ALAMEDA Alliance FOR HEALTH

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Quality Improvement Health Equity Committee Voting Items Policies & Procedures November 14, 2025

Please click on the hyperlink(s) located on the following summary pages to direct you to corresponding material for each item.

Policy Procedures Summary of Changes

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)
QI	QI-104	Potential Quality of Care Issues	Describes the evaluation, monitoring and appropriate action to address all PQIs	Added DSNP line of business	X		
QI	QI-119	Provider Preventable Conditions (PPC) and Adverse Events	Describes how PPCs are identified, processed,investigated, and reported to DHCS	Added DSNP line of business Added reporting instructions to submit PPCs to the DHCS online portal Revised reporting form to Alliance	X		
QI	QI-133	Inter-Rater Reliability (IRR) - Testing for Clinical Decision Making	Describes monitoring of the consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	Added DSNP line of business Minor update to roles/titles	X		
QI	QI-136	Clinical Practice Guidelines	Describes how Alliance adopts, disseminates, and monitors the use of preventive care and other clinical practice guidelines in alignment with DHCS contract and other regulatory bodies	Added DSNP requirements Added APL 23-010 Autism and ASAM for Substance use disorder Added APL 25-015: Assembly Bill 144 and Coverage of Preventive Care Services	x		
QI	QI-101	Quality improvement and Health Equity Program	Describes development and implementation of a Quality Improvement and Health Equity (QIHE) Program, and the appropriate monitoring of the adequacy, accuracy, accountability and activities of the functions conducted as part of the QIHE Program	Aligned verbiage and integrated CMS DSNP requirements into the QIHE program, including addition of Stars, Model of Care, MCAHPS, HOS activities	X		
QI	QI-D-001	Quality Improvement Project Selection Criteria	This policy establishes the criteria and process for selecting Quality Improvement Projects (QIPs) to ensure they address high-impact clinical and non-clinical areas, improve health outcomes, and beneficiary satisfaction, reduce disparities in healthcare, and align with CMS priorities	New policy to establish the criteria and process for selecting Quality Improvement Projects (QIPs)		x	

Policy Procedures Summary of Changes

QI	QI-D-002	Health Outcomes Survey	This policy outlines the requirements and procedures for administering the Health Outcomes Survey (HOS) for Dual Eligible Special Needs Plans (D-SNPs) enrolled in Alameda Alliance Wellness D-SNP, in alignment with federal Centers for Medicare and Medicaid (CMS) guidelines and the California Department of Healthcare Services (DHCS) California-specific mandates under the CalAIM initiative.	New policy outlining Health Outcomes Survey (HOS) for DSNP as required by CMS		x	
QI	QI-D-003	Model of Care (MOC) Annual Evaluation Policy	Policy is to ensure accuracy and compliance with the Model of Care Annual Evaluation Policy for Alameda Alliance Wellness	New policy outlining process for Model of Care annual evaluation as part of the QIHE program		x	
QI	QI-D-004	Core Measures and Reporting Policy	Outlines standardized processes for collecting, analyzing, measuring, and reporting of key metrics.	New policy processes for collecting, analyzing, measuring, and reporting key quality metrics. This includes: 1.CMS Stars Program metrics 2.Annual Quality Improvement Work Plan (QIWP) 3.Health Equity reporting and interventions 4.CMS-required KPIs (e.g., HEDIS, CAHPS, HOS, NCQA reporting)		x	
QI	QI-111	Delegation of Management and Oversight	Policy outlines the overight of delegated QI responsibilities through the QIHE Program	Added: DSNP LOB for delegated oversight Revised: Delegation reports are reviewed by the Subcontractor & Delegation Oversight Committee (SDOC) with a summary to the Compliance Committee	x		
BH	TBD	DSNP Behavioral Health Services	The new D-SNP policy outlines behavioral health services covered for Alliance members.	New		X	

Policy Procedures Summary of Changes

BH	TBD	Behavioreal Health_DSNP_Roles and Responsibilites	This new D-SNP Policy outlines the roles and responsibilities of behavioral health staff involved in the D-SNP Model of Care to ensure coordiantion, high-quality care of the Alliance Members.	New		X	
BH	TBD	Behavioral Health Crisis Intervention	This new D-SNP policy outlines the standardized procedures for crisis recognition, immediate safety response, coordination with providers and county services, and ongoing follow-up.	New		X	
BH	BH-001	Behavioral Health Services	This policy outlines the behavioral health program for the Medi-Cal and GroupCare Line of Business.	The policy update is update language for DHCS minor consent language, NSMHS outreach and education and clinician override procedure for DHCS screening tools.	X		
CBAS	CBAS 001	Initatal Member Assessment & Reassessment	Describes policy for initial assessments and annual reassessments for CBAS members	Added DSNP Language & references, annual policy update. Reformatted some of the Procedure section to reduce duplication.	X		X
CBAS	CBAS 002	Expedited Initial Member Assessment	How to priotitize CBAS referral for members Discharging Acute Hospital or SNF.	Added DSNP Language & references, annual policy update.	X		X
CBAS	CBAS 004	Member Assignment to a CBAS Center	How to Link members to CBAS centers	Added DSNP Language & references, annual policy update. Updated quality issues related to why we would not approve a CBAS Center	X		X
CBAS	CBAS 005	Provision of unbundled CBAS Services	How to provider services when there is no center available	Added DSNP Language & references, annual policy update. Updated language per guidance from DHCS	X		X
CBAS	CBAS 006	Emergency Remote Services (ERS	How to utilize CBAS ERS Services	Added DSNP Language & references, annual policy update. Reformatted some of the Procedure section to reduce duplication.	X		X
CHS	CHS-001	CHS-001 CHW Services	CHW policy outlines CHW services	Updated to reflect Medi-Cal/Medicare language and department/title changes	x		
CHS	CHS-02	Community Health Strategy – Prescreening Process	Describes prescreenining and onboarding process for entities interested in delivering Community Health Worker services	New policy		X	
ECM	CM-010	Enhanced Care Management – Member Identification and Grouping	Describes the identification and grouping of AAH members into Enhanced Care Management (ECM)	Transitional Rent, reimbursement model	X		
ECM	CM-041	Enhanced Care Management – Outreach/Member Engagement	Describes engagement for Enhanced Care Management (ECM) eligible members, using state determined, Centers for Medicare & Medicaid Services (CMS) approved criteria.	Transitional Rent	X		

Policy Procedures Summary of Changes

CMDM	CM-043	Child Welfare Liaison	Addressing APL 24-013 that describes the role of the Child Welfare Laision(s) and responsibilities	Updated policy to addressing missing language around ensuring appropriate participants are present during care coordination meetings	X		
CMDM	CM-D-006	CICM Outreach/Member Engagement	Outreach and engagement of members for CICM			X	
CMDM	CM-D-008	CICM Continuity of Care	Continuity of care for members who are enrolled in ECM and enroll in DSNP			X	
CMDM	CM-D-101	DSNP Care Coordination Expectations	Expectations regarding PCP role, coordination of services and process for coordination	new policy		X	
CMDM	CM-D-102	Case Management Care Coordination Activities	Care coordination identification and actions to take (ccordination care, communication, documentation,etc) to support DSNP members			X	
CMDM	CM-D-104	Individualized Care Plan Process	Individualized care plan development for DSNP members			X	
CMDM	CM-D-109	Internal Audit and Monitoring	Oversight and monitoring of team members productivity for DSNP members			X	
CMDM	CM-D-110	Care Coordination - Local Education Agency Services	Care coordination with LEAs for DSNP Members			X	
CMDM	CM-D-111	Case Management (CM) Staff Roles and Responsibilities	Roles and responsibilities of staff, including oversight			X	
CMDM	CM-D-112	DSNP Care Transitions Protocols	Protocols for planned and unplanned transitions, care coordination team, timely response, member and provider communication, monitoring and evaluation for Care Transitions	new policy		X	
CMDM	CM-D-113	DSNP Care Transitions Personnel	Roles and responsibilities of care transition personnel	new policy		X	
CMDM	CM-D-114	DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process	roles and responsibilities to build the individualized care plan	new policy		X	
CMDM	CM-D-115	DSNP Planned Care Transitions Process - Member Personal Health Information	The process of communication of member transitions and expectations pre- and post-discharge	new policy		X	
CMDM	CM-D-116	DSN Planned Care Transitions Process - Member Self Management Activities	A structured approach that provides education and support to members and their caregivers, helping them manage and understand their condition while empahsizing self-care.	new policy		X	
CMDM	CM-D-117	DSNP Planned Care Transitions Process - Notification and Point of Contact	Assignment and notification of the Point of Contact	new policy		X	

