TMIPA
Provider Training
2025

Welcome to Provider Training.

The training is intended to provide you with an overview compliance requirements and resources related to the successful management of your TMIPA members. If you would like more information, please reference the IPA-Specific Provider Manuals by visiting https://www.torrancememorialipa.org/ipa/for-providers/. For assistance, please contact the Provider Relations Department at 310-257-7265.

Topics Covered in this Training

- Clinical Protocols & Evidence-Based Guidelines
- Continuity of Care (COC) and Transition of Care (TOC)
- Model of Care (COC)
- Advanced Directives & Physician Orders for Life-Sustaining Treatment (POLST)
- Member Satisfaction Policy & Procedure
- Cultural & Linguistic Sensitivity – Including HIPAA Privacy, Breach Notification and Compliance
- Fraud, Waste & Abuse
- General Compliance
- OIG/SAM/Medi-Cal Exclusions
- Critical Incidents
- Documentation Requests & Modifications
- Health Equity (new)
- Appointment Access & Availability Standards (updates)

Clinical Practice Protocols – All Lines of Business

Clinical Guidelines & Practice Protocols for Non-Contracted Providers

- All clinical practice protocols are available upon request

- Non-Contracted and Out-of-Network Providers who do not receive TMIPA Network Provider training may request Health-Plan specific evidence-based clinical guidelines and TMIPA clinical protocols by clicking on the following link: https://www.torrancememorialipa.org/ipa/contact-us/.

Continuity of Care (COC) & Transition of Care (TOC)

Introduction: Continuity of Care (COC)

Purpose

To provide an inform and provide an overview of TMIPA's Continuity of Care (COC) policy and procedures, which:

- Ensure that TMIPA members receive timely and appropriate continued care when
    1) There is a change in relationship between TMIPA and the member's TMIPA provider
    2) The member is newly enrolled with TMIPA and has been in active treatment with Out-of-Network (non-TMIPA provider(s)
    3) When established members are transitioning from pediatric care to adult care providers.

Policy Statement: Continuity of Care

Torrance Memorial IPA ensures members receiving ongoing care from a provider, medical, behavioral health, and/or long-term services and support will continue with that same provider through the course of treatment, until the member no longer needs the care and services of the provider or, when there is a natural break in the treatment plan, at which time care can be transitioned to an alternative provider.

Continuity of Care: Terminating TMIPA Provider

When there is a change in relationship between TMIPA and the member's TMIPA provider:

1. Contracted providers must notify TMIPA in writing at least 90 days in advance of their intended date of termination. This is a regulatory requirement which enables TMIPA and/or the health plan to notify impacted members of the termination and allows TMIPA to arrange for transfer of the member's care to other provider(s).
2. When the member is in the midst of an active course of treatment, or in post-partum care, the member may be eligible to continue to receive care from the provider after termination, when certain conditions are met. TMIPA then works with the terminating provider to develop a reasonable transition plan for each continuing member at the time of the provider's termination.

Continuity of Care: Terminating TMIPA Provider

When there is a change in relationship between TMIPA and the member's TMIPA provider (continued):

3. An active course of treatment is defined as: prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may be, but is not, required to be part of a treatment plan. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

4. Postpartum period: begins immediately after childbirth and extends for approximately six weeks.

Continuity of Care: Terminating TMIPA Provider

5. In order for the member to access continued care with the terminating provider, the provider must agree to:
   a) Continue treatment for an appropriate period of time (based on transition plan goals).
   b) Share information about the treatment plan with TMIPA.
   c) Continue to follow the organization's UM policies and procedures.
   d) Terminating provider agrees to payment rates and charge the member only the copayment as applicable to the member's benefit plan.

Continuity of Care: Newly Enrolled Members

Medicare Advantage and Dual Eligible Members:

1. New to TMIPA Medicare Advantage and new Dual Enrollees are provided a minimum 90-day transition period for an active course(s) of treatment, even if the service is furnished by an out-of-network provider. This applies to members previously enrolled with another Medicare Advantage Plan, Original Medicare or newly enrolled to Medicare Advantage.

2. These members are therefore granted 90-day transition of care period where authorizations that started prior TMIPA enrollment are honored for the first 90 days; this may include both in and out of network services.

3. Duration of Authorization: Authorization decisions are valid for the full course of treatment or service and based on coverage guidelines and member medical needs.

Continuity of Care: Newly Enrolled Members

Medicare Advantage and Dual Eligible Members:

4. TMIPA does not disrupt or require reauthorization for an active course of treatment for impacted new plan enrollees for a period of at least 90 days.
5. This provision applies only to active course of treatment, where enrollee started the course of treatment before enrollment with TMIPA.

Continuity of Care 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. Medicare continuity of care requirements to dual eligible special needs plans (D-SNPs) in California, beginning January 1, 2023. These requirements are in addition to any existing federal Medicare Advantage (MA) requirements. These requirements are in accordance with Assembly Bill 133 (Chapter 143, Statutes of 2021), the Health Omnibus Budget Trailer Bill, Welfare and Institutions Code Section 14184.208:

2025 NCQA Network Standards

- NETWORK MANAGEMENT 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.
- NETWORK MANAGEMENT4 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. *All practitioners must notify TMIPA 90 days* prior to the planned effective termination date.
- NETWORK MANAGEMENT4 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.

