

L.A. Care Health Plan
 DMHC 1115 MEDICAID WAIVER SENIORS AND PERSONS
 WITH DISABILITIES ENROLLMENT SURVEY
 CORRECTIVE ACTION PLAN

Audit Period Review: June 1, 2011 through May 31, 2012

Survey Dates: July 10, 2012 – July 12, 2012

L.A. Care is required to complete the “Actions Taken To Correct Deficiencies and The Results.”		If a deficiency may be reasonably determined to require long term corrective action or are of a nature which may reasonably be expected to require a period longer than 30 days to remedy, then please complete the applicable cells below:		
Deficiencies Identified	Actions Taken To Correct Deficiencies and The Results	Evidence That Remedial Action(s) Are Being Taken	How The Action Will Achieve Compliance	Date When Full Compliance Will Be Achieved
GRIEVANCE & APPEALS Deficiency 1: The Plan does not consistently ensure adequate consideration of enrollee grievances. Section 1368(a)(1).	Action Taken: 1) The L.A.Care Appeals & Grievance (A & G) Department has initiated a process to outline each specific issue in a fax communication when seeking a response from the involved provider and delegated IPA 2) A&G Department has assigned a Lead Grievance RN/Compliance Nurse to perform the following: (a) review outbound grievance letters to ensure that each specific grievance issue is addressed (b) review the clinical and nonclinical files, when necessary (c) conduct staff trainings (d) prepare for internal and external audits, and (e) keep policies and procedures updated	1. Copy of fax outlining each request for response on specific issue (See Attachment 1A) 2. A new template resolution letter has been prepared with a numbering format that provides for resolution of multiple grievance issues in a single grievance transaction (See Attachment 1B) 3. A sign-up sheet will document attendance at trainings and weekly meetings for management review and compliance auditing.	The actions taken will ensure that all A&G coordinators and Nurse Specialists address each specific issue in a grievance and ensure adequate consideration of enrollee grievances by : 1) Improved format of template resolution letter prompts to include all enrollee grievance issues received 2) Train Appeals & Grievance Department staff through case examples to ensure appropriate attention to each expression of dissatisfaction ensures improved compliance.	July 1, 2013

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	3) A new monthly training program has been designed for A&G staff. A monthly meeting will reinforce the importance to identify each issue in a member complaint. The meeting will encompass case review and include the following: <ul style="list-style-type: none"> a. Select sample grievance cases for review. Selection of cases by A&G Coordinators and Specialists b. Discuss selected cases and SPD examples from the DMHC audit findings. c. Determine information to be obtained from PPG/Providers for review 		3) Review resolution letters prior to mailing to verify compliance.	

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	<ul style="list-style-type: none"> d. Importance of identifying and resolving each issue raised in the grievance filed 4) Grievance resolution notices have been designed in a numbered template format to ensure inclusion of all issues listed in a member grievance. See Attachment 1B. 5) Quarterly regulatory compliance refresher training for the entire staff of the A & G Department. More frequent training will occur if management observes an increase in error rates, individually or collectively. 			

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	6) Independent internal audit to assess compliance and report to Internal Compliance Committee. Results: The actions taken will result in resolution letters that ensure adequate consideration of enrollee grievances and compliance with all requirements.			

ATTACHMENT 1A

Fax



To: **Pages:** 2 (including coversheet)
Date: **From:** NAME, G&A Coordinator
Title/Dept: **Title/Dept:** L.A. Care Health Plan
Fax: **Fax:** 213-438-5772
Phone: **Phone:** 213-694-1250 x XXXX

CONFIDENTIAL PATIENT HEALTH INFORMATION (PHI)
 Thanks in advance for your assistance!