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CMDM	CM-D-118	DSNP Face-to-Face Encounters	Defining who can provide a face-to-face encounter, the required timing of face-to-face encounters, monitoring and scheduling face-to face encounters to assist with compliance of the regulatory requirements	new policy		X	
CMDM	CM-D-119	Interdisciplinary Care Team (ICT) Overview	Membership for ICT and requirements for Palliative Care and Dementia Care ICT	new policy		X	
CMDM	CM-D-120	Interdisciplinary Care Team (ICT) Participants	The roles and responsibilities of the members of the ICT and how each contributes to the development and implementation of the an effective interdisciplinary process to support the member's clinical and social needs	new policy		X	
CMDM	CM-D-121	DSNP Most Vulnerable Population (MVP)	Definition, identification and stratification of the DSNP MVP	new policy		X	
CMDM	CM-D-122	Disease Management Programs	Identification and screening, enrollment, assessment, care plan development and management and disease management evaluation and program closure for the disease management programs	new policy		X	
CS	CS-002	ity Supports-Housing Transition Navigatio	da Alliance for Health processes the Housing Tra	Updated Referral langauge and member consent language	X		
CS	CS-003	Community Supports-Housing Deposits	ich Alameda Alliance for Health processes the H	Updated member consent language	X		
CS	CS-004	y Supports-Housing Tenancy snd Sustainin	a Alliance for Health processes the Housing Ten	Updated member consent language	X		
CS	CS-007	s-Medically Supportive Food_Meals_Med	nce for Health processes the Medically Tailored	Updated member consent language and urgency TAT language	X		
CS	CS-013	Community Supports – Transitional Rent	This policy outlines the process in which Alameda Alliance for Health processes the Transitional Rent Community Support. Transitional Rent assists individuals who are homeless or at risk of homelessness with 6 months of rental assistance in interim and permanent settings.	New		X	
CS	CS-014	Non-Housing Community Supports Criteria	This policy outlines the criteria that Alameda Alliance has established for Community Supports along with the DHCS Medi-Cal Community Supports (CS) or In Lieu of Services (ILOS), Policy Guide (April 2025).	Updated criteria to felect new policy guide , Added D-SNP	X		
UM	DSNP	Case Rounds& Team Review	New policy to describe UM Rounds	NEW D-SNP Policy		X	
UM	DSNP	Integrated Orginzation Deteminations	New policy describing D-SNP Letters	NEW D-SNP Policy		X	

Policy Procedures Summary of Changes

UM	DSNP	QIO Fastrack Appeals- for Medicare Covered Services	New process describing the QIO Process	NEW D-SNP Policy		X	
LTC	LTC-001	Long Term Care Program	This policy outlines the process for providing Long Term Care (LTC) services in the following settings: •LTC Nursing Facilities (NF)-Freestanding and Hospital Based •Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD) •Subacute (SA) care facilities •Pediatric Subacute (PSA) care facilities. This policy outlines the process for providing Long Term Care (LTC) services in the following settings: •LTC Nursing Facilities (NF)-Freestanding and Hospital Based •Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD) •Subacute (SA) care facilities •Pediatric Subacute (PSA) care facilities.	Updated APLs, Added D-SNP	X		
LTC	LTC-001	Long Term Care	This policy outlines the process for providing Long Term Care (LTC) services in the following settings: •LTC Nursing Facilities (NF)-Freestanding and Hospital Based •Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD) •Subacute (SA) care facilities •Pediatric Subacute (PSA) care facilities.	Updated to add Hospice Language per DHCS request for APL 25-008	X		
LTC	LTC-004	LTC Bed Hold and Leave of Absence	The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for approving Bed Holds and Leave of Absence (LOA) for members residing in Long Term Care facilities.	Updated APLs, Added D-SNP, Updated TCS wording	X		
LTC	LTC-006	servation (Personal Attendants/Sitter) in N	This policy is to outline the requirements for Alameda Alliance to consider coverage of One to One Observation (Personal Attendants/Sitter) at a nursing facility.	New		X	

Policy Procedures Summary of Changes

UM	UM-008	Coordination of Care- California Children's Services	Describes the roles and responsibilities of Alliance in the UM of members with access to CCS services	Updated language to align with DHCS APL 23-014 related to the CCS Laision. Also conducted Annual review with minor formatting updates	X		X
UM	UM-011	oordination of Hospice and Terminal Illne	Policy for Authorization of Hosipce Services	Updated to Align for new APL 25-008 with updates related to LTC Hospice	X		X
UM	UM-015	Emergency and Post Stabilization Services	Process for approving post Stabilation Services	Updated for D-SNP references and processes	X		X
UM	UM-024	Care Coordination- Dental Services	UM Process for coordinating Dental services	Change name to Dental Services to better align with CM-D-101 which talks about the care coordination pieces.	X		X
CMDM	UM-025/CM-044	Guidelines for Obstetrical Services	Providing services include care coordination, assessment and individualized care plan development for pregnancy members	Updated policy to include new changes to regulatory requirements and DSNP Moving from UM to CM.	X		
CMDM	UM-030/CM-045	Referrals to Supplemental Food Program for Women, Infants and Children (WIC)	identification of members, and referral process to WIC	Moving from UM to CM and therefore monitoring will be completed by Compliance and CM annually. One policy for all lines of business	X		
UM	UM-035	Vision Services	UM process for coordinating Vision Services	Updated for D-SNP references and processes	X		X
UM	UM-051	Timeliness of UM Decision Making and Notification	Alameda Alliance maintains current regulatory required timeliness standards for Utilization Review decision making and subsequent notification timeframes of the decision to both the Member and Provider.	Updated with D-SNP verbiage including new attachment of the D-SNP/ MCAL/ GC TAT grid. Reformatted for readability of the policy	X		
UM	UM-051	Timeliness of UM Decision Making and Notification	Timeliness of UM Decision Making	Need to update the TAT grid- 5 business days to 7 calendar days	X		X
UM	UM-054	Notice of Action	Process for completing decision notifications for MCAL and IHSS	Annual review- no major changes	X		X
UM	UM-056	Standing Referrals	This policy establishes guidelines for issuing standing referrals to specialists for DSNP enrollees with chronic or disabling conditions that require ongoing specialty care to ensure continuity of treatment, reduce administrative burden and improve health outcomes.	D-SNP references added. Minor grammar revisions	X		
UM	UM-057	Authorization Service Request	Alameda Alliance for Health (Alliance) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.	DSNP Revisions completed. Reformatting completed to remove some duplication and increase readability	X		

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UM	UM-057	Authorization Request Services	Describes the UM functions of the Alliance team in approving authorizations	Added CS language r/t expedited auths post discharge, updated 5 business days to 7 calendar days, added language r/t CHME approval of certain DME items. Minor formatting updates	X		X
UM	UM-067	Varicose Veins	Policy for coverage of medically Necessary treatment for members with Varicose veins	This policy was originally created and sent through UMC/ QIHEC in 2020. It was never completed and presented at AOC- so bringing heree to re-request implementation of this policy		X	
UM	UM-068	Tertiary Quaternary Review Process	The purpose of this policy is to establish and implement the Tertiary and Quaternary Review Process. This policy is implemented to outline the standard process utilized in reviewing appropriateness of referrals and transitions to a tertiary and quaternary level of care. This will ensure consistency of all reviews both internally and externally. This will result in the timely transition of members to the right level of care at the right time and high-quality outcomes	Notes for UMC: Added DSNP Reference, clarified COC process for member request, Added examples of TQ appropriate requests vs requests that should be redirected back to the community provider level	X		
UM	UM-069	Continuous Glucose Monitoring Equipment	This policy establishes guidance for clinical decision making related to Continuous Glucose Monitoring equipment (CGM).	Notes for UMC: Reformatted Policy section into policy statement only and moves specific processes into the procedure section. Removed footnotes and replaced them with the references only. Added DSNP Process to use MediCal RX for the DSNP CGM.	X		
UM	UM-070	UM Denial System Controls	Process of oversight and montioring of Changes/ Modificaions to reciept dates for UM auth requests	Upated language related on how we audit and approve date changes	X		X
UM	UM-071	Major Organ Transplant	Policy related to all components of major organ transplants	Updated language to be inclusive of D-SNP regulations and processes for MOT/	X		X
QI	QI-D-005	DSNP MOC Training	This policy ensures compliance with 42 CFR § 422.101(f) and the CMS-approved Model of Care (MOC) requirements established under Social Security Act § 1859(f)(7), as well as relevant DHCS D-SNP Program Guide provisions for Medicare-Medi-Cal integration.	New policy outlining MOC training		X	

POLICY AND PROCEDURE

Policy Number	QI-104
Policy Name	Potential Quality of Care Issues (PQIs)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Line(s) of Business	MCAL, IHSS, DSNP
Effective Date	11/20/2006
Committee Name	Quality Improvement Health Equity Committee
Committee Approval Date	~~2/14/2025~~8/8/2025~~11/14/2025~~
Administrative Oversight Committee Approval Date	~~4/16/2025~~

OVERVIEW

Alameda Alliance for Health's (AAH) Quality Improvement (QI) Department will monitor, evaluate, and take appropriate action to address any potential quality of care (PQI) issue defined as:

> *An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.*

The PQI review, evaluation and monitoring process applies to all providers rendering services to Alliance members/enrollees on the Plan's behalf, within all care settings. QI has the responsibility for ensuring and maintaining a timely PQI review process from the receipt of all Potential Quality Issues (PQI) through investigation, appropriate intervention, and resolution. AAH considers this system process a critical component of the Quality Improvement Health Equity Program.

