18 and older
Specific orders for current treatment	General instructions for future treatment
Can be signed by decision maker	Appoints decision maker

What should I do with the forms?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.
- For California Nursing Home Residents ONLY
  - Give this form to your nursing home director. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.
- Print and carry a wallet card

Member/Caregiver Responsibility

- Members have a right to enact Advance Directives.
- Advance Directives should be provided to the primary care provider upon enacting an Advance Directive.
- When Advance Directives are revoked and/or the agent made changes, the information should be updated with the health care provider.
- The Member has a right to not be discriminated against because there is an Advance Directive in place.
- Members have the right to be treated with dignity.

Provider Responsibility

- Advance Directives are to be copied and maintained in the Medical Records.
- In the event that a physician or other appropriate health care professional refuses to comply with an Advance Directive on the basis of policies based on moral convictions, religious beliefs or other conscientious objections, at the request of the Member or authorized representative care of the Member, the Member must be transferred to another physician willing to care them.
- Members/caregivers are allowed to have input into their plan of care.

Additional Resources

- Advance Directive
  https://prepareforyourcare.org/en/advance-directive
- POLST – California
  https://capolst.org/
- POLST – National
  https://polst.org/

Member Rights & Responsibilities – Medi-Cal

Member Rights & Responsibilities

PURPOSE
To ensure members receive quality care delivered in a professional manner with respect for the Member and their rights. Additionally, to ensure members are informed of their rights and ensure the protection of member rights during healthcare delivery.

POLICY
It is the policy of the IPA/medical group to demonstrate a commitment to treating members with dignity and in a manner that respects their rights. This policy will be distributed to all contracted practitioners, reviewed annually, and revised as necessary.

The designated IPA/medical group Member has the right to:

- Exercise these rights without regard to age, ancestry, color, disability (physical or mental), ethnic group identification, evidence of insurability (including conditions arising out of acts of domestic violence), gender, gender identity, genetic information, health status, marital status, medical condition, national origin, race, religion, sex, sexual orientation, source of payment and status as a parent.
- Be provided with comprehensible information about our medical group, services, providers, and healthcare service delivery process. This information includes instructions about how to obtain care with various providers and varied facilities (e.g., primary care, specialty care, behavioral health services, and hospital services). Additionally, information will be included about how to obtain services outside of the IPA system or service area.
- Be informed of emergent and non-emergent benefit coverage and cost of care and receive an explanation of the Member's financial obligations, as appropriate, prior to incurring the expense (including co-payments, deductibles, and co-insurance).
- Be provided with instructions in accordance with prudent layperson standards and address the needs of non-English speaking members with information about how to obtain care after normal office hours and how to obtain emergency care, including when to directly access emergency care or use 911 services.
- To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services, and Emergency Services outside the Contractor's Network pursuant to the federal law.
- To access Minor Consent Services.
- Examine and receive an explanation of bills generated for services delivered to the Member.
- Be provided with information on how to submit a claim for covered services.
- Be informed of the name and qualifications of the physician who has primary responsibility for coordinating the Member's care; and be informed of the names, qualifications, and specialties of other physicians and non-physicians who are involved in the Member's care.
- Have 24-hour access to the Member's primary care physician (or covering physician).
- Receive complete information about the diagnosis, proposed course of treatment or procedure, alternate courses of treatment or non-treatment, the clinical risks involved in each, and prospects for recovery in terms that are understandable to the Member, so that the Member may give informed consent or refuse that course of treatment.
- Candidly discuss appropriate or medically necessary treatment options for the Member's condition, regardless of cost or benefit coverage.

- Receive confidential treatment of all member information and records used for any purpose.
- Actively participate in decisions regarding the Member's health care and treatment to the extent permitted by law. This includes the right to refuse any procedure or treatment. If the recommended procedure or treatment is refused, an explanation will be given addressing the effect that this will have on the Member's health.
    - To formulate advance directives.
- Be treated with respect and dignity.
- Receive considerate and respectful care with full consideration of the Member's privacy.
- Be informed of applicable rules in the various health care settings regarding member conduct.
- Express opinions or concerns about our medical group of the care provided and offer recommendations for change in the healthcare delivery process by contacting the Member Services Department.
- Be informed on how to express a complaint, grievance, and appeal, including having knowledge of the entire process.
- The member or legal guardian via telephone, in writing or in person, will express an issue of concern or grievance. The information will be handled according to the contracted IPA/Medical Group approved confidentiality policies and procedures.
- To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend, or correct their Medical Record.
- Be informed of the termination of a primary care provider or practice site and receive assistance in selecting a new primary care provider or site within Contractor's Network in this situation.
- Change primary care physicians within Contractor's Network by contacting the health plan Member Services Department.
- Be provided with information on how we evaluate with health plans, new technology for inclusion as a covered benefit.
- Receive reasonable continuity of care and be given timely and sensible responses to questions and requests made for service, care, and payment (including complaints and appeals).
- Be informed of continuing health care requirements following office visits, treatments, procedures, and hospitalizations.
- Have all member rights apply to the person who has the legal responsibility to make health care decisions for the Member.
- To make available and/or assist Limited English Proficiency (LEP) members access to their contracted health plan interpreter services, or when requested, at any scheduled or unscheduled visits at provider offices, including ancillary providers, specialty service providers, diagnostic testing facilities, and urgent care at no cost to the Member.
- To receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b) (12).
- Right to make recommendations regarding member rights and responsibility policies.
- Request enrollment in or to decline or disenroll from case management and/or disease management programs.
- For any member denial, the Member will be able to contact the Medical Group and request a copy of the criteria used to make the decision on a denial that the group has made.