2025 NCQA Network Management Standards 4B Explanation

- All practitioner specialties are included in previous slide NET 4 Element B (1)
  - **Physicians must notify** TMIPA to ensure the 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**.
  - An 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.

2025 NCQA Network Management Standards 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.).

Transition of Care Definition

- Transition of Care (TOC) applies to members who require assistance when their benefits end/exhaust, per the 2025 NCQA standards below:

QI 3 Element E 2025 The organization helps with members' transition to other care when their benefit ends, if necessary.	**Explanation: Exhausted benefits** If the organization's covered benefits are exhausted while a member continues to need care, the organization must notify the member about alternatives for continuing care and how to obtain care, as appropriate. NCQA does not expect the organization to develop alternative resources, only to notify members of available 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 4 Delegation of QI (of QI 3D above) If the organization delegates NCQA-required QI activities, there is evidence of oversight of the delegated activities.	**QI 4, 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.	

Transition of Care Requirements

- TMIPA is required only to *notify* members about healthcare alternatives, resources for continued access to care and how to obtain them. TMIPA assist the member to transition to a resource that will meet their needs, as possible.
- TMIPA 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

Model of Care (MOC) Training for Contracted Network Providers

42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual

Content

- Overall Goals of Model of Care
- Model of Care (MOC) and SNP/MMP Population
- Target Population
- 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 an 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 providers serve and include 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

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. Dementia Care Aware Warmline is available to Health Care Professionals, offering Education and decision-making consultation 1-800-933-1789
- **End-of-life** – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

Target Population

A special needs individual could be any one of the following:

- I-SNP-An institutionalized individual
  - defined as those who reside or are expected to reside for 90 days or longer in a long-term care facility (defined as either: skilled nursing facility (SNF)/NF, ICF or inpatient psychiatric facility), or those living in the community but requiring an equivalent level of care to those residing in a long-term care facility.
- D-SNP-A dual eligible
  - defined as individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of MediCal/Medicaid benefit.
- C-SNP-An individual with a severe or disabling chronic condition, as specified by CMS.
  - defined as individuals who have acquired one or more disabling chronic conditions, including, but not limited to: cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD and HIV/AIDs.

Fully integrated dual eligible (FIDE) D-SNP

- Provide Medicare and Medicaid benefits*
- Include LTSS benefits (eligibility rules apply) *
- One identification card used to access both Medicare and Medicaid services*
- Integrated materials and processes*
- States may carve out Medicaid Behavioral Health benefits from the contract
- If unaligned coordination between Medicare and Medicaid plans or other agencies required

*Applicable only in an aligned FIDE

Coordinate Medicare/Medicaid (D-SNP)

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

- Patients informed of benefits offered by both programs
- Patients assisted to maintain Medicaid eligibility
- Patient access to staff that have 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 or other means of communication and providing education.
- **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:

1. Individualized service planning and delivery
2. Participation of the person and, as appropriate, family members and others chosen by the person in service planning and delivery
3. Consideration of the person's values, culture, traditions, experiences and preferences in the definition of quality
4. Recognition and support of a person's self-care capabilities
5. Integration of formal and informal supports