POLICY

The purpose of this policy is to describe the system and process for identifying any PQI that:

a. is not consistent with plan operations
b. indicates a potential or suspected deviation from accepted standards of medical and/or clinical care
c. may potentially or result in an adverse outcome for the member or enrollee

1. PQIs are referred to the Quality Improvement (QI) Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

2. PQIs may be *reported* by anyone, and sources commonly include:
   a. AAH staff
   b. Contracted or non-contracted providers
   c. Behavioral Health / ASD Staff / Providers
   d. Health plan members/enrollees via the grievance process

3. PQIs may be *identified* internal and external to the organization:
   a. Member/enrollee or provider complaints – ***Grievance and Appeals, Compliance***
   b. Member or provider satisfaction surveys – ***Access and Availability***
   c. Claim and encounter data – ***Claims and Data Analytics***
   d. Prior authorization activities through concurrent, prospective, and retrospective review – ***Utilization Management***
   e. Care Coordination and Management activities – ***Case Management or ~~Long Term~~Long-Term Care***
   f. ASD / Behavioral Health Activities **– *Behavioral Health***
   g. Reports on provider practice patterns – ***Data Analytics***
   h. Pharmaceutical data and related studies – ***Pharmacy***
   i. Information from provider regulatory agencies – ***State and County reporting***
   j. Community and public sources – ***Delegate Reporting***
   k. Facility Site and Medical Record Review audit results – ***Quality Improvement***
   l. Notification and complaints from other provider sources – ***Provider Services Peer Review and Credentialing***
   l. Quality Improvement Projects
      - Medical record audits
   m. Preventable Provider Conditions – ***Claims, Quality Improvement***
   n. Retrospective review of any of the above data sources

4. PQIs are submitted through the Alliance Health Suite member database and/or the Grievance and Appeals App with an auto feed directly into the PQI App internally. PQIs externally are received in writing, by fax, the provider portal, or by email to the QI department. PQI referrals received from external sources are manually entered into the PQI App. Each PQI referral received is evaluated by a Registered Nurse or Physician.

5. In accordance with ~~contractual~~the contractual agreement with AAH, participating delegates and its subcontracted providers will perform its PQI activities in compliance with this policy and procedure. Delegates not contracted to perform the PQI activities are responsible for reporting PQIs to AAH promptly for review and investigation.

6. AAH shall ensure that PQI assessments, planning, interventions, and evaluations are consistent with AAH policies, Medi-Cal benefit guidelines, medical/clinical evidence-based guidelines and accepted standards of care.

PROCEDURE

1. PQIs are identified through but not limited ~~to,~~to the following methods or criteria:
   a. Premature discharge from acute or ancillary services.

b. Post-op and other unexpected complications.

c. Alleged communication barriers, inappropriate comments, or rudeness of provider/staff.
d. Sentinel/adverse events ~~such as:~~such as inappropriate evaluation of medical care, allegation of inappropriate medical care, deviation from standard of care, misdiagnosis or unexpected member mortality.
e. Delay or omission of necessary service
f. Delay or barrier to care or service

2. Training for member-facing staff, including but not limited to, Member Services and Provider Relation staff, is conducted at least annually to ensure an understanding of the internal PQI reporting, investigation, and communication process.

3. PQI cases classified as Quality of Care (QOC) or Quality of Service (QOS) issues are investigated through the acquisition of medical records and/or other pertinent documentation where appropriate using the following process:
   a. QI clinical staff identify and coordinate with administrative staff to make medical record requests from providers/vendors/entities via fax/phone/secure email/mail.
   b. When a provider fails to respond to a medical record request within the designated timeframe, staff follow the "Escalation Process for PQI Medical Request Requests" process.

4. Each PQI referral within the PQI App contains but is not limited to the following information:
   a. Current Status: Open - Closed
   b. Service Request (SR) ID
   c. Member ID
   d. Member DOB
   e. Member Name
   f. Received Date
   g. Closed Date
   h. Referral source
   i. Provider name
   j. Name of RN Reviewer
   k. Name of MD Reviewer
   l. Case Type (QOA, QOC, QOS)
   m. Recommended Case Leveling for QOC
   n. Against Facility/Provider Name
   o. Reason for referral

5. Using the APIE model of nursing documentation, the QI Review Nurse will review, and document case components as follows:
   a. A-assessment
   b. P-planning
   c. I- intervention
   d. E- evaluation/Resolution

6. All PQI referrals will be triaged by the QI RN Supervisor or clinical staff designee to determine PQI type, ie, Quality of Care (QOC), Quality of Services (QOS), Quality of Access (QOA) or Quality of Language (QOL).

PQI Designations:

- ***Quality of Acces***s PQIs are referred to the ***Access to Care*** team for appropriate intervention including but not limited to, tracking, trending, and confirmatory surveying. See P&P **QI-114**.
- ***Quality of Language*** PQIs are referred to the Cultural and Linguistics team for appropriate intervention including but not limited to tracking, trending, and confirmatory surveying.
- ***Quality of Service*** PQIs are reviewed by a QI RN Reviewer and may be discussed with vendors in weekly/ad hoc rounds and Joint Operations Meetings (JOM). These cases are investigated through the acquisition of medical records and/or other pertinent documentation requested from the provider(s) as appropriate. A referral to the ***Provider Services*** department is made for QOS PQIs related to suspected or substantiated access and service issues. A referral is made to the ***Compliance*** department for all QOS PQIs related to HIPAA, FWA, PHI violation allegations.
- ***Quality of Care*** PQIs are presented to the ~~QI~~ Medical Director ~~or designated Medical Director~~ post RN review and investigation for review, final resolution, and recommendations. These cases are investigated through the acquisition of medical records and/or other pertinent documentation requested from the provider(s) as appropriate. Based upon the outcome of the case review, each QOC case shall be leveled reflecting the severity of the outcome as follows:

Commented [DC1]: Change all "QI Medical Director" to just "Medical Director"

Quality of Care (QOC) Issue	
Severity Level	**Description**
C0	No QOC Issue
C1	Appropriate QOC - May include medical / surgical ~~complication~~complications in the *absence of negligence* Examples: Medication or procedure side ~~effect~~effects
C2	Borderline QOC - With potential for adverse ~~effect~~effects or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC (substantial harm) - *Actual* adverse effect or outcome (non-life or limb threatening) Examples: Delay in unnecessary test *resulting in* poor outcome
C4	Serious QOC (substantial harm) - With significant adverse ~~effect~~effects or outcome (life or limb threatening) Examples: Life or limb threatening

a. If the case is leveled as a C2, C3, or C4 by the ~~QI~~ Medical Director, he/she will determine if the case requires:
   i. external review (Advanced Medical Review)

ii. a provider letter for response
iii. a Corrective Action Plan (CAP) mailed to the provider for response, or
iv. presentation to Peer Review Committee (PRC).

Clinical Review and Reporting of Potential PPCs

A. Potential PPCs reported to Quality from Claims, Utilization or Case Management, or discovered during a PQI investigation will be reviewed to validate whether a reported incident meets the definition of a PPC.
B. The scope of the PPC review by Quality shall include but not be limited to, both a medical record and claims history review.
C. The potential PPC will be reviewed by the QI Nurse Reviewer to determine if the case is a potential quality issue (PQI) and will need to go through the PQI review process. See policy **QI-119.**
D. All potential PPCs are forwarded to the Chief Medical Officer or physician designee for secondary review and final PPC validation.
E. Medical Director validated PPC cases may be presented to and reviewed by the Peer Review Committee (PRC) for comment and/or any corrective actions
F. Findings of all potential PPC ~~investigated cases~~cases investigated will be reported to the claims department designee.
G. Notification of the reported incidents is also sent to the Alliance internal Compliance Department.

CORRECTIVE ACTION PLAN (CAP)

AAH will ensure that effective follow-up action with providers (such as via barrier analysis, provider CAPs, enhanced monitoring, or re-measurement activities), is taken to address any needed improvements in quality of care (QOC) delivery to prevent the recurrence of identified issues.

1. The action taken on the completion of each QOC investigation is dependent on the leveling score. If the case levels as a C2, C3, or C4, the ~~QI~~ Medical Director will determine whether a letter or CAP will be mailed to the provider. When a CAP is sent to a provider for a requested response:
    a. If a provider fails to provide additional information, either a written CAP response or requested medical records, within the required timeframe the RN Supervisor or designee will send a reminder notice with a request for an immediate response.
    b. In addition to the content in the original CAP letter, the following will be included
        i. A reminder that the provider/organization's Alliance contract requires them to adhere to Alliance policies and procedures, which includes timely response to potential quality incidents; and
        ii. An additional 14 calendar day deadline for response.
        iii. If no response from the provider/organization for a second time, the CMO or designee will contact the provider or organization to ensure that the letter was received.
    c. If no response is received, the CMO or designee may choose to level the case using the information on hand.

