AltaMed

WORK BOLDLY. LIVE BRILLIANTLY.

November 2021 Edition

A Note from Dr. Ursula Baffigo

Thinking back this year, fortitude is the word that comes to mind. We started the year at the height of the pandemic. We modified our offices and schedules to provide a safe environment to our staff and patients. We changed the way we communicated and took care of our patients through phone calls and telemedicine visits. Our hospitalists and hospital partners devoted every possible resource to keeping our sickest patients alive. And everyone in health care felt the unease of the unknown.

Fortitude is the ability to withstand and adjust to challenges. It comes from having experienced prior challenges and uncertainties and knowing that one will find a way to move beyond one's current situation and come out on the other side, not fully unscathed, but learned and grateful to have endured.

Although the pandemic is not over, we have learned to manage it by taking the upper hand with vaccinations, treatments, and safety measures. We are venturing and creating new routines that incorporate the past and the present state. And we move forward with gratitude for all that you, our provider network, has done for our AltaMed patients. We salute you!

Sincerely,
Ursula Baffigo M.D., MPH, Medical Director, Medical Management

Network Management Updates

Senate Bill 137 - Provider Directory Accuracy

In an effort to remain compliant with California Senate Bill 137 (SB 137), we are to provide current and accurate provider demographic information to patients via their respective health plan directories. Our bi-annual provider data validations were scheduled to be mailed out by November 5 to your primary office. Please remain alert for the notice as your completion of the document, even if there are no changes, is both required and appreciated. If you did not receive the form, and/or have any questions or concerns, please feel free to email us directly at **directoryvalidation@alturamso.com**.

Provider Network Changes

Kindly use your best efforts in notifying AltaMed of all demographic changes at least 90 days in advance of their effective date in order to remain compliant with all health plan regulatory standards. All updates may be routed via your assigned Provider Network Administrator (PNA) and/or sent over to the shared **Contracting** mailbox where your request will be reviewed and completed respectively. Please refrain from making any changes without communicating them over to AltaMed with ample lead time.

PACE Quality Improvement

AltaMed PACE Quality Improvement (QI) department continuously measures, assesses, and improves outcomes of care, services, and processes by ongoing monitoring of services rendered to our PACE participants. PACE QI, in collaboration with our PACE Quality Improvement committee, has established priorities for the improvement or resolution of known or potential issues that directly or indirectly affect care and services. The department and committee monitor and evaluate the quality of care provided by staff and contracted providers through grievances and participant satisfaction.

Grievances and complaints are received by the PACE QI team and are reviewed for opportunities for improvement. Dedicated PACE social workers, in collaboration with AltaMed Member Services, work diligently with the participant and the specialist to ensure a prompt and satisfied resolution. PACE QI monitors this internal process and is involved every step of the way. If needed, PACE QI reaches out directly to the specialist to ensure prompt resolutions. PACE leadership also hosts routine joint operational meetings with contracted specialists to discuss grievances and other quality care related topics. All grievances are reported to CMS.

AltaMed PACE QI performs an annual evaluation of our PACE Quality Improvement Plan. The revision of our QI Plan involves a variety of internal processes, audits, data on grievances and appeals, and Quality Outcome Measures. For more information on AltaMed PACE QI, contact **Victoria Donato-Hernandez**, PACE Quality Improvement Manager, at (323) 558-7628.

Medicare Health Assessment Incentive Program

The Medicare Health Assessment Incentive Plan applies to Medicare Advantage and Cal-MediConnect members enrolled with AltaMed Health Services Corp. Non-AltaMed or Medicare Fee for Service (FFS) members do not qualify as for the 2021 Medicare Health Assessment Incentive. Providers completing Medicare Health Assessments for the patients noted above (must be eligible with AltaMed when MHA is completed) will be eligible for an incentive (amount TBD and will be communicated separately).

For an MHA to be eligible for this incentive:

- Providers must utilize the standard Medicare Health Assessment (MHA) template provided by AltaMed or a pre-approved EHR template.
    - The purpose of the standard MHA is to have a universal template that will be accepted by all health plans and pass all RAD V audits at the end of the year.
- Member must be eligible with AltaMed IPA when the MHA is provided.
- The MHA is filled out completely with no missing sections and have proper documentation to support diagnosis submitted.
- All Hierarchical Condition Categories (HCC) and Suspect review conditions listed in Cozeva must be captured/reviewed in the MHA visit.
- The MHA is submitted via the Cozeva application. **No fax or email submissions are accepted.**
- A claim / encounter is submitted for the MHA visit.