The Member has the responsibility to:

- Be familiar with the benefits and exclusions of the Member's health plan coverage.
- Provide the Member's health care provider with complete and accurate information which is necessary for the care of the Member (to the fullest extent possible).
- Be on time for all appointments and notify the provider's office as far in advance as possible for appointment cancellation or rescheduling.
- Report changes in the Member's condition according to provider instructions.
- Inform providers of the Member's inability to understand the information given to him/her.
- Carry out the treatment plan which has been developed and agreed upon by the health care provider and the Member.
- Contact the Member's primary care physician (or covering physician) for any care which is needed after that physician's normal office hours.
- Treat the health care providers and staff with respect.
- Obtain an authorized referral from the Member's primary care physician for a visit to a specialist and/or to receive specialty care.
- Be familiar and comply with the IPA/medical group health care service delivery system regarding access to routine, urgent, and emergent care.
- Contact the Member Services Department or the Member's health plan Member Services Department regarding questions and assistance.
- Respect the rights, property, and environment of all physician and medical group providers, staff, and other members.
- Have all these responsibilities apply to the person who has the legal responsibility to make health care decisions for the Member.
- Make recommendations regarding our member rights and responsibilities.

Some important notes for our members and providers:

We do not reward or offer incentives to employees or associates to encourage inappropriate underutilization of services. We are committed to providing quality care to our members, and therefore:

- Utilization Management decision-making is based only on the appropriateness of care and service and the existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or service care.
- Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

Cultural & Linguistic Sensitivity - All Lines of Business (LOBs)

Culturally and Linguistically Appropriate Service (CLAS) Provider Toolkit – ICE for Health

Purpose

- To provide resources to assist with addressing health care delivery to a diverse population of patients while adhering to legal mandates

Benefits

- Provides tips for the following:
  - How to interact with diverse patients
  - How to communicate across language barriers
  - How to develop an understanding of patients from diverse cultural backgrounds
  - Where to access resources and important references, including a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards."
- For the provider tool kit, please visit: [ICE C&L Provider Toolkit]

Tips for Successful Patient Encounters - ICE

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

- Styles of Speech – People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.
- Eye Contact – The way people interpret various types of eye contact is tied to cultural background and life experience.
- Body Language – Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.
- Gently Guide Patient Conversation – English predisposes us to a direct communication style, however other languages and cultures differ.

Tips for Office Staff to Enhance Communication – ICE

- Build rapport with the patient.
- Make sure patients know what you do.
- Keep patients' expectations realistic.
- Work to build patients' trust in you.
- Determine if the patient needs an interpreter for the visit.
- Give patients the information they need.
- Make sure patients know what to do.

Non-Verbal Communication and Patient Care - ICE

Non-verbal communication is a subtle form of communication that place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. This may account for 70% of a communication episode.

A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants.

- Eye Contact
- Touch and Use of Space
- Gestures
- Body Posture and Presentation
- Use of Voice

Guidelines for Gender Inclusive Language

ICE – Communications Tool Kit

Purpose

- This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).
- We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents- whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use.

COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).

We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

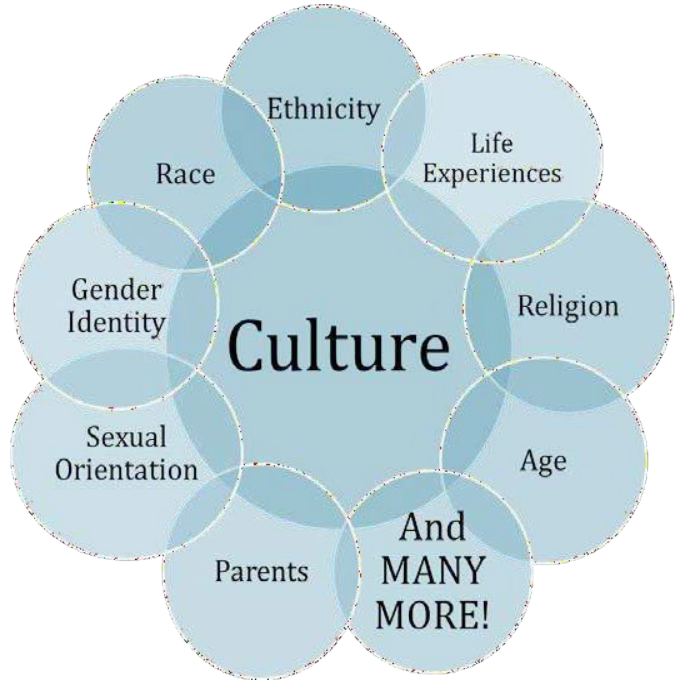
Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials: email Diana M. Carr, ICE Co-Chair at Diana.M.Carr@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

What is Culture?