REQUEST FOR INFORMATION (GRIEVANCE)	
Member Name: Member DOB: Member ID#:	PCP: Incident Date: Grievance Case#: SSO & Access#
Reason for Grievance:	Member has filed a grievance alleging the following: 1. 2. 3. 4. 5.
Comments:	Please provide a response from the provider(s) involved regarding the above allegation(s) and all other pertinent information by DATE .
Assigned Nurse:	<input type="checkbox"/> Carmie Avila, RN (213) 694-1250 x4641 cavila@lacare.org <input type="checkbox"/> Elsa Gardner, RN (213) 694-1250 x4640 egardner@lacare.org <input type="checkbox"/> Carlo Braza, RN (213) 694-1250 x4159 cbraza@lacare.org <input type="checkbox"/> Twila Maxson, RN (213) 694-1250 x4726 tmaxson@lacare.org <input type="checkbox"/> Kyle Ann Carlson, RN (213) 694-1250 x4374 kcarlson@lacare.org <input type="checkbox"/> Ivona Malouf, RN (213) 694-1250 x4728 imalouf@lacare.org

NOTE: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the intended recipient, or the employee or agent responsible for delivering this communication to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender and delete any copies.

ATTACHMENT 1B



L.A. Care
HEALTH PLAN

"Medi-Cal_MemGri_Eng"

MEMBER GRIEVANCE

Date

(Parents of) Member Name
Member's Address
City, State, Zip

Member Name: Member's name
Member ID: Member's ID#
Reference Number: Reference number
Line of Business: **LOB**
Date of Service: **DOS**
Regarding: Type of service

Dear Member Name or Parents,

Thank you for bringing your concerns to our attention at L.A. Care Health Plan (L.A. Care).

Concern:

On DATE, you contacted L.A. Care to file a grievance regarding:

- 1.
- 2.
- 3.
- 4.
- 5.

Resolution:

To investigate this grievance, we asked for your medical records and a statement from XXXX and your medical group, XXXX. All of the information given to us by you, XXXX and XXXX was given to our Medical Director (doctor) to review. Below is our response to the specific issues you have brought to our attention:

- 1.
- 2.
- 3.
- 4.
- 5.

If you have any further questions, please call the L.A. Care Health Plan Member Service Department at 1-888-839-9909 for assistance.

Thank you for taking the time to express your concerns. We apologize for any inconvenience or hardship this situation may have caused you. We hope you find future services satisfactory.

In regards to your concerns, we will follow-up and take action as necessary. Because of federal and state confidentiality laws (California Evidence Code Section 1157; Health and Safety Act, Section 1370; and California Business and Professional Code, Section 805) and medical peer review requirements, we cannot share the details of the investigation or the outcome of any peer

ATTACHMENT 1B

review activities. We do track and monitor all quality of care concerns as part of our comprehensive Quality Improvement program; however, you will receive no further communication regarding this concern.

Please be aware that in addition to filing a grievance with L.A. Care Health Plan you have the right to file a grievance with the Department of Managed Health Care. The California Department of Managed Health Care is responsible for regulating health care service plans. The State Medi-Cal Managed Care 'Ombudsman Office' is available to answer questions and help you with this notice. You may call them at **1-888-452-8609**. You may also get help from your doctor.

You also have other appeal rights:

YOUR RIGHTS UNDER MEDI-CAL MANAGED CARE

You may:

- Ask for a "State Fair Hearing"
- Ask for an "Independent Medical Review (IMR)"

Forms are included to make these requests. You will not have to pay for either of these.

STATE HEARING

You may ask for a State Hearing in writing. **The form to file for a State Fair Hearing is also enclosed.** Fill out the enclosed form or send a letter to:

**California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430**

Alternatively, you may call **1-800-952-5253** to ask for a State Hearing. This number can be very busy so you may get a message to call back later. If you have trouble hearing or speaking, you can call **TDD 1-800-952-8349**.

If you want a State Hearing, you must ask for it within **90 days** from the date of **the initial denial, UNLESS you and your treating provider** want to **keep your treatment going** that this Notice of Action is stopping or reducing. **Then, you must ask for a State Hearing within 10 days from the date the initial denial letter was postmarked or personally delivered to you, or before the effective date of the action which you are disputing.** Please state that you want to keep getting your treatment during the hearing process.