For questions, inquiries, or feedback, contact **RAP@alturamso.com.** We will respond within 72 hours.

Medical Records

As a contracted specialist, please be aware that you must submit to AltaMed the results of the consultation examination and recommendations for each member seen. These results shall be submitted in a legible format within three days from the date of service. To better assist you, refer to the step-by step **User Guide** on how to upload specialty note visit to Connect.

Please note AltaMed's contracted providers can also request limited access to our EHR system. AltaMed Health Information Management will need to receive the Business Associate Agreement (BAA) that accompanied your contract with AltaMed. Email the completed BAA to **shjones@altamed.org**. Click **here** for additional information.

Our of network providers can request medical records from HIM by either sending a request by phone to (888) 499-9303; email to **recordrequest@altamed.org**; fax to (323) 201-3212; or mail to AltaMed Health Services, 2035 Camfield Avenue, Commerce CA 90040, Attention: HIM Department.

Capitation and Eligibility Reports

As a Practice or Portal Administrator, you can now obtain access to and manage Capitation and Eligibility Reports. Click **here** to learn more.

Timely Access to Care

The law requires health plans licensed by the DMHC to make providers available within specific geographic and time-elapsed standards. Health plans must ensure their network of providers, including doctors, can provide enrollees with an appointment within a specific number of days or hours.

Links have been provided for you to see the DMHC standards:

- **Appointment Availability**
- **After-hours and Appointment Availability**

Plans shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

Current Capitated Agreements for Durable Medical Equipment (DME), Gastroenterology, Hematology, and Oncology Services

AltaMed is currently entered into capitated arrangements for Durable Medical Equipment (DME), Gastroenterology, Hematology, and Oncology services. All new and renewal authorizations should be sent to AltaMed's capitated providers. If you have a patient receiving medical care or DME supplies from another provider, contact AltaMed's Utilization Management department to assist with the transfer of care.

Click **here** for capitated provider information.

Access to OB/GYN Services at AltaMed Staff Model Clinics

At AltaMed, we are committed to improving and expanding access to OB/GYN and women's health services in the communities we serve. We are also committed to ensuring that access is simple for patients needing family planning and OB/GYN services. Prior authorizations and referrals from Primary Care Physicians are not required to schedule patients for OB/GYN services. Patients have direct access

to family planning and OB/GYN services at AltaMed.

Patients should be instructed to call the Patient Service Center at (888) 499-9303 to schedule an appointment at the AltaMed clinic of their choosing. Also instruct patients to bring a copy of their photo ID, insurance card, and printed copies and/or CDs with images of related medical records to their first visit.

AltaMed Transitions of Care Program

In April, AltaMed Health Services rolled out its first Transitions of Care (TOC) program to help members safely discharge from an acute hospital stay back to their homes. This team is made up of one Nurse Practitioner, two LVN case managers, and a care coordinator. They engage with members by video and telephone visits. The TOC team will assist patients with scheduling PCP/specialist appointments, review their discharge instructions, perform medication reconciliations, and addresses any gaps related to social determinants of health. Summaries of both the hospital stay and TOC encounters are also provided to the PCPs prior to their next scheduled appointments. The aim of the program is to reduce any unnecessary hospital re-admissions and improve member satisfaction.

The current scope of the TOC program includes adult admissions for the LA Care Medi-Cal and Promise Medi-Cal health plans. Anticipated phase two expansion plans will include both OB and pediatric patients, additional health plans, and a remote patient monitoring program.

For questions regarding the TOC program, contact **Thomas Kim, MD**, Medical Director of Hospitalist Services and Post-Acute Care, or **Christopher Bui, MD**, Medical Director for Senior and Complex Care.

Contracting

AltaMed Extends Contract with SCAN to Include Orange County

AltaMed finalized an agreement with SCAN Health Plan (Medicare) to extend our contract to include Orange County, effective August 1, 2021. This has been a few years in the making on extending our relationship with SCAN from Los Angeles to Orange County.