2. After further review, the ~~QI~~ Medical Director will determine if the case and its findings are to be presented at the Peer Review Committee (PRC). The PRC will review the QOC findings and may determine an action plan, which may include a CAP or other further actions. CAP outcome letters are stored in a secure database. CAP decisions leading to a change in credentialing status are shared with Provider Services and decisions involving HIPAA, PHI, and fraud/waste/abuse are shared with Compliance.

    a. As deemed appropriate for each case by the PRC, appropriate referrals are made to the regulatory/licensing agencies and per reporting requirements under the California Business and Profession code §805 (PRCC CRE-006).
    b. The PRC recommends an ~~action~~action, and final action is rendered after ratification, and the provider is provided his or her process rights (PRCC CRE-006).

CONFIDENTIALITY

All PQI files, records, and proceedings are kept confidential. Access to the files, records, or minutes of proceedings shall be limited to QI staff involved in the review and PRC process when applicable. All records are securely retained and compliant with the record retention policies and procedures.

REPORTING

1. The Internal Quality Improvement Committee (IQIC) reviews reports of all potential quality of care issues. The report is then reviewed ~~by the~~by the Quality Improvement Health Equity Committee (QIHEC) for recommendations.
2. The QI Department is responsible for any follow-ups and /or corrective actions recommended by QI committee(s).
3. Cases for care or service providers that exceed three (3) PQIs leveled C2-4 in the previous 6 months will be escalated to PRC per Medical Director recommendations

TRACKING AND TRENDING

The QI Department is responsible for tracking and trending all PQI referrals, including retrospective trend analysis of the provider's practice patterns via history of complaints at least every 6 months.

1. Any trends are noted, summarized, and reviewed with the ~~QI~~ Medical Director and Provider Services Director via QI committees and ad hoc for further evaluation and action
2. Providers with significant PQI issues, as determined by PRC, are subject to termination from the AAH network
3. When deficiencies or patterns of non-compliance [as defined in Rule 1300.67.2.2(b)(12)] resulting in substantial harm to a member are found through the monitoring process, the Alliance will issue time sensitive CAPs to all identified contracted providers and delegates as appropriate

EXEMPT GRIEVANCES

1. The ~~Sr. Director of Quality or Quality Supervisor~~ Sr Director of Quality or designee will review a minimum of 100 randomly selected exempt grievances per quarter that were

Commented [DC2]: Change to "Sr Director of QI or Quality Sup" to just"Sr Dir of Quality or designee"

NOT referred to the QI Department as a PQI. The purpose of these reviews will be to determine if these cases should have
been routed as a PQI to the QI Department and whether the process followed the current training and policy guidelines. On review, cases identified as PQIs will be brought to the attention of the Director of Member Services. The Director of Member Services will then implement the appropriate training and correction steps.

2. QI Staff will hold regular trainings to ensure staff education and encourage clinical oversight of exempt grievances.

AUDITING AND OVERSIGHT

1. The Sr. Director of Quality or designee ~~Quality Supervisor~~ is ~~are~~ responsible for resolving any discrepancies between the number of PQIs within the PQI Application and those sent by email with IT.

2. Sr. Director of Quality will review determined QOAs, QOS PQIs, and Exempt Grievance files reviewed by the Sr Director of Quality or designee ~~QI Nurse Supervisor~~ during the audit month for accurate and appropriate documentation:
   i. Timely review within ~~120~~ 150 days of receipt
   ii. Type
   iii. Assessment of problem/grievance – Hospital readmissions < 30 days, possible PPC
   iv. Plan
   v. Intervention
   vi. Evaluation/Resolution
3. Pass rate of 90% must be met
4. Retraining of ~~QI Supervisor/~~Review Nurse will be conducted for a score of less than 90%
5. Two (2) consecutive months of failure to achieve passing score will lead to progressive disciplinary action.

INTER-RATER RELIABILTIY (IRR): See **QI 133**

Commented [DC3]: Change QI Nurse Supervisor to Sr Dir of Quality or designee

DEFINITIONS / ACRONYMS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below:

1. **Corrective Action Plan (CAP)** – Action requested to correct a noted deficiency.

2. **High Priority** – This is an option within the PQI application to denote a PQI that needs to be a top priority for the assigned RN reviewer. This designation/determination is made during the clinical triage that is conducted during case assignment.

3. **Inter-Rater Reliability**- Assessment used to measure the level of consistency among the group of raters and adherence to the medical criteria standards.

4. **Peer Review –** In accordance with California Business and Professional Code section 805, Peer Review is a process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, to do either or both of the following:
   a. Determine whether a licentiate may practice or continue to practice in a health care

facility, clinic or other setting providing medical services, and, if so, to determine the parameters of that practice

b. Assess and improve the quality of care rendered in a health care facility, clinic or other setting providing medical services.

5. **Potential Quality of Care Issue ("PQI")** – An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.

6. **Provider Preventable Conditions** - A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b).

7. **Quality of Care** - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.

8. **Quality of Access** – The degree to which timely access and availability of care for members promotes positive health outcomes and are consistent with all regulatory standards.

9. **Quality of Service –** The degree to which timely health care services are available for members and promotes positive member satisfaction.

10. **Sentinel Event** - Any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof defined as any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

11. **Shadow Case** – This is a term within the PQI Application that is used to differentiate between the multiple issues that can exist in one complaint. As a result, this allows the QI Department to track and trend all the issues that exist within one interaction/complaint from a member.

12. **Substantial Harm** -- Substantial harm indicates loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.

13. **Task Owner** – This is a field within the PQI Application that denotes the individual within the QI Department who is responsible for completing an assigned task within the PQI workflow.

14. **Turn-Around-Time (TAT)** – The Plan intends to completely its full investigation and leveling of all PQIs that are referred to QI for review within ~~120~~ 150 days of receipt unless an extension on a case-by-case basis is deemed warranted by the CMO or Medical Director.

15. **Unsubstantiated PQI** – This option is selected within the PQI application to designate a QOS or QOA that cannot be supported based on clinical review.

AFFECTED DEPARTMENTS/PARTIES

Grievance and Appeals
Peer Review and Credentialing

Compliance
Case Management
Provider Services
Member Services
Utilization Management

RELATED POLICIES AND PROCEDURES

CRE-006 Reporting to Authorities
CRE-009 Ongoing Monitoring of Practitioners
QI-101 Quality Improvement Health Equity Program
QI-111 Delegation Management and Oversight
QI-114 Monitoring of Access and Availability Standards
QI-116 Provider Appointment Availability
QI-119 Adverse - Sentinel Events and Provider Preventable Conditions
QI-133 Interrater Reliability

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

PQI Assignment Desktop Procedure

REVISION HISTORY

1/1/2008, 10/1/2009, 2/26/2010, 5/21/2012, 9/10/2012, 11/6/2014, 4/13/2015, 6/16/2016, 11/10/2016, 3/9/2016, 9/12/2017, 12/5/2017, 4/12/2018, 5/3/2018, 7/19/2018, 9/6/2018, 11/15/18, 1/17/19, 5/21/2020, 7/16/20, 11/18/21, 03/22/2022, 6/28/2022, 03/21/2023, 12/19/2023, ~~**4/16/2025**~~**, 8/8/2025, 11/14/2025**

Blue = material updates

REFERENCES

DHCS Contract Attachment 4-1, 14-2.B, C, D, F Title 28 CCR, Section 1300.70 (a) (1)
42CFR, Section 447.26
California Code, Civil Code - CIV § 3428
DMHC Rule 1300.67.2.2(b)(12)

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards.

POLICY AND PROCEDURE

Policy Number	QI-119
Policy Name	Provider Preventable Conditions (PPC) and Adverse Events
Department Name	Quality Improvement Division
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~7/5/2024~~
Administrative Oversight Committee Approval Date	~~9/18/2024~~

Purpose:

To define the process by which Provider Preventable Conditions (PPCs) are identified, processed, investigated, and reported to the Department of Health Care Services (DHCS). Pursuant to the 2010 Federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations (CFR), section 447.26, 434.6(a)(12)(i), and 438.3(g) and Welfare and Institutions Code Section 14131.11, Medi-Cal managed care plans are prohibited from permitting payment of Medicaid providers for treatment of PPCs (except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider). PPC's include both the "Health Care Acquired Conditions" (HCACs) defined in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act and Other Provider Preventable Conditions" (OPPCs). Furthermore, the federal Centers for Medicare & Medicaid Services (CMS) specifies that managed care organizations must participate in reporting PPC related encounters.

Policy:

Alameda Alliance for Health (the Alliance) and Alameda Alliance ~~for~~ Wellness (D-SNP) maintains systematic processes to:

A. Promote quality care and member safety and minimize loss through;
   a. decreasing the frequency and severity of adverse events
   b. risk identification, evaluation, and management.

B. Identify, report, and manage adverse events to ensure that appropriate care is delivered during surveillance for and

correction of material causes for these events.