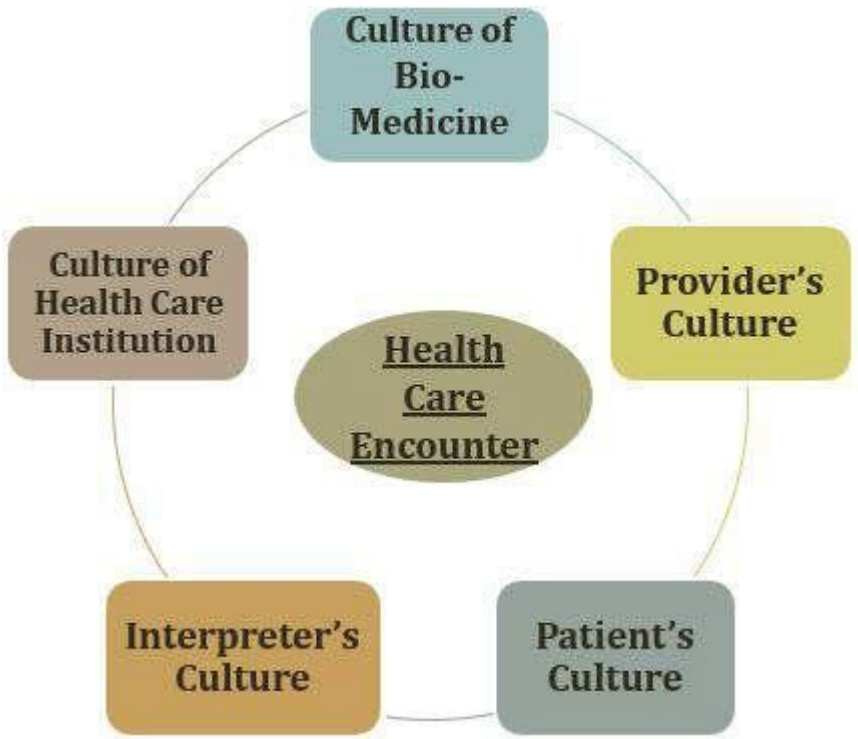
- Integrated patterns of human behavior that include language, thoughts, actions, customs, beliefs, values, and institutions that unify a group of people.
  - Influences how people act in social contexts
  - Informs the choices people make
  - Is used to create standards for social behavior



For the complete Training Module, please visit: [ICE Cultural Competency & Patient Engagement]

Health Care and Culture

- Each individual's culture is a unique representation, learned throughout life, shaped by society, and changes throughout the course of one's life.
- Each individual's culture is present wherever they go, including each health care encounter.
- Culture affects:
  - Views of illness and its causes
  - Attitudes toward health care providers
  - When health care assistance is sought out
  - Attitude toward seniors and those with disabilities
  - Caregiver roles
- There are many cultures at work in each health care visit.



Cultural Competency Continuum

For Each row, CIRCLE where you are now

Area of Competency	Stage 1 Culturally Unaware	Stage 2 Culturally Resistant	Stage 3 Culturally Conscious	Stage 4 Culturally Insightful	Stage 5 Culturally Versatile
Knowledge of Patients	Doesn't notice cultural differences in patients' attitudes or needs.	Denigrates differences encountered in racial/ethnic patients.	Difficulty understanding the meanings of attitudes/ beliefs of patients different from self.	Acknowledges strengths of other cultures and legitimacy of beliefs whether medically correct or not.	Pursues understanding of patient cultures. Learns from other cultures.
Attitude Towards Diversity	Lacks interest in other cultures.	Holds as superior the values, beliefs and orientations of own cultural group	Ethnocentric in acceptance of other cultures.	Enjoys learning about culturally different healthcare beliefs of patients.	Holds diversity in high-esteem. Perceives as valuable contributions to healthcare, medicine, patient well-being from many cultures.
Practice Related Behaviors	Speaks in a paternalistic manner to patient. Doesn't elicit patient's perspectives.	Doesn't recognize own inability to relate to differences. Tends to blame patient for communication or cultural barriers.	May overestimate own level of competent communication across linguistic or cultural boundaries.	Able to shift frame of reference to other culture. Can uncover culturally based resistance, obstacles to education & treatment	Flexibly adapts communication, inter-actions to different cultural situations. Can negotiate culture-based conflicts in beliefs and perspectives.
Practice Perspective	Believes one approach fits all patients. No "special treatment."	Has lower expectations for compliance of patients from other cultural groups.	Recognizes limitations in ability to serve cultures different from own. Feels helpless to do much about it.	Incorporates cultural insights into practice where appropriate.	Incorporates cultural insights into practice where appropriate.

Impacts of Clear vs Unclear Com

Clear Communication

- Safety & Adherence
- Physician & Patient Satisfaction
- Office Process
- Saves Time & Money

Unclear Communication

- Malpractice Risk
- Medical Error
- Reduces Cost

Effective Use of A Professionally Trained Interpreter

- Hold a brief introductory discussion with the interpreter
  - Introduce yourself and provide a brief description of the call/visit
  - Reassure the patient about your confidentiality practices
- Speak directly to the patient, not the interpreter
- Speak in the first person
- Speak in a normal voice; try not to speak too loud or quickly
- Pace your discussion with the patient to allow time for interpretation and avoiding interrupting during interpretation
- Speak in concise sentences
- While interpreters are trained in medical terminology, interpretation will be smoother if you avoid acronyms, medical jargon, and technical terms
- Be aware of the cultural context of body language

Limited English Proficiency

Here's What Patients Wish Their Health Care Team Knew...	Here's What Your Team Can Do...
• My English is pretty good but at times I need an interpreter	• Office staff should confirm language preferences during scheduling
• Some days it's harder for me to speak English	• Consider offering an interpreter for every visit.
• When I don't seem to understand, talking louder in English intimidates me	• Match the volume and speed of the patient's speech
• If I look surprised, confused or upset I may have misinterpreted your nonverbal cues	• Mirror body language, position, eye contact
	• Ask the patient if they're unsure

Language Assistance Services

- Language assistance is available at no cost to Members & Providers:
  - Interpreter support at a medical point of contact
  - Sign language interpreters
  - Speech to text interpretation for hearing loss in patients who do not sign
  - Member informing materials in alternative formats (i.e., large print,
  - audio, and Braille)
- **Contact the Health Plan for assistance with Language services**

Provide Alternate Forms of Communication

- Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.
- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language interpreters, Tactile interpreters, captioning and assisted listening devices.