We have built a membership base with SCAN Health Plan in Orange County from scratch, so there will be no membership assignment out the gate. Also, the August 1, 2021 effective date allowed AltaMed to be listed in SCAN's directory and marketing tools, in preparation for the Medicare Annual Enrollment period in October. The larger membership assignment in Orange County will occur on January 1, 2022.

- KPC Health Global Medical Centers will be the members assigned hospital network in OC.
- KPC Hospital System (Orange County)
- Click **here** for a list of participating hospitals.

AltaMed Contracts with Alignment Health Plan

AltaMed has also finalized an agreement with Alignment Health Plan (Medicare only), effective October 1, 2021. This is a newly contracted health plan with AltaMed that will cover Los Angeles and Orange County. It is a shared risk set-up: AltaMed is responsible for Professional Services and Alignment Health Plan is responsible for Institutional Services.

Utilization Management

Utilization Management Updates

The Utilization Management (UM) department implements the UM program, policies, and processes for effectively handling requests for authorization of services to include:

- Pre-service review
- Concurrent inpatient review
- Retrospective review

The UM Department performs an annual program evaluation. In order to do so, it performs a variety of internal processes and audits including but not limited to:

- Monitoring over/under utilization of medical services
- Evaluating all medical necessity reviews to ensure that decisions are made through consistent adherence to the evidence-based guidelines
- Collaborating with other AltaMed departments to meet provider network adequacy
- Identifying appeals and grievances, then directing them to the health plans for resolution

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Continuity of Care

Newly enrolled members transitioning into AltaMed and existing members undergoing care with a terminated provider have the right to request continuity of care in accordance with California Law and Managed Care Plan (MCP) contracts, with some exceptions. This allows members to complete treatment of an acute episode or care already in process, without interruption until the care can be transitioned to the AltaMed provider network.

However, continuity of care protections does not extend to the following services: durable medical equipment, transportation, other ancillary services, and carve-out service providers.

UM Department Staff Availability

- UM staff are available to members and providers Monday through Friday between 8:00 a.m. and 5:00 p.m.
- The toll-free number is (855) 848-5252. Providers should identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.
- The TDD/TTY service number is (800) 735-2922 and is available to members who have hearing or speech impairment.
- Language assistance is available to members to discuss UM issues.

Treatment Authorization Process (TAR) Process

AltaMed accepts TAR submissions via the online portal, phone, fax, and mail. Phone requests must be followed by a written request. To avoid delays in the decision-making process, providers should submit TAR request with relevant clinical information (e.g., the reason for services requested, significant findings, procedures performed, and care, treatment, and services previously provided for the member's condition). When a TAR does not have the supporting clinical information, it may lead to an adverse determination or a delay in TAR processing. All decisions are made within the required timelines, based on the member’s clinical information using evidence-based criteria, and UM matrix.

Turnaround Times

Turnaround times are established as follows per regulatory requirements:

Authorization Request Type				
Line of Business	**Urgent / Expedited**	**Routine / Standard**	**Retrospective**	**Urgent Concurrent**
Medi-Cal	72 hours	5 business days	30 calendar days	24 hours
Medicare	72 Hours	14 calendar days	30 calendar days	24 hours
Cal MediConnect	72 Hours	5 business days	30 calendar days	24 hours
Commercial	72 Hours	5 business days	30 calendar days	24 hours
Pharmacy infusion/injectables	24 hours	72 hours	72 hours	24 hours or less

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Urgent Referral Requests

Referral requests are processed based on the member's condition, which may be classified as urgent or routine. To prevent delays in processing authorization requests for members who need urgent care, providers should classify the referral to coincide with the member's health care needs.

"Urgent care" means health care for a condition that requires prompt attention, consistent with subsection (h)(2) of HSC § 1367.01. This occurs when:

- When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function.
- The normal time frame for the decision making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function.
- Decisions to approve, modify, or deny urgent requests by providers prior to or concurrent with the provision of health care services to enrollees, must be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

How Decisions Are Made

AltaMed renders coverage determinations based on benefit coverage, medical necessity, and medical appropriateness. AltaMed adopts clinical criteria and guidelines to make determinations of treatment requests. The UM department involves actively practicing health care providers, including Behavioral Health practitioners, in the decision-making process. Clinical criteria used to make utilization decisions and the procedure for appropriately applying these criteria, are reviewed annually, and updated when appropriate. Only licensed physicians or licensed health care professionals—with expertise in their respective fields—involved in administering the health care services requested by the provider, may deny or modify requests for authorization of health care services for members for reasons of medical necessity.