Procedure:

1. Reporting Requirements

A. Alameda Alliance for Health ~~(the Alliance)~~ and Almeda Alliance ~~for~~ Wellness D-SNP (The Alliance), requires all contracted providers and facilities to report all PPCs for Medi-Cal and DSNP members to the Department of Health Care Services (DHCS) via DHCS' secure online reporting portal. This applies to all PPCs not present on admission (POA) or at the time of initial treatment at a healthcare facility.

B. Alliance providers must report all PPC occurrences for Medi-Cal and DSNP members directly to the Alliance using the PPC reporting form. Reporting must be made within five (5) working days of PPC discovery to compliance@alamedaalliance.org.

C. The Alliance notifies providers of this reporting requirement via the Alliance Provider Manual and special notices.

D. It is the policy of the Alliance to identify claims and encounter data containing PPC diagnoses and report this information to DHCS via the secure online reporting portal per the requirements of APL 17-009: Reporting Requirements Related to Provider Preventable Conditions. Instructions for the online portal can be found at: http://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx. The online portal can be accessed at: https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx.

~~D.~~

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2. Screening of Claims/Encounter Data

A. Alliance Analytics Department runs a monthly report to monitor facility claims/encounters with Present on Admission (POA) indicators that contain a N, W, U or blank. Per Medi-Cal guidelines, these indicator values are to be considered as not present on admission.

The report that indicates a paid claim with a POA indicator that was not present on admission is reviewed for possible recoupment.

3. Clinical Review and Reporting of Potential PPCs

A. Potential PPCs reported to Quality from Claims, Utilization or Case Management, or discovered in the course of a PQI investigation will be reviewed to validate whether a reported incident meets the definition of a PPC. Refer to TERMS/ACRONYMS/DEFINITIONS section of this policy

B. The scope of the PPC review by Quality shall include but not be limited to, both a medical record and claims history review.

C. The potential PPC will be reviewed by the QI Nurse Reviewer to determine if the case is a potential quality issue (PQI) and will need to go through the PQI review process (see policy QI-104).

D. All potential PPCs are forwarded to the Chief Medical Officer or physician designee for

secondary review and final PPC validation.

E. Medical Director validated PPC cases may be presented to and reviewed by the Peer Review Committee (PRC) for comment and/or any corrective actions (see policy QI-104).
F. Findings of all potential PPC investigated cases will be reported to the claims department designee.
G. Notification of the reported incidents is also sent to the Alliance internal Compliance Department.

5. Payment Recoupment for Confirmed PPCs

A. The Claims department will follow the CLM-008 Overpayment Recovery policy and procedures for claims that have a POA indicator of not present on admission and associated payments will be reviewed for possible recoupment.

6. Document Retention

Copies of any PPC submissions to DHCS by the Alliance and supporting medical record evidence, as well as claims/encounter data shall be maintained in accordance with Alliance P&P CMP-012 Record Retention.

TERMS/ACRONYMS/DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below:

1. **Adverse Event** - Any unintentional, undesirable injury to a member/patient resulting from a medical intervention.

2. **Encounter** - Any single medically related service rendered by (a) medical provider(s) to a Member enrolled in Alameda Alliance for Health during the date of service. It includes, but is not limited to, all services for which the Alliance incurred any financial liability

3. **Health Care Acquired Conditions (HCACs)** - As defined in Tile 42 of the Code of Federal Regulations (C.F.R), Section 447.26(b), any one of the following conditions, occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition (HAC) by the Secretary under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act.
    a. Any unintended foreign object retained after surgery
    b. A clinically significant air embolism
    c. An incidence of blood incompatibility
    d. A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital
    e. A significant fall or trauma that resulted in fracture, dislocation, intracranial

injury, crushing injury, burn, or electric shock
   f. A catheter-associated urinary tract infection
   g. Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity
   h. A surgical site infection following:
      i. Coronary artery bypass graft (CABG) - mediastinitis Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
      ii. Orthopedic procedures; including spine, neck, shoulder, elbow
      iii. Cardiac implantable electronic device procedures
   i. Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions
   j. Iatrogenic pneumothorax with venous catheterization
   k. A vascular catheter-associated infection

4. **Provider Preventable Condition (PPC) -** A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b)

5. **Sentinel Event** - Any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof defined as any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

6. **Other Provider Preventable Conditions (OPPCs)** - As defined in 42 CFR 447.26, a condition occurring in any health care setting that meets the following criteria:
   a. Is identified by the State Plan;
   b. Is reasonably preventable through the application of procedures supported by evidence-based guidelines.
   c. Has negative consequences for the Member.
   d. Is auditable; and
   e. Includes, at a minimum, the following procedures:
   f. Wrong surgical or other invasive procedure performed on a patient.
   g. Surgical or other invasive procedure performed on the wrong body part.
   h. Surgical or other invasive procedure performed on the wrong patient.

AFFECTED DEPARTMENTS/PARTIES

Claims
Compliance
Credentialing
Grievances & Appeals
Member Services
Pharmacy
Provider Relations Department

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RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Health Equity Program
QI-104 Potential Quality Issues
CMP-012 Record Retention
CLM-08 Overpayment Recovery

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 1/1/2008, 10/28/2009, 2/26/2010, 12/10/2012, 1/18/2013, 11/6/2014, 1/7/2015, 2/11/15, 12/15/16, 4/12/2018, 01/21/2021,01/20/2021, 03/22/2022, 6/20/2023, 9/18/2024, 8/22/25

REFERENCES

Affordable Care Act of 2010 (ACA) Section 2702 DHS Contract Attachment 4, Sec. 1-9
42CFR, Section 434.6, 438.3 and 447.26, §I.H.
DHCS All Plan Letter 17-009 Reporting Requirements Related to Provider Preventable Conditions

MONITORING

This policy will be reviewed annually to ensure effectiveness.

State of California - Health and Human Services Agency Department of Health Care Services

Reporting Form to Alliance only

Medi-Cal Provider-Preventable Conditions ~~(PPC)~~ Reporting (PPC) Reporting Form

1. Name of facility		1 2. National Provider Identifier (NPI):
3. Type of facility:	0 In-patient	0 Outpatient
4. Address:		
City:	State:	Zio code:

By law, providers must identify provider-preventable conditions that are associated with claims for Medi-Cal payment or with courses of treatment furnished to Medi-Cal patients for which Medi-Cal payments would otherwise be available. See instructions for a more detailed description of PPCs.

PPC-Other Provider-Preventable Condition(OPPC) in any health care setting:	
5. Date of OPPC:	
6. O~~D~~ Wrong surgery/invasive procedure	
7. O Surgery/invasive procedure on the wrong body part	
8. O Surgery/invasive procedure on the wrong patient	
PPC-Health Care-Acquired Conditions(HCAC) in an acute inpatient setting:	
9. Date of HCAC:	
10. 0 Air embolism	11. 0 Blood incompatibility
12. 0 Catheter-associated urinary tract infection	13. 0 Deep vein thrombosis/pulmonary embolism
14. 0 Falls/trauma	15. 0Foreignobject retained after surgery
16. O Iatrogenic pneumothorax with venous catheterization	
17. O Manifestations of poor glycemic control	18.0Stage Ill or IV pressure ulcers
19. 0 Surgical site infection	20. 0 Vascular catheter-associated infection
21. Patient under 21 years old? Y O N O	
22. Patient's name:	
23. Client Index Number (CIN):	
24. Does the patient have Managed Care Medi-Cal? Y O N O	
25. Patient's address:	
City: State: Zip Code: Apt.:	
26. Name of person completing report:	
27. Title:	
28. Phone: Email: Fax:	

Signature: ———————————————— Date: ————————————

29. Mark "PROTECTED HEALTH INFORMATION: CONFIDENTIAL" and send completed report related to ~~a Medi-Cal beneficiary~~the Alliance within 5 working days of discovery to compliance@alamedaalliance.org. ~~to:~~

~~*Via Secure Fax* (916) 650-6720 Department of Health Care Services Audits and Investigations Division Occurrence of Provider-Preventable Conditions~~

~~*Via U.S. Post Office*~~

~~Department of Health Care Services Occurrence of Provider-Preventable Condition Audits and Investigations Division, MS 2100~~

~~P.O. Box 997413~~

~~Sacramento, CA 95899-7413~~

~~DHCS 7107 (Rev 5/13)~~

~~*Via UPS, FedEx, or Golden State Overnight*~~

~~Department of Health Care Services Occurrence of Provider-Preventable Condition Audits and Investigations Division, MS 2100 1500 Capitol Ave., Suite 72.624 Sacramento, CA 95814-5006~~

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INSTRUCTIONS

Providers must complete and send one form for each provider-preventable condition (PPC). Please note that reporting PPCs to the Department of Health Care Se/Vices for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare associated infections (HAis), pursuant to the Health and Safety *Code, to the California Department of Public Health for the same beneficiary. Providers must report any PPC to DHCS that did not exist prior to the provider initiating treatment for* a *Medi-Ca/ beneficiary, even if the provider does not intend to bill Medi- Cal.*

Facility information (boxes 1-4)

1. Enter name of facility where the PPC occurred.
2. Enter the facility's National Provider Identifier (NPI).
3. Check the appropriate box if the PPC occurred in an inpatient or outpatient facility.
4. Enter the street address, city, state, and zip code of the facility where the patient was being treated when the PPC occurred.