Refusal of Interpretive Services Document (English)

Request/Refusal Form for Interpretive Services

Patient name:

Primary language:

☐ **Yes, I am requesting interpretive services.**
Language(s):

☐ **No, I prefer to use my family or friend as an interpreter.**

☐ **No, I do not require interpretive services.**

☐ **Not Applicable.**

Please explain:

Patient Signature **Date**

Please place this form in the patient s medical record.
equest/ efusal - English

Refusal of Interpretive Services Document (Spanish)

Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente:

Idioma preferido:

☐ **Si, necesito servicios de intérprete.**
Idioma(s):
_____

☐ **No, Prefiero utilizar un familiar o amistad como intérprete.**

☐ **No, requiero servicios de intérprete.**

☐ **No, me corresponde.**

Por favor explique:

_____

_____

_

Firma del paciente **Fecha**

Please place this form in the patient s
medical record. equest/ efusal - panish

Provider Health Plan LEP Contact Grid

Purpose

- To identify and provide a list Health Plan Interpreter services that are affiliated with South Atlantic Medical Group

Interpreter Service Contact Information for Health Plans Affiliated with South Atlantic Medical Group

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Alignment Health Plan	All Threshold Languages - using Voiance Language Services	**Medicare:** **Voiance Language Services:** (866) 998-0338 **Account Number:** 30488 **4 digit pin code:** 1099 **Face to Face:** Not Available **Additional Resource:** http://interpret.voiance.com/about/
Anthem Blue Cross	All Threshold languages	Services are arranged through Anthem Blue Cross Health Plan's Member Services department. Face to face visit require advanced notification. **Medi-Cal** (888) 285-7801 (inside Los Angeles County) (800) 407-4627 (outside Los Angeles County) **After business Hours:** call the 24/7 Nurse Line at (800) 224-0336 **Commercial and Medicare Advantage** Providers can call the Anthem's Provider Services Department at (800)677-6669 to receive assistance with translation and interpretation services. Members can contact the number on the back of their ID card for assistance. **Additional Resource:** https://mediproviders.anthem.com/ca/pages/free-interpreting-services.aspx
Blue Shield of California, Promise Health Plan (formally Care1st)	Oral translations in all languages, print translations Spanish & Traditional Chinese	Face to Face and telephonic interpreting services are arranged bye Blue Shield of California, Promise Health Plan. Face to face visits need to schedule 4 days in advance. **Medi-Cal** (800) 605-2556 **Medicare** (800) 544-0088 **CalMedi Connec**t (855) 905-3825 **After Business Hours:** Call Pacific Interpreters: (877) 904-8195 **ACCESS CODE:** 828201

Interpreter Service Contact Information for Health Plans Affiliated with South Atlantic Medical Group

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Health Net of California, Inc.	Interpretation available in all languages	Services are arranged through Health Net. Telephonic and Face to Face services available. Service available 24 hours a day, 7 days a week. Medi-Cal: (800) 675-6110 Cal Medi-Connect – Los Angeles: (855) 464-3571 Cal Medi-Connect – San Diego (855) 464-3572 Commercial: (800) 520-0088 After Hours, weekends and holidays: (800) 546-4570 Medicare Advantage: (800) 929-9224 (M-F 8AM – 5PM) TTY: 711 **Additional Resource:** www.healthnet.com (Click 'Language' tab on the top part of the website)
LA Care Health Plan	All languages	**All Lines of Business;** (855) 322.4034 Provide the member's LA Care Member ID and the Physician's NPI number. **Face to Face and Telephonic services** **Medi-Cal:** (888) 839-9909 **Cal Medi-Connect:** (888) 522-1298 **L.A. Care Covered:** (855) 270-2327 **PASC-SEIU:** (844) 854-7272 Face to face visits require advanced notification: **Additional Resource:** http://www.lacare.org/nondiscrimination-notice

Interpreter Service Contact Information for Health Plans Affiliated with South Atlantic Medical Group

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Molina Healthcare of California	All languages through Globo, third party vendor	**Globo:** (844) 311-9777 **Location Code:** 1011 (California) **Product Line:** 1 - Medi-Cal 2 - Marketplace 3 - CalMedi Connect (Duals) 4 - Medicare **Department Code:** 088 (Provider Office) or **Medi-Cal:** (888) 665-4621 Mon-Fri, 7am-7pm **Marketplace:** (888) 858-2150 Mon-Fri, 8am-6pm **Medicare:** (800) 665-0898 Mon-Fri, 8am-8pm **Cal MediConnect (Duals):** (855) 665-4627 Mon-Fri, 8am-8pm **After Hours and Weekends,** call Molina's Nurse Advice Line to arrange for service: **English:** (888) 275-8750 **Spanish:** (866) 648-3537 **Face to Face** services must be arranged in advance through Molina's Member Services department. **Additional Resource:** http://www.molinahealthcare.com/providers/ca/medicaid/resource/Pages/ask_cultural.aspx

Additional Resources

- ICE – Cultural Competency Training for Health Care Providers
- ICE – Better Communication, Better Care – Provider Tools to Care for Diverse Populations
- ICE – Interpreter Services for Health Plans in California
- ICE – Interpreter Quality Standards Guidance
- SAMHSA - Resource on Cultural Competency

HIPAA Privacy, Breach Notification & Compliance – All Lines of Business (LOBs)

HHS Privacy & Security

- South Atlantic Medical Group is committed to helping protect the privacy and integrity of our member's Protected Health Information (PHI). As a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have an obligation and responsibility to protect your patients' and our members' PHI.
- The following provides information to help you understand how to integrate HIPAA Privacy and security Requirements into your practice.
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf

Overview

- HIPAA Security Rule
- Encryption versus Password Protection
- Your Role in HIPAA Security
- Security Safeguards
- Ways to report Compliance Issues