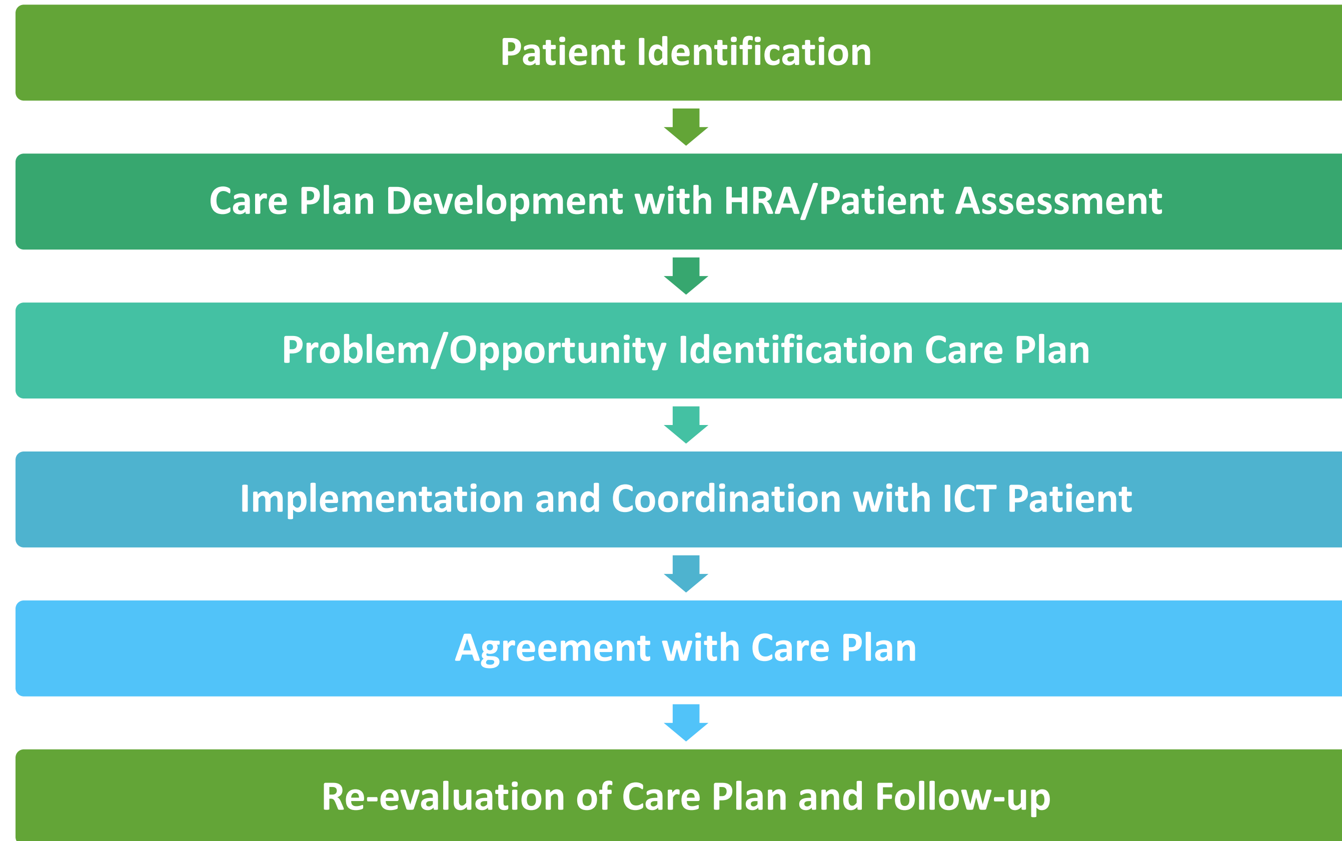
Care Coordination Processes

- 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 can 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

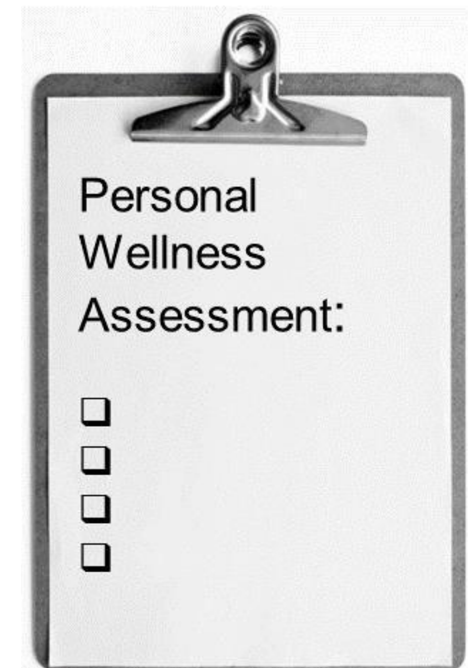
ICP → Individualized Care Plan

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?

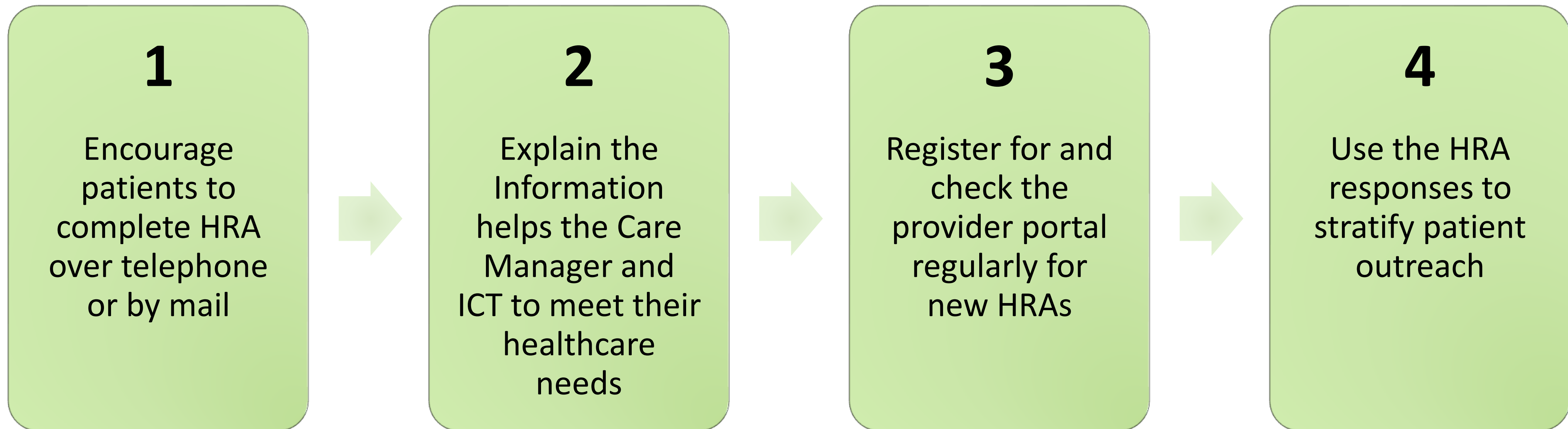
THE HRA IS A MEDICARE REQUIREMENT FOR ALL SNP AND MMP MEMBERS.