If you use the enclosed form or write a letter to ask for a State Hearing, be sure to include your name, address, phone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address and phone number to the form or letter. If you need a free interpreter, tell us what language you speak.

ATTACHMENT 1B

After you ask for a hearing, it could take up to 90 days for your case to be decided and an answer sent to you. If you believe waiting that long will seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, ask your doctor or **L.A. Care Health Plan** for a letter. The letter must explain how waiting for up to 90 days for your case to be decided will seriously jeopardize your life or health or ability to attain, maintain or regain maximum function. Then ask for an **expedited hearing** and provide the letter with your request for hearing.

LEGAL HELP

You may speak for yourself at the State Hearing or have someone else speak for you, including a relative, friend or attorney. You must get the other person yourself. You may be able to get free legal help. Call the Health Consumer Center of Los Angeles at **1-800-896-3203**. You may also call the local Legal Aid Society in Los Angeles County at **1-800-399-4529**.

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-888-839-9909)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

This notice does not affect any other insurance coverage or services.

To request free interpreting services or for information in another language, large print, audio or Braille, call L.A. Care at 1-888-839-9909 or TTY 1-866-522-2731.

Sincerely,

Nurse Name
Nurse Reviewer
L.A. Care Health Plan

ATTACHMENT 1B

Enclosures: Form to File State Fair Hearing
IMR Application Form and Instructions

Cc: (Physician Reviewer) **Physician Reviewer Name**

ATTACHMENT 1B

FORM TO FILE A STATE HEARING

You can ask for a State Hearing by calling: 1-800-952-5253.

TDD users, call 1-800-952-8349.

Or you can fill out this form and FAX it to State Hearing Support at 916-229-4110.

Or you can mail this page to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on 'Your Rights.'

I do not agree with the decision about my health care. Here's why:

(If you need more space, use another piece of paper. Make a copy for your records.)

Check these boxes only if they apply to you:

- (1) I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to the hearing, and speak for me.

Name: _____

Address: _____

Phone Number: _____

- (2) I need a free interpreter. My language or dialect is: _____

- (3) I also want to file a grievance against the health plan. I understand the State will send my health plan a copy of this form.

- (4) My situation is **urgent**. I need a quick decision and cannot wait 90 days because:
(Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

- (5) *Please continue the service my Plan has stopped until my hearing.*

My Name: _____

My Social Security Number: _____

Address: _____

Phone Number: _____

My signature: _____ Today's Date: _____

(After you complete this form, make a copy for your records.)

ATTACHMENT 1B

State of California
Business, Transportation and Housing Agency
Department of Managed Health Care
INDEPENDENT MEDICAL REVIEW APPLICATION-English
DMHC20-086 New: 01/02 Rev: 04/06

HMO Help Center

State of California
Department of Managed Health Care



INDEPENDENT MEDICAL REVIEW APPLICATION

If you want to give another person the authority to assist you with your IMR, you must also complete the Authorized Assistant Form.

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Day Phone # _____ Evening Phone # _____

Health Plan Name _____

Patient's Health Plan Membership Number _____

Patient's Date of Birth (mm/dd/yy) _____

Do you have Medi-Cal? Yes No

Do you have Medicare or Medicare Advantage? Yes No

Have you filed a complaint or grievance with your health plan? Yes No

Are you seeking payment for a service that you have already received? Yes No

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents if needed.)

1 What is your health condition or doctor's diagnosis? _____

2 What medical treatment or service are you requesting? _____

3 How would you like this case to be decided? _____

4 Do you have a condition that is a serious threat to your health? Yes No

If "yes," please explain. _____

5 Did your health plan say that the treatment you want is (check one):

Not medically necessary Experimental or investigational Other _____

6 List the name and phone number of your primary care doctor and other doctors who have seen, treated or advised you for your condition. Are they in your health plan's network? (Use a separate sheet if needed.)