HIPAA Security

- Technical, Physical and administrative safeguards to protect electronic protected health information (ePHI)
  - Confidentiality: No disclosure of ePHI to unauthorized individuals or processes
  - Integrity: No unauthorized alteration or destruction of ePHI
  - Availability: e-PHI accessible and usable on demand by authorized persons
- Two elements required for PHI:
  - Medical Information: Information related to a member's past, present or future physical and/or mental health or condition, treatment or payment
  - Identifying Information: Includes at least one of 18 personal identifiers such as: Account number, Name including initials, Dates of service, Full-face photos, Other unique identifying characteristic
- Technical safeguards:
  - Only authorized users access minimum necessary information to perform job
  - Ability to record and audit ePHI IT activity
  - Integrity & encryption of data in transmission

HIPAA Security (Cont'd)

- Technical safeguards
  - Only authorized users access minimum necessary information to perform job
  - Ability to record and audit ePHI IT activity
  - Integrity & encryption of data in transmission
- Physical safeguards
  - Limit access to places where ePHI stored
  - Safeguards for use and security of ePHI on desktops, laptops
  - Disposal and reuse of media with ePHI
- Administrative safeguards:
  - Risk analysis and risk management
  - Sanction policy
  - Information system audits
  - Security officer appointment
  - Ensure workforce access to ePHI appropriate
  - Security incident response team
  - Backups, disaster recovery and business continuity
  - Security & awareness training for workforce

Encryption vs Password Protection

- If an encrypted device with ePHI is lost or stolen, it is usually not a reportable HIPAA breach
  - But if a password protected device with ePHI is lost or stolen it is usually a reportable HIPAA breach
  - This is so even if we remotely wipe the device
- Password protection is not encryption
- Encryption converts regular text into encoded text using an algorithm called an encryption key
  - Converting the encoded text back into regular text without the encryption key is very difficult
  - Keep the encryption key secure and separate; don't keep it in writing near the device

Your Role in HIPAA Security

- Security safeguards are only 10% technical & 90% of security safeguards rely on users following good computer practices.
- Review these security safeguards and understand them
- Ask questions if you don’t understand security safeguards
- Report any suspected security incident compliance@samg.org

Security Safeguards

Unique User ID or Log-in: Don't share user ID or passwords	Secure Remote Access & Work from Home Procedures
Strong Password Protection: Passwords should be no less than ten characters, and contain upper and lowercase letters, numbers, symbols	Email Security: Be on the look-out for suspicious senders & don't click on links you do not trust
Workstation Security: Log out and lock up before leaving your desk	Internet Safety & awareness: Pay attention to alerts from IT or Compliance
Encryption for portable devices & laptops	Always Report Security Incidents or Breaches
Back-up info on a shared drive, not C:/ and safely disposal of ePHI	Follow Policies & Procedures: Ask IT or Compliance if you have questions

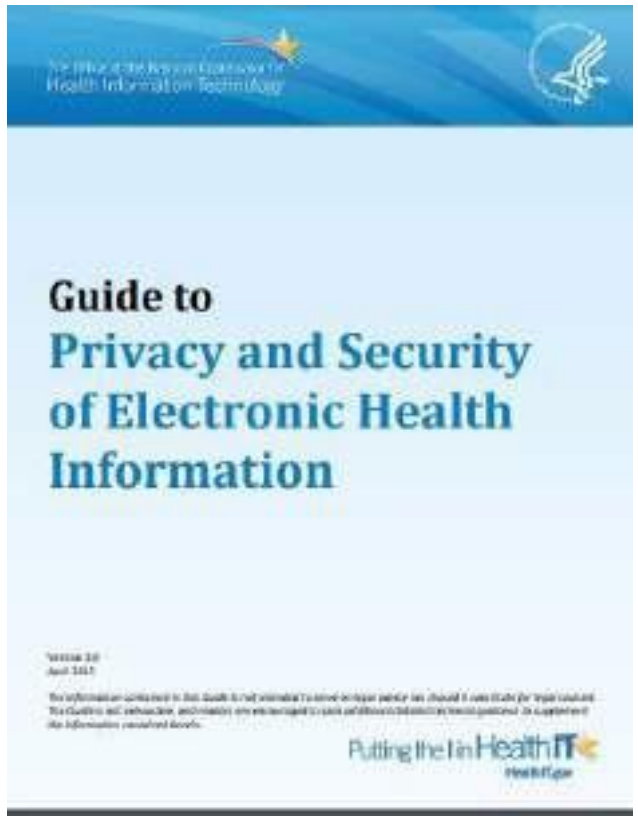
Reporting Security Issues

- Contact Adriana Martinez- SAMG Compliance Officer
  - E-mail: amartinez@samg.org
  - Phone: 323-725-0167

You may report fraud anonymously (24) hours a day, (7) days a week Compliance Hotline: 1-833-718-1025
Fax: (323) 725-6933
E-mail: compliance@samg.org.
Mail:
SAMG Compliance Officer
5504 E. Whittier Boulevard,
Los Angeles, CA 90022

Additional Resources

- HHS – Guide to Privacy and Security of Electronic Health Information



Fraud, Waste & Abuse – All Lines of Business (LOBs)

Health Care Fraud and Abuse Training – ICE for Health

Purpose

- To successfully Prevent, Detect and Report Health Care Fraud & Abuse

Training Goals

- **Identify** fraud and abuse
- **Understand** fraud and abuse laws & penalties
- **Recognize** government agencies and partnerships dedicated to fighting fraud and abuse
- **Recognize** risk areas or **red flags** in claims, utilization management, member services, documentation and coding
- **How to report fraud and abuse**
- **What happens after detection?**

- For the complete training Module, please visit: Health Care Fraud and Abuse Training

What is Health Care Fraud?