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



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 Communicated by the patient regarding their life, health, worries and behaviors	**Goals** What the patient hopes to achieve regarding their health	**Barriers** Lack of transportation, finances, housing, treatment side effects	**Interventions** 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

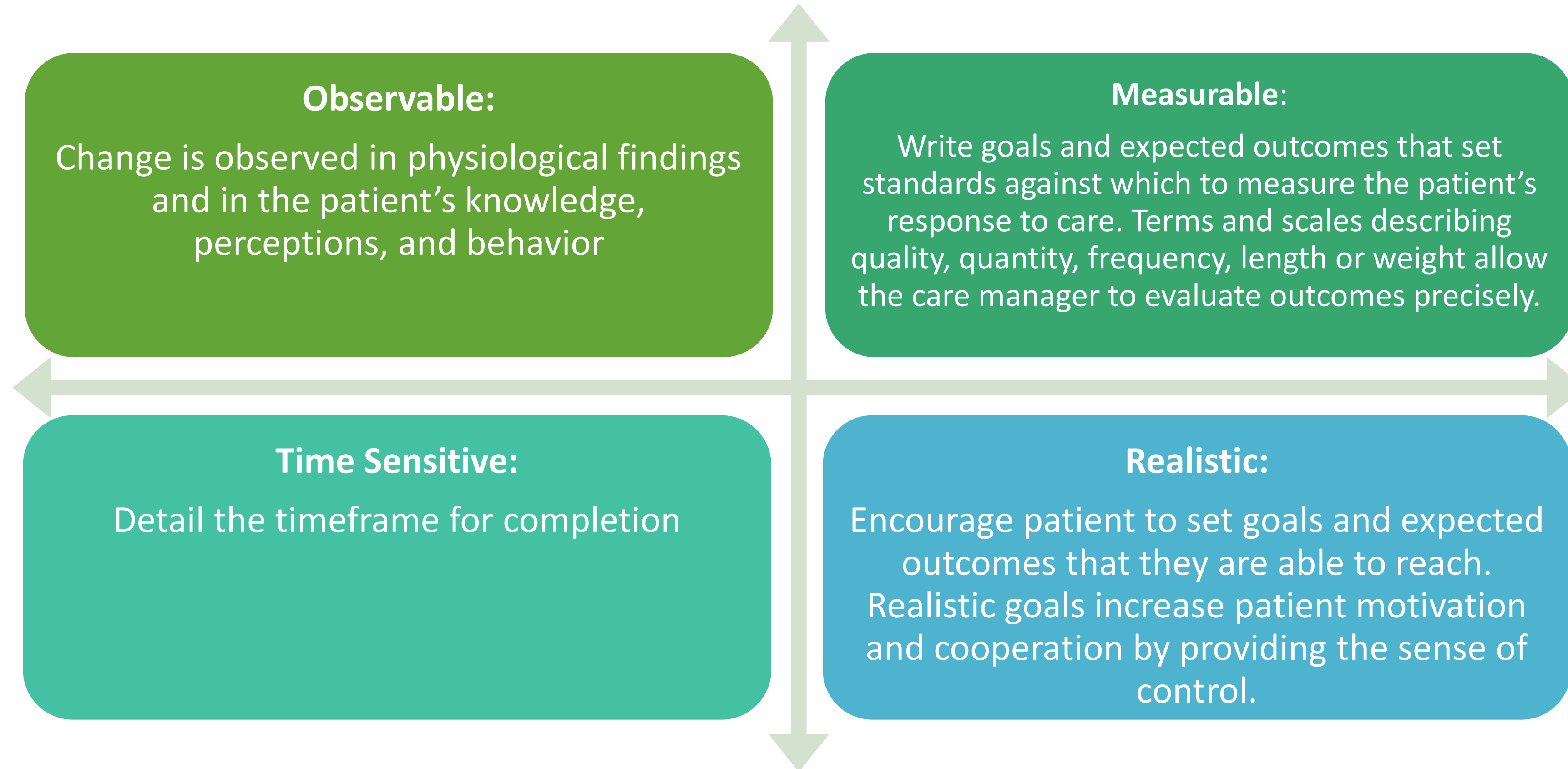
ICP Problems (Cont'd)