PPC - Other Provider-Preventable Condition (boxes 5-8)

5. If reporting an OPPC (inpatient or outpatient), enter the date (mm/dd/yyyy) that the OPPC occurred.
6. Check the box if the provider performed the wrong surgical or other invasive procedure on a patient.
7. Check the box if the provider performed a surgical or other invasive procedure on the wrong body part.
8. Check the box if the provider performed a surgical or other invasive procedure on the wrong patient.

PPC-Health Care-Acquired Condition (boxes9-20)
HCACs are the same conditions as hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception of reporting deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age as noted below.

9. If reporting an HCAC (inpatient only), enter the date (mm/dd/yyyy) that a provider detected the HCAC.
10. Check the box if a patient experienced a clinically significant air embolism.
11. Check the box for an incidence of blood incompatibility.
12. Check the box if a patient experienced a catheter-associated urinary tract infection.
13. Check the box if the patient experienced deep vein thrombosis (DVT) pulmonary embolism (PE) following total knee replacement or hip replacement in an inpatient setting. Do not check the box if the patient was under 21 or pregnant at time of PPC.
14. Check the box if the patient experienced a significant fall or trauma that result in:
    - Fracture
    - Dislocation
    - ~~I~~Intra-cranial injury
    - Crushing injury
    - Burn
    - Electric shock
15. Check the box for any unintended foreign object retained after surgery.
16. Check the box if the patient experienced iatrogenic pneumothorax with venous catheterization.
17. Check the box if the patient experienced any of the following manifestations of poor glycemic control:
    - Diabetic ketoacidosis
    - ~~Nonketotichyperosmolar~~Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
18. Check the box if the patient developed a stage Ill or stage IV pressure ulcer.

19. Check the box if a patient experienced:
    - Mediastinitis following coronary artery bypass graft (CABG)
    - A surgical site infection following o Bariatric surgery
        - Laparoscopic gastric bypass
        - Gastroenterostomy
        - Laparoscopic gastric restrictive surgery
    - A surgical site infection following: *(continued)*
        - o Orthopedic procedures
            - Spine
            - Neck
            - Shoulder
            - Elbow
        - o Cardiac implantable electronic device (CIED) procedures
20. Check the box if a patient experienced a vascular catheter-associated infection.

Patient information (boxes 21-25)

21. Check "yes" if the patient was under 21 years old or "no" if the patient was age 21 or older when the PPC occurred.
22. Enter beneficiary's name (last, first, middle) as listed on the Beneficiary Identification Card.
23. Enter beneficiary's Client Index Number (CIN) from the Beneficiary Identification Card.
24. Check "yes" if the beneficiary receives Medi-Cal through a managed care contract or "no" if the patient has Fee-For-Service (FFS) Medi-Cal.
25. Enter beneficiary's home street address, including city, state, zip code, and apartment number, if applicable.

Provider Contact information (boxes 26-28)

26. Enter the name of the person completing this report.
27. Enter the title of the person completing this report.
28. Enter a work phone number, email address, and fax number where DHCS can contact the person completing this report.

~~*Department of Health Care Services (box 30)*~~

~~29. Providers must send this form to the Department of Health Care Services (DHCS), Audits and Investigations Division via fax, U.S. Post Office, UPS, or FedEx. Providers must submit the form within five (5) working days of discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. The preferred~~

29. ~~methods of sending the reports for confidentiality are No. 1, overnight courier with appropriate marking, No. 2, secure fax machine with appropriate marking, and No. 3, U.S. mail with appropriate marking.~~ Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of patient information. Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

THE INFORMATION CONTAINED IN THE COMPLETED FORMS IS *PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION, UNDER FEDERAL (HIPAA) LAWS AND CA STATE PRIVACY LAWS. IT MUST BE SHARED ONLY WITH DHCS' AUDITS AND INVEST/GATIONS DIVISION. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE CONFIDENTIALITY OF THIS INFORMATION.*

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POLICY AND PROCEDURE

Policy Number	QI-133
Policy Name	Inter-Rater Reliability (IRR) - Testing for Clinical Decision Making
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior ~~Medical~~ Director, Quality
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/15/2018
Administrative Oversight Committee Approval Date	6/18/2025

POLICY STATEMENT

1. Alameda Alliance for Health (The Alliance) and Alameda Alliance Wellness (D-SNP) collaboratively as The Alliance monitors the consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.
2. The Chief Medical Officer or their designee will review and approve the assessment report of decision--making performance of staff responsible for conducting clinical reviews. The results and recommendations for improvement will be presented at least once a year to each reporting departments sub-committee (IQIC, UMC). These minutes will be presented to the Quality Improvement Health Equity Committee (QIHEC).
3. Entities delegated responsibility for clinical evaluation will also evaluate the consistency of staff in applying various criteria including but not limited to UM, BH, and Pharmacy UM Decision Making, Grievance and PQI Decision Making. Oversight of these entities' processes and compliance with NCQA standards will be conducted during the annual audit.

PROCEDURE

This Policy and Procedure (P&P) applies to all Alliance staff and clinicians who make clinical decisions.

As such, this P&P applies to the following categories of staff that will be tested as separate

groups given that their decision-making responsibilities are discrete from one another:

1. Physicians
2. Prior Authorization Clinical Reviewers
3. Inpatient Concurrent Review Nurses
4. Pharmacists
5. Quality Review Nurses
6. Long- Term Care Nurses
7. Psychologists
8. Behavioral Health Nurses, LCSWs and LMFTs

The Alliance maintains a process to ensure decisions made by non-clinical reviewers based on policy are evaluated for appropriateness of decision making. Non-clinical reviewers include:

1. Authorization Unit Specialist
2. UM Specialist
3. Quality Coordinators or Specialists and Staff
4. Grievance Specialists and Staff
5. Pharmacy Technicians
6. Behavioral Health Navigators

Although the minimum requirement is annual testing, the Alliance may conduct semi-annual testing in each year as needed.

Overall Process and Methodology

The Alliance utilizes the National Committee for Quality Assurance (NCQA) '8 and 30' Rule to evaluate the consistency of clinical decision making among staff for some departments, while others rely on the MCG Learning Site for their IRR Questions and the Internal Testing Methods developed by the Medical Directors and department leads

The '8 and 30' rule procedure for file sampling, involves reviewing an initial sample of eight files, then reviewing an additional sample of 22 files if any of the original eight fails the review (a total of 30 records).

The statistical test underlying the classification decision is based on the binomial distribution. This allows the classification decision to be based on 30 files. The use of the binomial distribution is possible because the decision based on the 8 and 30 file sampling methodology is binary – i.e., the decision based on the file review falls into one of two possible categories ("in compliance" / "out of compliance").

Pharmacy: Clinical Decision Reviewers

Within the Department of Pharmacy, the Pharmacy Director is responsible for the IRR Process.

On an annual basis, the Director of Pharmacy or Clinical Designee will randomly select 30 cases from the previous 12 months based on applicable case types and settings. The Pharmacy Director or Clinical Designee will have 8 cases reviewed for the accuracy of decisions. The Pharmacy

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Director or clinical designee will review the pharmacist determination results for each pharmacist to identify opportunities for education and process improvement. The results of the pharmacist case determinations IRR will be compiled to produce the Pharmacy Determination Accuracy Report. The Pharmacy Determination Accuracy report will be reported to the P&T Sub-Committee on an annual basis

Using the randomly selected cases, as needed, the Pharmacy Director will select and review appropriate cases with the Chief Medical Officer or Clinical Designee.

Case results are provided within 2 weeks and reviewed based on the scoring table below.

Quality Improvement: Clinical Decision Reviewers

Within the Department of Quality, the Senior~~QI Medical~~ Director of Quality or designee is responsible for the IRR Process.

On an annual basis, the Medical Director or Designee will randomly select 30 cases from the previous 12 months based on applicable case types and settings. The Medical Director will have 8 cases reviewed for the accuracy of decisions. The Medical Director or clinical designee will review the PQI Nurse Determination results for each PQI Nurse to identify opportunities for education and process

improvement. The results of the QI nurse case determinations IRR will be compiled to produce the PQI IRR Report. The QI nurses PQI Accuracy report will be reported to the IQIC and QIHEC on an annual basis.

Case results are provided within 2 weeks and reviewed based on the scoring table below.

Grievance and Appeals: Clinical Decision Reviewers

Within the Department of Grievance and Appeals, the UM Director, or designee, is responsible for the IRR Process.

The Alliance utilizes the MCG module, Inter-rater reliability (IRR), to evaluate the consistency with which staff involved in the application of UM criteria for clinical decision making. The module utilizes hypothetical cases and evidence-based criteria in the curriculum.