Intentional Act for Gain

- Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain payment.
- Knowingly receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal or private health care programs
- Making prohibited referrals for certain designated health services
- Documenting a verbal denial falsely attributed to a medical professional

Deception

- Falsifying documents to indicate notifications approving, modifying, or denying requests for authorization were sent to the member &/or provider
- Altering claim audit files to fraudulently show compliance with health plan audits to hide failure to pay claims due to financial insolvency
- Submitting inaccurate financial reports related to outstanding claims liability
- Redirecting care from a contracted provider because of economic profile (cost) without regulatory approval

What is Health Care Abuse?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to Health Care Programs. Abuse includes any practice inconsistent with providing patients medically necessary services, meeting professionally recognized standards of care, and charging fair prices.

The difference between “fraud” and “abuse” depends on specific facts, circumstances, intent, and knowledge.

Additional Resources

- ICE – Fraud and Abuse PowerPoint Training
- ICE – Fraud and Abuse Online Training

General Compliance – All Lines of Business (LOBs)

General Compliance Training– ICE for Health

Purpose

- To successfully understand how to prevent, detect & report, and correct non-compliance and Fraud, waste, and abuse (FWA)

Training Goals

- Recognize how a compliance program operates
- Understand your responsibilities in reporting actual or suspected non-compliance
- Understand how to ask questions, report suspected or detected non-compliance
- Recognize disciplinary guidelines for non-compliant and/or fraudulent behavior
- Understand non-retaliation and discrimination policies

- For the complete Training Module, please visit: General Compliance Training

Ethics – Do the Right Thing!

- Compliance ensures we conduct our business within the boundaries of the law; and guides us in acting ethically and legally.
- When we make ethical decisions and commit to doing the right thing, we build trust with our members/enrollees, providers, stakeholders, and regulators. We must:
  - Act fairly and honestly
  - Adhere to high ethical standards in all you do
  - Act with integrity, transparency, and accountability
  - Comply with all applicable laws, regulations, and CMS & DMHC requirements
  - Report suspected violations
  - Do the right thing!

What is Non-Compliance?

- Non-compliance is conduct that does not conform to law, State, or Federal health care program requirements, Code of Conduct/Ethics, and business policies.
- Sometimes good intentions can lead to non-compliance. The key is to always act with integrity – always do what is right even when it is hard or when no one is looking.

High Risk Areas for Non-Compliance

- Agent/broker/delegate misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims and Utilization Management processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care
- IT System access and safeguards
- Claims and Utilization Management documentation manipulation

Additional Resources

- ICE – General Compliance PowerPoint Training
- ICE – General Compliance Online Training

OIG/SAM/Medi-Cal Exclusions

–

All Lines of Business (LOBs)

OIG/SAM/Medi-Cal Exclusions Screening Attestation

South Atlantic Medical Group is committed to ensuring that our first-tier, downstream and related entities (FDR) are in compliance with applicable state and federal regulations, including regulations concerning the Office of the Inspector General (OIG) and General Services Administration (GSA). Specifically, the regulations require that all FDRs that participate in the delivery of governmental funded health care programs must review the OIG, GSA System for Awards Management ("SAM") and Medi-Cal Exclusion Lists upon initial hiring of or contracting with personnel and monthly thereafter to ensure that any employee, manager or downstream entity is not on any such list. FDRs must retain documentation to support results. Screen prints of negative results are sufficient.

In order to validate that each FDR has met the requirements, we must obtain a completed Attestation from an authorized representative of every FDR (i.e. Compliance Officer, CEO, CMO, Practice Manager Provider, Owner, etc.). Please be advised that pursuant to the terms of your agreement with IPA/Medical Group or an affiliated entity, you are required to comply with all applicable federal, state, and municipal rules and regulations and that this request is directly related to such provision. Please also be advised that such screenings are required under the contract between IPA/Medical Group or an affiliated entity, on the one hand, and the health plan, on the other hand.

To assist you with the implementation of your OIG_GSA Exclusion process, we are providing links to the relevant exclusions lists in order to comply with the regulations:

http://exclusions.oig.hhs.gov/
https://sam.gov/content/exclusions
https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx

Please note that these three lists do not necessarily overlap and thus all three lists must be checked as to each employee, manager or downstream entity. For example, an employee could be listed on the Medi-Cal exclusion list but not listed on the OIG and SAM exclusion lists.

Please execute and return the included Attestation Form at your earliest opportunity.
Thank you.

Critical Incident Training – Cal MediConnect

Overview

- A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or wellbeing of a member.
- Members of Cal MediConnect are adults (age 21 or older) may be vulnerable to abuse or neglect due to medical or mental health condition or disability, age and frailty, social isolation, and poverty.

Reportable Critical Incidents

Abuse	Death
Neglect	Medical Psychiatic Emergency
Exploitation	Restraints/Seclusion
Rights Violations	Medical Errors
Missing Person/Disappearance	Suicide Attempt
Serious, life-threatening event requiring immediate emergency evaluation	

Reporting

Staff identifying the Critical Incident is required to report the incident immediately upon awareness to their immediate supervisor who will follow-up with the appropriate authority in accordance with departmental policies and procedures.

- If the employee/supervisor is not sure how to report or categorize the Critical Incident, they may contact the Quality Improvement (QI) Nurse Specialist in the Quality Management (QM) Department to discuss.
- Critical incidents may be reported to the QM Department:
  - Name: Edita Reyes, RN
  - Email: Ereyes@samg.org
  - Call 323-725-0167
- The QI Nurse will determine if there is an immediate need for:
  - Activating emergency assistance if required
  - Provision of medical assistance if required
  - Provision of relevant support services
  - Endorsement to the State Agency(s) responsible for overseeing responding directly to critical incidents

Critical Incident Report Form

Critical Incident Report			
Date of incident:	__/__/__	**Time of incident**	_____ am/pm
Location: (include address, where applicable)			
Name of person completing form:			
Position of person completing form:		**Contact number:**	
Employees, Volunteers or Directors involved in incident:			
Name:		**Contact number:**	
1.			
2.			
3.			
4.			
Clients or community members involved in incident:			
Name:		**Contact number:**	
1.			
2.			
3.			
4.			
Description of incident and background:			
(Include all relevant circumstances and information leading up to the incident, whether the incident was witnessed, and any other relevant issues.)			