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

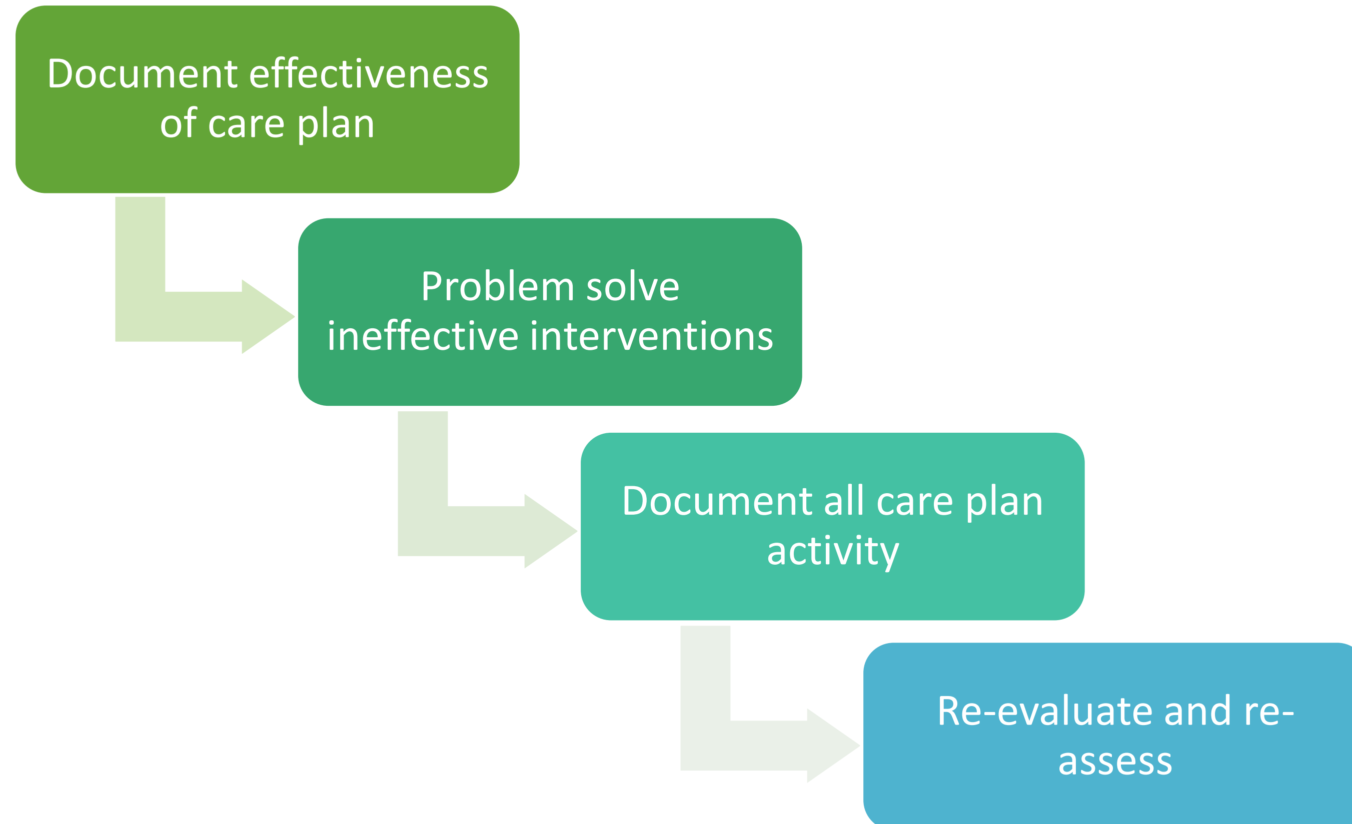
- Access to providers and patient medical records
- Communication with care team
- Coordinating needed care
- Navigating the healthcare system
- Managing information about the patient’s condition

ICP Interventions

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

Monitoring the Care Plan

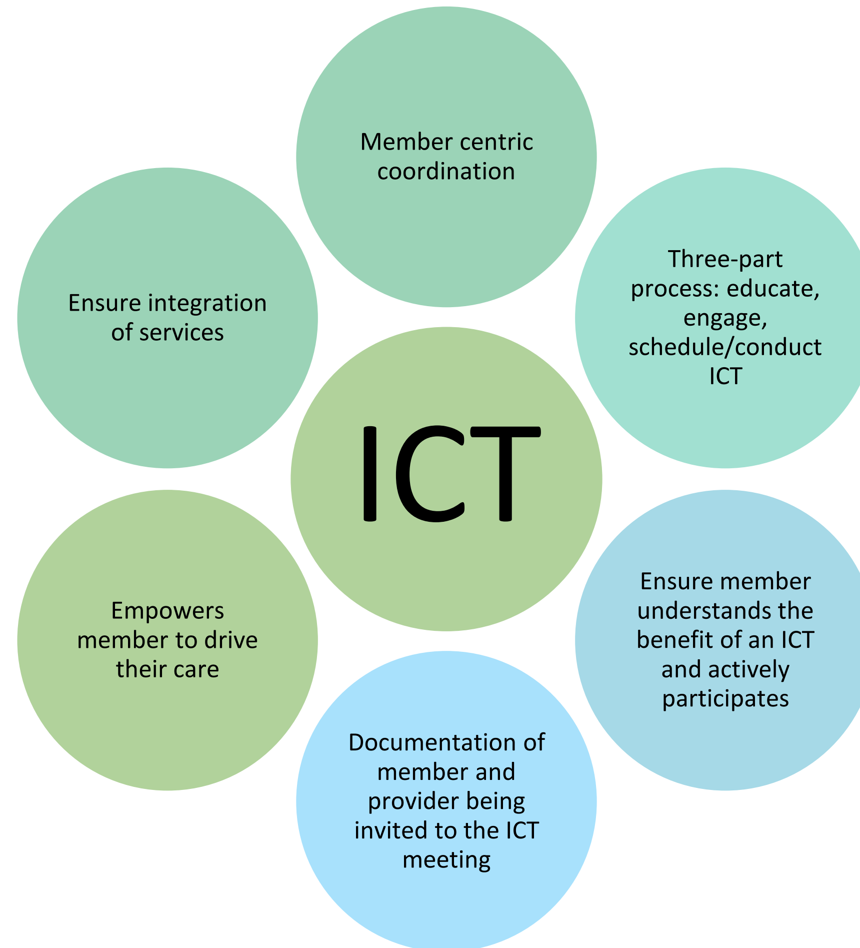
The care plan is an active, dynamic document