Criteria/Guidelines Are Available

AltaMed makes utilization decisions based on clinical evidence using written clinical criteria or guidelines. The process for applying objective clinical guidelines is based on members' individual needs. It is used when determining the medical appropriateness of requested health care services. Providers and members have the right to request a copy of the guidelines that AltaMed use to make service or treatment request determinations. Specific guidelines are also available to the public, upon request, with the following disclosure: "The material provided to you are guidelines used by this plan to authorize, modify,

deny care for the person with similar illnesses or conditions. Care and treatment may vary depending on individual need and the benefits covered under your contract." Please contact the UM department at (855) 848-5252 to obtain a copy of a specific guideline.

Peer-to-Peer Requests

AltaMed UM representatives can help coordinate any peer-to-peer requests for services that have been denied. The UM representative will connect the provider with the reviewing Medical Director or schedule a date and time for a peer-to-peer discussion. To initiate a peer-to-peer request, please contact the UM department at (323) 597-2928. The following services, which **do not** require prior authorization, will be approved and covered for claim settlement:

- Preventive Health Services, including immunizations
- Annual Well-Women Care
- Laboratory Services when referred by member's contracted PCP
- Emergency Related Services
- 911 Ambulance/Paramedic Services
- Out-of-Network Renal Dialysis Services for up to 3 months or until coordination is provided for in-network
- Sexually Transmitted Disease (STD) services for both within and outside provider network
- Family Planning Services provided to members of childbearing age in order to delay or prevent pregnancy through any family planning providers
- Emergency Services (i.e. medical screening and stabilization) including emergency behavioral health care
- Crisis stabilization, including behavioral health
- Urgent Care Services
- Communicable Disease Services
- Sensitive Services for Minors
- Basic Prenatal Care, including OB/GYN in-network referrals and consults
- Sensitive and Confidential Services and Treatment (including, but not limited to, services relating to sexual assault, pregnancy and pregnancy related services, family planning, abortion/pregnancy termination, sexually transmitted disease, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment)

AltaMed Ensures Appropriate Utilization

AltaMed clinical staff ensures appropriate utilization of medical services by basing decisions on evidence-based guidelines/criteria and the existing benefit coverage. Additionally, AltaMed does not specifically reward practitioners, providers, or other individuals for issuing denials of coverage or service. No financial incentives exist for UM decision makers to encourage decisions that result in low utilization.

24/7 Nurse Line

AltaMed uses its Plan partner nurse lines to perform 24/7 assistance to its members. This service provides 24/7 access to registered nurses who can assist members with making informed decisions on their health care needs.

Nurses assist members in the following:

- Offering recommendations on self-care for minor injuries or illnesses
- Determining the appropriate level of care for the member's condition at the time of the call
- Answering questions about the member's health condition, treatment options or medications

Members can reach the Nurse Advice Line by calling the following telephone numbers:

Health Plan	Phone Number
Aetna	(800) 556-1555
Anthem Blue Cross	
Commercial	(800) 700-0196
Exchange	(800) 249-3617
Medi-Cal	(800) 224-0336 TTY: (800) 368-4424
Medicare	(855) 658-9249
Blue Shield	(877) 304-0504 (888) 687-7321 (24-hr Nurse Advice Line)
Promise Health Plan	(800) 609-4166
Brand New Day	(800) 835-2362 (24-hr Doctor Advice Line)
CalOptima	(844) 447-8441
Central Health Plan	AltaMed Providers Nurse Advice Line
WellCare	(800) 581-9952
Health Net	(800) 440-5724
LA Care Health Plan	(800) 249-3619
Molina Health Care	(888) 275-8750
SCAN Health Plan	AltaMed Providers Nurse Advice Line
United Health Care	(877) 365-7949

When to Request a Second Opinion

AltaMed will approve referrals for a second opinion when requested by a member or a provider, who is treating a member, for the following reasons:

- Uncertain of the reasonableness or necessity of recommended surgical or medical procedures
- Uncertain or hesitant about a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment (including, but not limited to, a serious chronic condition)
- Requests further professional guidance or description on the clinical indications that may be too complex and confusing
- Receives conflicting test results
- Provider is unable to diagnose the member's condition
- If the current treatment plan is not improving member's medical condition within an appropriate period of time of receiving the diagnosis
- Any other reasonable circumstance or necessity