Critical Incident Report Form	
Who was informed of the incident? **(For example, CEO, manager, mental Health Services, police, fire department, Mental health, family members, and so on.)**	
1.	4.
2.	5.
3.	6.
Actions taken to date: **(Including date and time of contact, contact number, and other contact numbers of agencies or people who were informed, as well details of support provided.)**	
1.	
2.	
3.	
4.	
5.	
Follow up actions planned:	
1.	
2.	
3.	
4.	
5.	
Critical Incident Report Form received by:	
_____ (Signature of Employee)	Date: _____/_____/_____
_____ (Signature of Manager)	Date: _____/_____/_____

Additional Resources

- Medicare Managed Care Manual (MMCM), Ch.5 "Quality Assessment," Section 30.1.1
- California Health & Safety Code, Section(s) 1368-1368.03
- Title 42 Code of Federal regulations (CFR)§422.152 (1) (3)
- The Centers for Medicare and Medicaid (CMS) and the state of California: California Readiness Review Criteria

Sterilization Requirements

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Medi-Cal

Sterilization Definition

- As any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations which are performed because pregnancy would be life threatening to the mother (so-called “therapeutic” sterilizations) are included in this definition. The term sterilization, as used in Medi-Cal regulations, means only human reproductive sterilization, as defined above.

Types of Consent forms

- PM 330 – Medi-Cal Sterilization Consent Form
- PM 284 Commercial Non-Federally Funded Sterilization Consent Form

Codes Requiring Consent Forms

CPT Code	Description
55250	Vasectomy, unilateral or bilateral, including postoperative semen examination(s)
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	with fulguration of oviducts (with or without transection)
58671	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral

HCPCS Code	Description
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system

Hysterectomy Requirements

Hysterectomy

Page updated: August 2020

This section is to assist providers in billing for hysterectomy services.

Hysterectomy Consent Form

The Hysterectomy – Informed Consent form in this section is included as a sample. A hysterectomy consent form may be a hospital form, a physician-designed form or a written statement by the person who secures authorization. To be acceptable, however, the form must include the following:

- A statement that the procedure will render the patient permanently sterile and
- The patient's signature and date of signing. The date of signing must be on or before the date of surgery.

For the purposes of Medi-Cal reimbursement, patients undergoing therapy that is not for, but results in, sterilization (formerly referred to as secondary sterilization) are not required to complete the Department of Health Care Services sterilization *Consent Form* (PM 330).

TAR Requirement

All hysterectomy services require a *Treatment Authorization Request* (TAR).

No Waiting Period

There is no waiting period for a hysterectomy.

- Although the consent form for sterilization, PM 330, (refer to the *Sterilization* section in this manual) and the federal forms are not ideal for hysterectomy patients because the age and waiting period restrictions are inapplicable, these forms are adequate so long as the name of the operation is clearly denoted as "hysterectomy." A consent form signed previously for a tubal ligation is not acceptable. (A sample informed consent form is included in this section, refer to *Figure 1*.)

HYSTERECTOMY – INFORMED CONSENT

This is to certify that I _____ (name of patient) have been advised by my physician or his/her designee _____ (name of physician/designee) that the hysterectomy which will be performed on me will render me permanently sterile and incapable of having children. I have been informed of my rights to consultation by a second physician prior to having this operation.

_____ _____
Patient Signature Date

_____ _____
Patient Representative (if any) Date

Prepare in triplicate: copy to patient; copy to patient records; copy attached to physician billing form.

Figure 1: Sample Informed Consent Form for Hysterectomy.

3. The claim must include documentation stating the hysterectomy is not being performed for sterilization. Include a diagnosis code or an explanation in the *Remarks* area/*Additional Claim Information* field (Box 19) of the claim.

Hysterectomy Codes

Medical Services and Outpatient Services

CPT Code	Description
51597	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy
51925	Closure of vesicouterine fistula; with hysterectomy
58150	Total abdominal hysterectomy, (corpus and cervix); with or without removal of tube(s), with or without removal of ovary(s)
58152	Total abdominal hysterectomy with colpo-urethrocystopexy
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with lymph node sampling
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy
58260	Vaginal hysterectomy, for uterus 250 grams or less
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with repair of enterocele
58285	Vaginal hysterectomy, radical
58290	Vaginal hysterectomy, for uterus greater than 250 grams

Medical Services and Outpatient Services

CPT Code	Description
51597	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy
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58260	Vaginal hysterectomy, for uterus 250 grams or less
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with repair of enterocele
58285	Vaginal hysterectomy, radical
58290	Vaginal hysterectomy, for uterus greater than 250 grams

CPT Code	Description
58575	Laparoscopy, surgical total hysterectomy for resection of malignancy (tumor debulking) with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy
58953	Bilateral salpingo-oophorectomy with omentectomy; total abdominal hysterectomy and radical dissection for debulking
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy
59525	Subtotal or total hysterectomy after cesarean delivery

Inpatient Services

Hospitals submitting claims for rooms in connection with hysterectomy services must include at least one of the following ICD-10-PCS codes in the *Principal Diagnosis Code* field (Box 67) to support the revenue code being billed:

0UT20ZZ	0UT57ZZ	0UT7FZZ
0UT24ZZ	0UT58ZZ	0UT90ZL
0UT27ZZ	0UT5FZZ	0UT90ZZ
0UT28ZZ	0UT60ZZ	0UT94ZZ
0UT2FZZ	0UT64ZZ	0UT97ZZ
0UT40ZZ	0UT67ZZ	0UT98ZZ
0UT44ZZ	0UT68ZZ	0UT9FZZ
0UT47ZZ	0UT6FZZ	0UTC0ZZ
0UT48ZZ	0UT70ZZ	0UTC4ZZ
0UT4FZZ	0UT74ZZ	0UTC7ZZ
0UT50ZZ	0UT77ZZ	0UTC8ZZ
0UT54ZZ	0UT78ZZ	0UTCFZZ

Such inpatient claims must be submitted with a Hysterectomy – Informed Consent form

Provider Non-Compliance

Any claim that does not meet all eight criteria requires followed up with the provider.