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

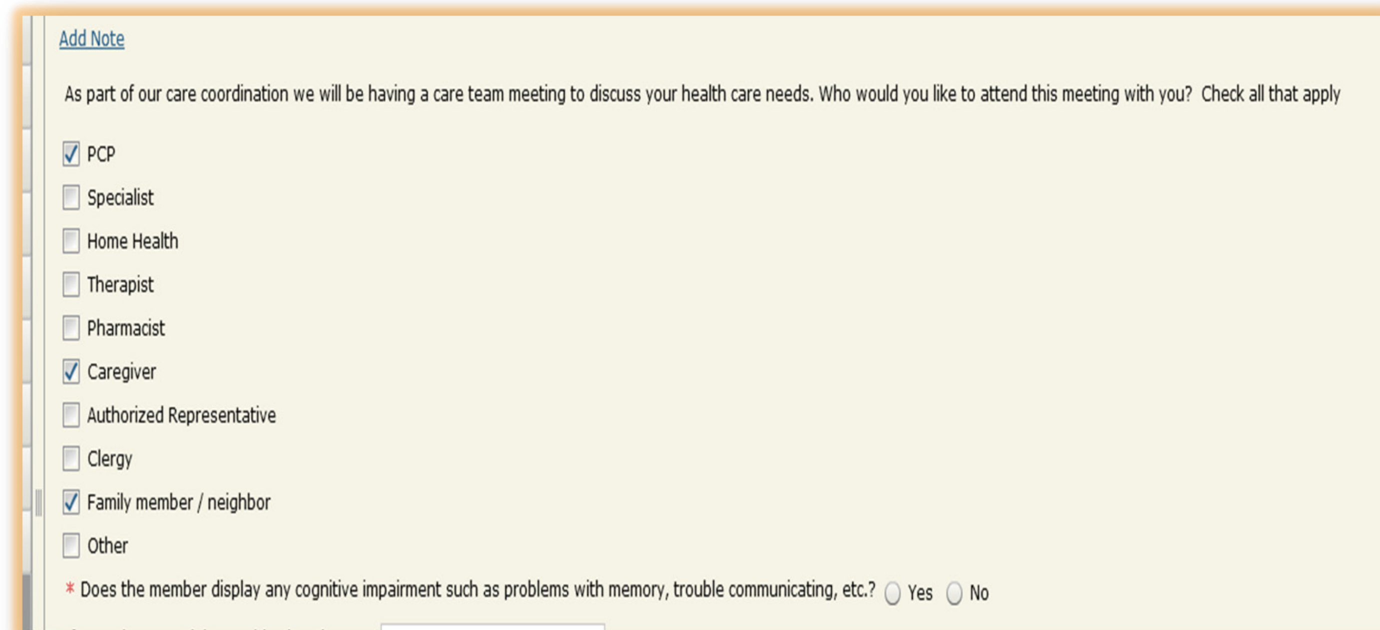
Regular Meetings

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:


Add Note

As part of our care coordination we will be having a care team meeting to discuss your health care needs. Who would you like to attend this meeting with you? Check all that apply

- [x] PCP
- [ ] Specialist
- [ ] Home Health
- [ ] Therapist
- [ ] Pharmacist
- [x] Caregiver
- [ ] Authorized Representative
- [ ] Clergy
- [x] Family member / neighbor
- [ ] Other

* Does the member display any cognitive impairment such as problems with memory, trouble communicating, etc.? ◯ Yes ◯ No

Documentation Required

Example: ICT Conference Note can be completed in an electronic system

Note Type:	Interdisciplinary Care Team Conference_V1
Note Category: *	Admin Note
Encounter Date:	09/09/2015
Interdisciplinary Team meeting conducted on:	09/09/2015
Location/Method of IDCT:	Facility/Clinic
Reason for conference:	Initial
Communication needs:	-- Select --
Member was invited to ICT:	Yes
Member's health care provider was invited to ICT:	Yes
Interdisciplinary care team members participating in meeting::	
Member:	Yes
Member designee:	-- Select --
Case Manager:	Yes
Behavioral Case Manager:	-- Select --
Primary Care Provider:	-- Select --
Long term supports and services:	Yes
Medical Director:	-- Select --
Pharmacy:	Yes
Disease Management:	-- Select --
Facility discharge planner:	-- Select --
Occupational/Speech/Physic	

Model of Care (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.
- MANAGEMENT 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, its services, its
  - practitioners and providers.
  - Privacy and right to be treated with respect, dignity, and courtesy from 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.*

Additional Resources at TMIPA

- **Clinical Care Coordinator Questions regarding this training please contact**:

  - Department: Integrated Care Teams
  - Email: tmipa.casemgmt@tmmc.com
  - Phone: 310-517-7076

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

1. **Living Will** - Indicates what kind of treatments you would want, and what treatments you wouldn't want
2. **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)

- POLST 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 Satisfaction Policies & Procedures – All Lines of Business (LOBs)

Member Satisfaction Survey

I. PURPOSE

a. To ensure Torrance Memorial IPA has a Member Satisfaction Survey System that provides feedback about whether member needs are being met through the Case Management program and helps to identify areas for improvement activities.