For situations where there is no case scenario, the UM Director, or designee, may elect to utilize UM hypothetical cases to address the situation or case conferences. The UM Director, or designee, may review each hypothetical scenario with the UM Medical Director prior to administering the IRR. The test scenario will address the:

1. Selection of the appropriate criteria for the case
2. Rationale used to make the determination
3. Final determination.

These scenarios may be administered and reviewed for consensus in the group. The extent ~~Extent~~ of agreement is evaluated using a simple test of Joint Probability of Agreement. Joint Probability of Agreement is simply the percentage of agreement among all cases by criterion.

Case results are provided immediately within the MCG module application and reviewed based on the scoring table below.

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Utilization Management: Clinical Decision Reviewers

The Alliance UM Manager and/or Director are responsible for the IRR process.

The Alliance utilizes the MCG module, Inter-rater reliability (IRR), to evaluate the consistency with which staff involved in the application of UM criteria for clinical decision making. The module utilizes hypothetical cases and evidence-based criteria in the curriculum.

Five (5) cases are randomly selected from the MCG module based on applicable case types and settings. The staff will be allowed 3 attempts for each case. Case results are provided immediately within the module application and reviewed based on the scoring table below.

For situations where there is no case scenario, the UM Director, or designee, may elect to utilize hypothetical UM cases to address the situation or case conferences. The UM Director, or designee, may review each hypothetical scenario with the UM Medical Director prior to administering the IRR. The test scenario will address the:

1. Selection of the appropriate criteria for the case
2. Rationale used to make the determination
3. Final determination

These scenarios will be made into a True/ False, Multiple Choice or Fill in the Blanks exam that may be administered and reviewed scored using methodology and programs such as a Survey Monkey Platform.

Utilization Management: Non-Clinical Decision Reviewers

Within the Department of Utilization Management, the UM Director, or designee, is ~~are~~ responsible for the IRR Process.

The Alliance maintains a process to ensure decisions made based on Alliance Policy are evaluated for appropriateness of decision making. Staff are annually evaluated to ensure the appropriate application of department policy as it relates to processing authorization requests, i.e. auto-authorizations, services that do not require prior authorization and exemption to prior authorization. The UM Director, or designee, may elect to utilize hypothetical cases or a sample of UM file cases to address the situation. The UM Director, or designee, may review each scenario with the UM Medical Director prior to administering the IRR. The test scenario will address the:

1. Selection of the appropriate policy,
2. Rationale used to make the determination; and
3. Appropriate final determination.

Behavioral Health: Clinical Decision Reviewers

The Alliance Senior Director of Behavioral Health or Medical Director are responsible for the IRR process.

approval

The Alliance utilizes the MCG module, Inter-rater reliability (IRR), to evaluate the consistency with which staff involved in the application of UM criteria for clinical decision making. The module utilizes hypothetical cases and evidence-based criteria in the curriculum. Five (5) cases are randomly selected from the MCG module based on applicable case types and settings. The staff will be allowed 3 attempts for each case. Case results are provided immediately within the module application and reviewed based on the scoring table below.

For situations where there is no case scenario or not enough cases in the MCG Module, the Senior Director of Behavioral Health, or designee, may elect to utilize hypothetical BH UM cases to address the situation or case conferences. The test scenario will address the:

1. Selection of the appropriate criteria for the case
2. Rationale used to make the determination
3. Final determination.

These scenarios may be administered and reviewed for consensus in the group. Extent of agreement is evaluated using a simple test of Joint Probability of Agreement. Joint Probability of Agreement is simply the percentage of agreement among all cases by criterion.

Case results are provided immediately within the MCG module application and reviewed based on the scoring table below. In the setting situations where there is no case scenario or not enough cases in the MCG Module, case results will be provided within 2 weeks of completion of the IRR.

Act on Opportunities

a. The respective Department Manager and/or Director will notify staff of the IRR schedule and cases for review.
b. Staff are given a defined period to complete the IRR process. As per the below table, staff are given three attempts to obtain the passing score prior to the end of the evaluation period

Score	Attempt 1: Action	Attempt 2: Action	Attempt 3: Action
High 90%-100%	No Action Required	No Action Required	No Action Required
Medium 71%-89%	Independent Materials Review then Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test

approval

Low Below 70%	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test. On-going oversight based on discretion by the Manager/Director	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test. On-going oversight based on discretion by the Manager/Director	If staff three times fails to pass the IRR, the case will be escalated to Human Resources which may result in further disciplinary action such as a Corrective Action Plan

a. The respective Department Director or Clinical Designee is responsible for the review of each staff member's IRR Performance and will review the outcomes of the evaluation with each staff member.
b. These results will be reviewed with the Respective Department Medical Director, CMO and Clinical Designee to identify any opportunities to improve the processes. These improvements may include, but are not limited to, updates to policy, processes, criteria or guidelines.

Delegate Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards.

DEFINITIONS

Inter-Rater Reliability (IRR). The degree of agreement among raters. It gives a score of how much homogeneity or consensus there is in test responses.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews

RELATED POLICIES AND PROCEDURES

None

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

approval

None

REVISION HISTORY

11/15/18, 3/21/19, 4/27/20, 3/18/21,03/22/2022, 03/21/2023, 6/12/2024,**6/18/2025**

Blue = substantive updates

REFERENCES

Department of Healthcare Services (DHCS)
Medicare Managed Care Manual Chapter 13
Title 42, CFR 422.631
~~None~~

MONITORING

The Quality Department will annually review this policy for compliance with regulatory and contractual requirements. All policies will be brought annually to the Quality Improvement Health Equity Committee and Administrative Oversight Committee.

approval

approval

POLICY AND PROCEDURE

Policy Number	QI –136
Policy Name	Clinical Practice Guidelines
Department Name	~~Health Care Services~~Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	12/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/15/2024~~
Administrative Oversight Committee Approval Date	~~12/18/2024~~

Commented [NB1]: @Thomsen, Michelle ,6.13.25 NB Reviewed: the title of this Policy states Clinical Practice Guidelines, however, the name under "Policy Statement" and Procedure state "Preventive Care Guidelines" I think we need to clarify that this is the correct title of the policy. In the MOC there is language regarding Adherence to Clinical Practice Guidelines, that we can add here if that is what is needed.

Commented [MS2R1]: @Bell, Nora yes, this is the correct title of the policy

Commented [MT3]: @Lam, Allison @DeRocht, Andrea please review for your areas

Commented [MT4]: @Lam, Allison @Findlater, Michelle Please review for UM.

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) and Alameda Alliance ~~for~~ Wellness (D-SNP) adopts, disseminates, and monitors the use of preventive care and other clinical practice guidelines in alignment with DHCS contract and other regulatory bodies. The Alliance adheres to and requires providers to follow the most current preventive care and behavioral health guidelines. The Alliance adopts and reviews other clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances and support Alliance wellness and prevention services.

PROCEDURE

~~1. Preventive Care~~Clinical Practice Guidelines

1.

1.1. Health and Safety Code sections 1342.2, 1342.3, and 1367.002 require health plans to cover preventive care items and services that have an "A" or "B" recommendation from the United States Preventive Services Task Force (USPSTF).

~~1.1.~~1.2. The Alliance requires that all network and delegate providers follow the most current preventive care guidelines.

~~1.1.1.~~1.2.1. For adults ages 21 and older, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) clinical preventive services to adults

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Review

ages 21 and older. All preventive services identified as USPSTF "A" and "B" recommendations must be provided.

~~1.1.2.~~1.2.2. For children and adolescents under 21 years old, Alliance providers are required to follow the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule, the ACIP, and/or the American Academy of Family Physicians.

~~1.1.3.~~1.2.3. The Alliance provides perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG).

~~1.1.4.~~1.2.4. The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) of the federal ~~and approved by the~~ Centers for Disease Control and Prevention (CDC), California Department of Public Health, or ~~and~~ other medical associations, regardless of member's age, sex, or medical condition, including pregnancy.

~~1.1.4.1.~~1.2.4.1. Adult vaccines recommended by the U.S. Food and Drug Administration (FDA), ~~and~~ ACIP, or California Department of Public Health are covered by the Alliance, without cost sharing or utilization management

~~1.1.4.2.~~1.2.4.2. Documentation of each member's need for ACIP recommended immunizations is required as part of all regular health visits, including but not limited to illness, care management, or follow up appointments, initial health appointment (IHAs), pharmacy services, prenatal and postpartum care, pre-travel visits, sports, school, or work physicals, visits to a local health department, and well patient check ups

~~1.1.4.3.~~1.2.4.3. All health care providers who administer vaccines must submit patient vaccination records to local health departments and appropriate immunization registries within the specified timelines in accordance with Health and Safety Code (H&S) 120440 and 16 CCR 174.4 (e) as applicable.

~~1.1.4.4.~~1.2.4.4. All immunization records must be reported within 14 calendar days, in accordance with state and federal law.

~~1.2.~~1.3. Mental and Behavioral Health Guidelines

~~1.2.1.~~1.3.1. The Alliance uses the following criteria for provision of Behavioral and Mental Health services: Milliman Clinical Guidelines, CALOCUS, LOCUS, ECSII, ~~and the~~ DHCS APL 23-010 Autism Spectrum Disorders, and ASAM for Substance Use Disorder. ~~APA Board Guidelines for Autism Spectrum Disorders~~.