- Non-compliant letter will be sent to the provider
- There will be 1 on 1 training with provider, including an attestation
- If necessary, Compliance Team may coordinate with Field Rep Team for help

Provider Education/Attestation

5504 East Whittier Boulevard
Los Angeles, CA 90022
Telephone: (323) 725-0167 – Facsimile: (323) 725-1471
Website: https://www.southatlanticmedicalgroupipa.com/

DHCS Sterilization Consent Form (PM330 and PM284) & Booklet Attestation Form

Due to South Atlantic Medical Group on or before XX/XX/XXXX

I, _____, attest to have received, read and reviewed the Physician or Delegated Physician Office Staff Member documents and education that was provided by South Atlantic Medical Group and understand and agree to the following:

- I will follow the DHCS Informed Consent Process and Requirements.
- **Correct Form**: The provider uses the correct PM 330 Consent Form
- **Consent to Sterilization**: Person to be sterilized was at least 21 years of age at the time the consent for sterilization is obtained, is not mentally incompetent, is able to understand the content and nature of the informed consent process, and is not institutionalized and has signed and dated the consent form
- **Interpreter's Statement**: An interpreter was provided if there is evidence that the patient did not understand the language and/or text of the informed consent process
- **Statement of Person obtaining Consent**: appropriate person completing consent section
- **Physician's Statement**: Physician completed section information as applicable and signed and dated the PM 330 consent form
- **Timeliness**: Sterilization was performed at least 30 days but not more than 180 days after the date upon which informed consent was obtained for the sterilization, except in cases involving emergency abdominal surgery or premature delivery in which specific requirements are documented to have been met
- **Materials**: Person to be sterilized will be provided with a copy of the consent form and the booklet on sterilization published by the Department of Health Services (in member's preferred language)
- Documentation exists in the member's medical record that a copy of the DHCS booklet on sterilization was provided.
- Upon request, I will provide any related evidence to support this process to the IPA, South Atlantic Medical Group, Health Plan or Regulatory Body within **2 business days** of request

Medical Records Guidelines

- Health Plans audit Medical Records for Appropriate Documentation

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment **RN/MD Review only**

Criteria	Documentation Reviewer Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list" page, or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented. Note: Chronic conditions are current long-term, on-going conditions with slow or little progress
C. Current continuous medications are listed.	Documentation may be on a separate "medication list" page, or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route, and start/stop dates. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present, when appropriate.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment. Informed Consents are signed for operative and invasive procedures. Human sterilization requires DHS Consent Form 330. Signed authorization is documented in the medical record for release of medical information. Note: Persons under the age of 18 years are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.
E. Advance Health Care Directive information is offered (Adults (18 years); Emancipated minors).	Adult medical records include documentation of whether member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).

Additional Guidance

- The claim must include documentation stating the hysterectomy **is not being performed for sterilization**. Look for a **diagnosis code or an explanation** in the Remarks area/Additional Claim Information field of the claim or on **the consent form**.
- The consent form is not required if an individual has **previously been sterilized** as the result of a prior surgery, menopause, prior tubal ligation, pituitary or ovarian dysfunction, pelvic inflammatory disease, endometriosis or congenital sterility. Provider must **state the cause of sterility** in the ***Remarks field/Additional Claim Information*** **field** of the claim form or **on an attachment**. This statement must be handwritten and signed by a physician.
- The consent form is not required in a **life-threatening emergency** in which the physician determines **prior acknowledgment was not possible**. In this case, **a handwritten statement**, signed by the physician certifying the nature of the emergency must accompany the claim. The certification of emergency must appear in the ***Remarks field Additional Claim Information*** **field** of the claim form or **on an attachment**.

Additional Resources

- DHCS Sterilization Booklets
- https://www.dhcs.ca.gov/Pages/permanentbirthcontrol.aspx
- DHCS Sterilization Guidelines
- https://files.medi-cal.ca.gov/pubsdoco/publications/Masters-MTP/Part2/ster.pdf
- PM330 Consent Form
- https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf
- DHCS Hysterectomy Guidelines
- https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/hyst.pdf
- DHCS Medical Record Guidelines
- https://www.dhcs.ca.gov/provgovpart/Documents/Medical%20Record%20Review%20Guidelines.pdf
- Title 22 California Code of Regulations (22 CCR § 51305.4)
- https://www.law.cornell.edu/regulations/california/22-CCR-Sec-51305-4
- DHCS State Agreement 04-36069, Exhibit A, Attachment 9, 9- A, 1, 2(h)(i) ; Medi-Cal Sterilization
- https://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf

Documentation Requests & Modifications

Requests & Modification Updates

- To request a Policy & Procedure related to the materials covered, including but not limited to the following:
  - Services (e.g., Provider Education, Panel Status Changes, etc.)
  - Policies (e.g., Prior Authorization, Pre-Natal Services, Member Satisfaction, etc.)
  - Procedures (e.g., DHCS Recommended Care Standards, Continuity of Care, Special Needs Plan (SNP), etc.)
- Please email: pkahen@samg.org