7 I am asking for an Independent Medical Review (IMR) to make a decision about my problem with my health plan. I allow my providers, past and present, and my health plan to release my medical records and information for this IMR. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department of Managed Health Care (DMHC) and IMR staff to review these records and information. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Signature _____ Date _____

Mail or fax this form and any attachments to: HMO Help Center, Department of Managed Health Care, IMR Unit,
960 9th St., Suite 500, Sacramento, CA 95814; FAX: 1-916-255-5241

ATTACHMENT 1B

IMR Application Instructions

If your health plan denies your request for medical services or treatment, you can file a complaint (grievance) with your plan. If you disagree with your plan's decision, you can ask the HMO Help Center at the Department of Managed Health Care for an Independent Medical Review (IMR). An IMR is a review of your case by doctors who are not part of your health plan. If the IMR is decided in your favor, your plan must give you the service or treatment you requested. You pay no costs for an IMR.

You Can Apply for an IMR if Your Health Plan:

- Denies, changes, or delays a service or treatment because the plan determines it is not medically necessary.
- Will not cover an experimental or investigational treatment for a serious medical condition.
- Will not pay for emergency or urgent medical services that you have already received.

Before You Apply

In most cases, you must complete your health plan's complaint process before you apply for an IMR. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/ investigational, you do not have to take part in your plan's complaint process before you apply for an IMR.

You must apply for an IMR within six months after your health plan sends you a written response to your grievance. We may accept your application after six months, if we determine that circumstances prevented timely submission.

Please be aware that if you decide not to participate in the IMR process, you may be giving up your statutory rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to Apply

Fill out the IMR Application Form. Fill out the Authorized Assistant form if someone is helping you with your IMR. If you have medical records from *non-contracting providers* regarding your health care issue, please include them with your application. Your health plan will be required to obtain medical records from contracting providers.

Attach copies of letters or other documents about the treatment or service that your health plan denied. This can speed up the IMR process. Send copies of documents, not originals. The HMO Help Center cannot return documents.

If you have questions about filling out your application form, call the HMO Help Center at 1-888-HMO-2219 or TDD 1-877-688-9891. There is no charge for this call.

Mail or fax your form and any attachments to:

**HMO Help Center
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725**

FAX: (916) 255-5241

What Happens if You Qualify for an IMR?

The HMO Help Center will review your application and send you a letter within 7 days telling you that you qualify for an IMR. When all your information is received, including relevant medical records, the IMR decision will be made within 30 days, or within 3 to 7 days if your case is urgent. You will be notified of the decision made by the doctors who have reviewed your case. If the IMR is decided in your favor, your plan must give you the service or treatment you requested.

What Happens if You Do Not Qualify for an IMR?

Your issue will be reviewed through the Department's standard complaint process. You will receive a written notice of our decision within 30 days.

This Notice Is Required by Law

- California's Knox-Keene Act gives the Department of Managed Health Care (DMHC) the authority to regulate health plans and investigate the complaints of health plan members.
- The DMHC's HMO Help Center uses your personal information to investigate your problem with your health plan and to provide an Independent Medical Review if you qualify for one.
- You give us this information voluntarily. You do not have to give us this information.
- However, if you do not give us the information, we may not be able to investigate your complaint or provide an Independent Medical Review.
- We may share your personal information, as needed, with the health plan and the doctors who are doing the Independent Medical Review.
- We may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (916) 322-6727.
- The law that requires this notice is the Information Practices Act of 1977 (California Civil Code Section 1798.71)

ATTACHMENT 1B

State of California
Business, Transportation and Housing Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM-English
DMHC 20-160 New: 04/06

HMO Help Center

State of California
Department of Managed Health Care



AUTHORIZED ASSISTANT FORM

- If you want to give someone the authority to assist you in your Independent Medical Review (IMR) or complaint, fill in Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form and you have legal authority to act for this patient, please complete Part B only. Also send a copy of the power of attorney for health care decisions or other legal document that says you can make decisions for the patient.

PART A: PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (DMHC). I allow the DMHC and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Signature _____ Date _____

PART B: PERSON ASSISTING PATIENT

Name of Person Assisting (print) _____

Signature of Person Assisting _____

Address _____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

- My power of attorney for health care decisions or other legal document is attached.