II. SCOPE

a. To obtain a better knowledge of how to better serve Torrance Memorial IPA members. The Case Managers are made aware of results of the member Satisfaction survey.

III. POLICY

a. Annually Torrance Memorial IPA assesses member satisfaction with the Case Management program in an effort to identify opportunities for improvement in the Case Management process.

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

Culturally and Linguistically Appropriate Service (CLAS)

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 (HICE)

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 (HICE)

- 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 HICE

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

Purpose

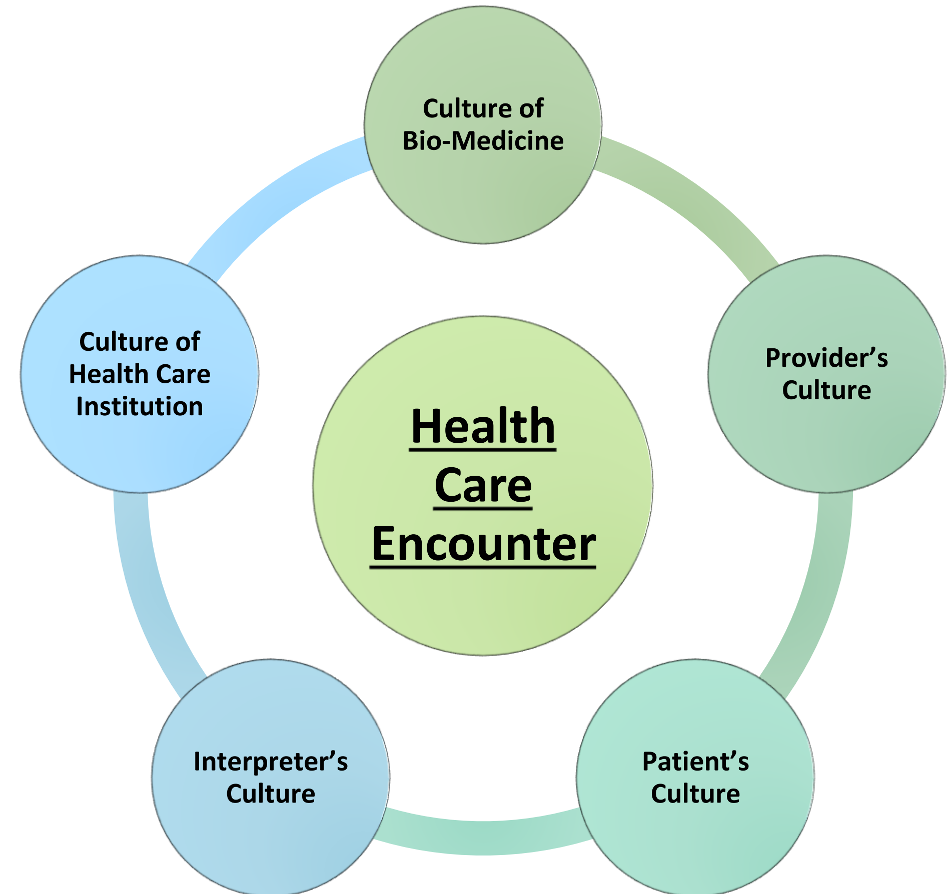
- The document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).
- We do not want to be exclusionary, insensitive, or contribute 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.
- Go to ICE C&L Provider Toolkit to obtain the full document

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

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, interactions to different cultural situation. 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 Communication

Clear Communication

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

Unclear Communication

- Malpractice Risk
- Medical Error
- Increase 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 • Some days it's harder for me to speak English • When I don't seem to understand, talking louder in English intimidates me • If I look surprised, confused or upset I may have misinterpreted your nonverbal cues	• Office staff should confirm language preferences during scheduling • Consider offering an interpreter for every visit. • Match the volume and speed of the patient's speech • 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 see TMIPA website for phone numbers.**

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.

Source National Center on Accessibility | IU Research Park, 501 North Morton Street, Suite 109, Bloomington, IN 47404-3732

Refusal of Interpretive Services Document Documentation is important

Provider Health Plan LEP Contact Grid

Purpose

- To identify and provide a list Health Plan Interpreter services that are affiliated with a health plan, go to the health plan website.