Screening, Brief Intervention, and Referral to Treatment Services

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is early intervention for individuals with non-dependent substance use to help before they need more extensive or specialized treatment. This approach differs from specialized treatment for those with more severe substance misuse or a SUD. A SBIRT assessment is completed during a member's visit with his or her Primary Care Physician (PCP). The PCP may utilize the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) Manual or the Drug Abuse Screening Test (DAST). For more information on SBIRT, please visit the Substance Abuse and Mental Health Services Administration website, hosted by DHS, by clicking **here**.

UM Resources and Communications

A new link has been added to the CONNECT Portal launch page that provides direct access to pertinent UM resources, including:

- UM Tar Form
- Listing of approved UM criteria
- Prescription Drug Form
- Medical Record Request information

To access the link, go to the **CONNECT Portal** and select UM Resources and Communication.

Initial Health Assessment

Initial Health Assessment

An Initial Health Assessment (IHA) is a comprehensive assessment completed during a member's visit with his or her Primary Care Physician (PCP). AltaMed Health Services (AHS) has undergone several Health Plan audits on the completion of an IHA.

IHA components include:

- Age appropriate comprehensive history, physical and mental status, developmental exam, and immunizations
- Individual Health Education Behavioral Assessment (IHEBA) using the Staying Healthy
- Assessment (SHA)
- Evaluation for Health Education and appropriate referrals for care coordination to include community resources

All Medi-Cal members should receive timely access to an IHA within 120 days of enrollment, regardless of age. For Medicare Advantage, providers must make a "best-effort" attempt to conduct an initial assessment of each member's health care needs. Providers must follow up on unsuccessful attempts to contact the member, within **90 days** of the effective date of enrollment. A total of three attempts must be made to reach the member, with at least one phone call and one mail notification. Additionally, if a member refuses an IHA, the refusal must be documented in the medical record.

IHA Exclusions:

- Existing members who have been your patient, for which documentation exists showing an IHA completed within the past 12 months.
- Members who refuse the IHA. Refusal must be noted within the medical record.
- Members who missed an appointment, where the provider documented two additional attempts to reschedule.

Based on the Health Plan audit results, a number of deficiencies were identified. In an effort to improve future outcomes AHS Medical Management team will perform the following:

- PCPs with a newly enrolled member list who require an IHA on a monthly basis.
- Perform random audits to ensure IHA completion Partner with Provider Network Operations to facilitate training, as needed.
- Provide PCPs with a Medicare and Medi-Cal IHA tool listing the required components of the IHA.

- **Medicare Exhibit A**
- **Medi-Cal Exhibit B**

Compliance Corner

Compliance Attestation Launched on October 4

AltaMed ensures that our vendors and contractors comply with applicable laws and regulations. Annually, we request an attestation regarding adherence to specific Compliance and Fraud as well as Waste and Abuse requirements. This year's attestation will be in the form of a survey or fax. Upon receipt, please complete the attestation in order to maintain compliance.

Should you have any questions, please contact Eddie Howard, Director of Compliance and Ethics, via email at **OCRMAudits@AltaMed.org**.

Cultural and Linguistic Competency

Regulatory Agency Requirements

Patients who are English learners experience more delays in care compared to English speakers. Language concordance opens the door to understanding the multiple needs of our patients. Communicating in the patients' preferred language and using qualified/certified interpretation services are key strategies as we strive for equity in healthcare. Below are several gaps that we can narrow with language concordance:

1. Becoming the patient's **usual source of care**: instead of going to care for emergencies, patients can be empowered to enjoy preventative services by coming to us for care;

2. Practice **cultural humility** in the encounter by asking and learning from the patient: understanding the context of our patients, removes assumptions about his/her cultural and linguistic needs;

3. Enhance **health literacy**: when patients understand, they are empowered to make decisions about their care and can voice their experience.

Resources and Tips

- Prepare for the patients that need interpretation services.
- The member's health plan can be contacted for interpretation services.
- Visit your **Provider Portal** for additional resources.

For information, contact **Evelyn González-Figueroa**, Director of Cultural and Linguistic Competency.

AltaMed