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

Privacy & Security

- Torrance Memorial IPA 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 Privacy, Breach, Report

- 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 it is remotely wiped
- **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 to tmipa.compliance@tmmc.com

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 dispose of ePHI	Follow Policies & Procedures: Ask IT or Compliance if you have questions

Reporting Security Issues

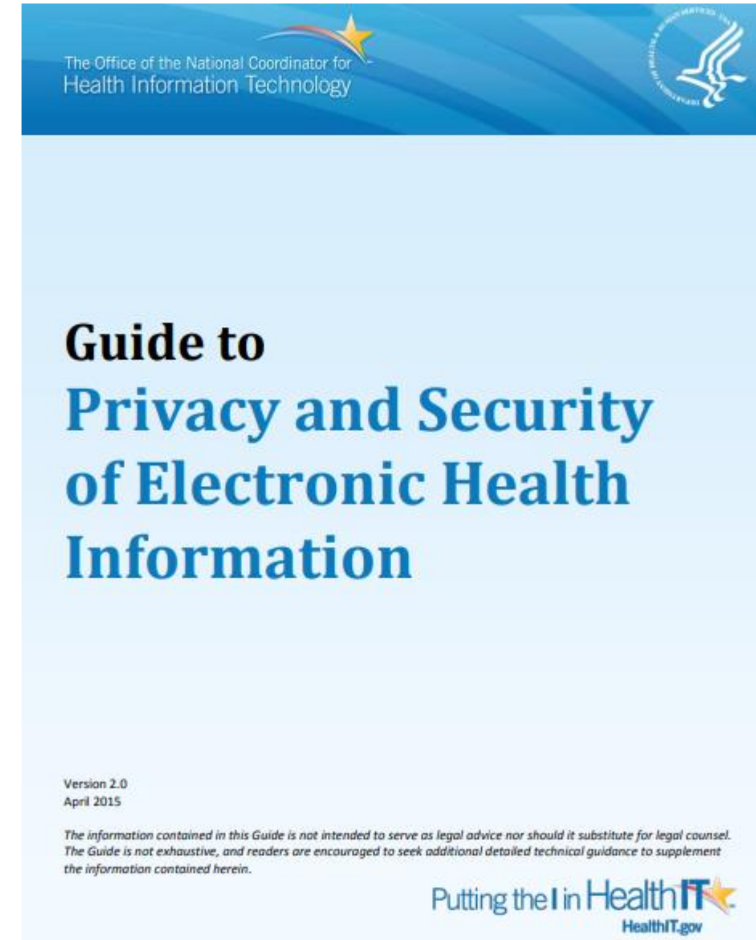
- Contact Compliance Department
  - Email: tmipa.compliance@tmmc.com

Information Sharing Methods

- Torrance Memorial IPA uses the following methods to share information with network providers, members, and/or other healthcare professionals:
  - Contracted providers
    - Website: https://www.torrancememorialipa.org/app/security/login.aspx?navigationNode=%2f1%2f17%2f12%2f1%2f&ReturnUrl=%2fipa%2ffor-providers%2ftmipa-providers-login%2f&restricted=True
  - Non-Contracted
    - Website: https://www.torrancememorialipa.org/ipa/contact-us/
  - Members
    - Website: https://www.torrancememorialipa.org/ipa/accessing-care/member-support/

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.

General Compliance – All Lines of Business (LOBs)

General Compliance Training– HICE 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/TMIPA 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

OIG/SAM/Medi-Cal Exclusions – All Lines of Business (LOBs)

OIG/SAM/Medi-Cal Exclusions Screening Attestation

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.

If you have any questions, please contact the Compliance department at

Thank you.

Critical Incident Training –

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.
- Be aware of members which 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 Psychiatric 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 TMIPA at 310-257-7250
- The Appropriate Personnel 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

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

Appointment Access and Availability Requirements for TMIPA Members

- Both CMS and the California Department of Managed Health Care have established regulatory requirements for HMO members access to appointments with providers. This to ensure members timely availability and accessibility to practitioners, providers, and health care services they need.

Appointment Access & Availability Standards

Appointment Type	Appointment Offered/Standard
Preventive Care appointment	Within 30 calendar days of request
Routine (non-urgent) appointment – Primary Care	Within 7 business days of request
Routine (non-urgent) appointment	Within 15 business days of request
Urgent appointment for services that ***do not require prior authorization*** (Primary Care)	Within 48 hours of the request
Urgent appointment for services that ***do require prior authorization***	Within 96 hours of request
Routine (non-urgent) appointment for *ancillary services* (lab, physical therapy, mammography, etc.)	Within 15 business days of request
In-office wait times	Not to exceed 15 minutes
After hours care	24/7 by telephone

Access to Care

Examples of non-physician behavioral health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

Examples of ancillary services include lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.

Appointment Access & Availability Standards – **Behavioral Health**

Appointment Type	Appointment Offered/Standard
Behavioral Health Routine (non-urgent) appointment – physician/prescriber	Within 7 business days of request
Behavioral Health Routine (non-urgent) appointment – non-physician provider	Within 7 business days of request
Behavioral Health follow-up visit – non-physician provider	Within 10 business days of prior visit
Behavioral Health urgent appointment – physician and non-physician	Within 48 hours of the request
Behavioral Health access to care for non-life-threatening emergency	Within 6 hours
Behavioral Health access to care for life-threatening emergency	Immediately

Appointment Access & Availability Standards – **Behavioral Health**

Appointment Type	Appointment Offered/Standard
Follow-up care after discharge of hospitalization for mental illness	Within 7 calendar days of discharge Plus: Follow-up visit with 30 calendar days of discharge
After-Hours Care	• 24/7 answering service or voice mail messaging system • Physicians: paging or cell phone availability • Non-physician providers: must have messaging system that refers members to licensed professional

Thank you for your time

Please sign the appropriate attestation provided on TMIPA provider portal website to ensure credit for completing this training

Updated 08/05/2025