~~1.3.~~1.4. Alliance providers must document the status of recommended services, The Alliance informs providers about required preventive care guidelines through:

~~1.3.1.~~1.4.1. Alliance clinical practice guidelines webpage

~~1.3.2.~~1.4.2. Quarterly provider communications

~~1.4.~~1.5. The Alliance monitors the use of required preventive care guidelines through Managed Care Accountability Set (MCAS)/Healthcare Effectiveness Data Information Set (HEDIS)/STARS performance, the Facility Site Review and Medical Record Review process, Initial Health Appointment (IHA) rate monitoring and chart audits, or ad hoc chart reviews. See Alliance policy *QI-005 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS) and QI-124 Initial Health Appointment.*

Commented [MS5]: @Currie, Peter Please review BH guidelines

Commented [6R5]: 1.2.1. is not completely correct. It should read "The Alliance uses the following criteria for provision of Behavioral and Mental Health services: Milliman Clinical Guidelines, CALOCUS, LOCUS, ECSII and the DHCS APL for Autism Spectrum Disorders."

Commented [MS7R5]: @Currie, Peter Updated!

Commented [CP8R5]: If you need the reference to the specific APL for Autism Spectrum Disorders it is APL 23-010. Also if you need to reference SUD we use ASAM criteria.

Commented [MS9R5]: @Currie, Peter added.

2. Clinical Practice Guidelines

2.1. The Alliance adopts, disseminates, and monitors the use of evidence-based ~~other~~ clinical practice guidelines (including MCG):~~to ensure high-quality care for its Dual Special Needs Plan (D-SNP) population and support to providers directly on Alameda Alliance for Health's Clinical Practice Guidelines webpage (Clinical Practice Guidelines-Alameda Alliance for Health) and Alliance staff. Adopted guidelines:~~

2.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field.

~~2.1.1.~~

2.1.2. Consider the needs of Members.

2.1.3. Stem from recognized organizations (e.g. American Diabetes Association, American Heart Association, American Thoracic Society, etc.) that develop or promulgate evidence-based clinical practice guidelines or are developed with involvement of board-certified Providers from appropriate specialties.

2.2. The guidelines are reviewed by the ~~Quality Improvement~~ Medical Director, subcontractors, and other network providers as appropriate. They are approved for adoption by the Internal Quality Improvement Committee (IQIC) and Quality Improvement Health Equity Committee.

2.3. The guidelines are reviewed and updated at least every two years.

2.4. The Alliance distributes the adopted clinical practice guidelines through the Alliance clinical practice guidelines webpage, provider communications, and on request.

~~2.4.~~2.5. For D-SNP, the Alliance~~s~~ utilizes National Coverage Determinations, Local Determinations when determining medical necessity.

Commented [NB10]: @Thomsen, Michelle Taken from the MOC page 171

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DEFINITIONS / ACRONYMS

AAP – American Academy of Pediatrics
ACIP - Advisory Committee on Immunization Practices
ACOG – American College of Obstetrics and Gynecology
CDC - Centers for Disease Control and Prevention
DHCS - California Department of Health Care Services
QIHEC – Quality Improvement Health Equity Committee
IQIC – Internal Quality Improvement Committee
PHM - Population Health Management
USPSTF – United States Preventive Services Task Force
NCD – National Coverage Determinations
LCD – Local Coverage Determinations

AFFECTED DEPARTMENTS/PARTIES

Behavioral Health
Case Management
Provider Services
Quality Improvement
Claims
Pharmacy

Preview

Utilization Management

RELATED POLICIES AND PROCEDURES

QI-105	Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-124	Initial Health Appointment (IHA)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

New Policy: 12/19/2023
Revision: 12/18/2024, 9/24/25

Red = Substantive Updates

REFERENCES

DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract
DHCS APL 24-008 Immunization requirements
Alameda Alliance For Health D-SNP Model of Care
Medicare Managed Care Manual
Title 42 CFR 422.202, 422.137
APL 25-015 Assembly Bill 144 and Coverage of Preventive Care Services

MONITORING

This Policy will be reviewed annually

review

POLICY AND PROCEDURE

Policy Number	~~DSNP~~ QI-101
Policy Name	~~DSNP~~ Quality Improvement and Health Equity Program
Department Name	~~Health Care Services Division~~Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality ~~Improvement~~
Line(s) of Business	~~MCAL, IHSS~~ DSNP, MCAL, IHSS
Original Effective Date	~~9/28/2006~~ 01/01/2026
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~7/5/2024~~
Administrative Oversight Committee Approval Date	~~9/18/2024~~

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POLICY STATEMENT

This policy ensures the development and implementation of a Quality Improvement and Health Equity (QIHE) Program, and the appropriate monitoring of the adequacy, accuracy, accountability and activities of the functions conducted as part of the QIHE Program. Alameda Alliance for Health (the Alliance) continuously monitors, evaluates, and takes action to address any needed improvements in the quality of care and health equity in its network. The QIHE Program is an organizational-wide, cross-divisional and comprehensive program that encompasses the Alliance's commitment to the delivery of quality and equitable health care services including the integration of quality, population health, and health equity principles.

The QIHE Program exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 422.152 438.330 and 438.340. Additionally, QIHE Program oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QIHE Program as applicable.

Quality Improvement Health Equity Program (QIHE) strives to ensure that ~~our D-SNP population~~all Alliance members (i.e. Medi-Cal, IHSS, and DSNP) have access to high-quality and safe healthcare services tailored to meet ~~their~~ each~~the D-SNP~~ population's unique needs. The Quality Improvement Health Equity (QIHE) program manages the governance, structure, operations, scope, goals, and measurable objectives of the~~our~~ quality program.

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PROCEDURE

A. Scope

The Alliance ensures that Network Providers, Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors (if an existing contract exists), participates and are updated on the QIHE Program and Population Needs Assessment activities, findings, and recommendations by the Quality Improvement Health Equity Committee (QIHEC). The QIHE Program encompasses quality of care, quality of services, patient safety, member experience, including health equity principles. The QIHE program objectively monitors and evaluates the quality, safety, appropriateness, and outcomes of care and services delivered to members. Its overall goal is to ensure that members have access to safe, effective, equitable medical and behavioral health care services aligned with their population needs.

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B. Board of Governors (BOG)

a. The Alliance's Board of Governors (BOG) maintains the ultimate authority and responsibility for the QIHE Program.
b. The BOG assesses the QIHE Program's effectiveness and direct modification of operations as indicated.
c. The Alliance BOG approves the overall QIHE Program and has delegated the QIHEC to oversee the QIHE Program.
d. The BOG routinely receives written progress reports from QIHE describing actions taken, progress in meeting QIHE Program objectives, and improvements made.

C. Quality Improvement Health Equity Committee (QIHEC)

The QIHEC oversees the development, implementation, and effectiveness of the QIHE Program and is accountable to the BOG. The activities are supervised by the Chief Medical Officer (CMO) and Medical Director of Quality, in collaboration with the Chief Health Equity Officer. The QIHEC oversees subcommittees and workgroups including, Access and Availability, Cultural and Linguistic, Internal Quality, DSNP Subcommittee, the Utilization Management Committee, and all subcommittees reporting to the Quality Improvement Health Equity Committee. The QIHEC is chaired by the Chief Medical Officer (CMO) and vice-chaired by the Medical Director of Quality.

1. The QIHEC is responsible for the following activities:
   a. Analyzes, evaluates, and provides feedback on the results of QIHE activities
   b. Ensures practitioner participation in the QIHE Program through planning, design, implementation or review
   c. Recommends needed actions
   d. Ensures follow-up, as appropriate
   e. Maintains signed and dated meeting minutes
   f. Oversee quality improvement projects ensuring timely execution and evaluation.
   g. Institutes actions and follow up to address performance deficiencies, including policy recommendations
   h. Review and approve the QIHE Trilogy Documents including the QIHE Program Description, Evaluation, and Workplan
   i. Review and approve the CM Trilogy Documents including the QIHE Program Description, Evaluation, and Workplan
   j. Review and approve the UM Trilogy Documents including the QIHE Program Description, Evaluation, and Workplan

k. Monitor and evaluate the DSNP Model of Care and workplans.

2. The QIHEC meets a minimum of four times per year or as often as needed, to follow-up on findings and required actions. For all meetings, the Senior Director of Quality or designee will submit QIHEC documents as required to the Compliance Department for monitoring, tracking, storing, and submission to the Department of Health Care Services (DHCS)
3. A written summary of the QIHEC activities, findings, recommendations, and actions are provided to the BOG, CMS, and DHCS upon request. QIHEC activities are made publicly available on the website at least on a quarterly basis.
4. QIHEC members are a multidisciplinary team that includes clinical leaders, Care management, Behavioral health, and Compliance representatives, and are representative of the contracted provider network, including but not limited to, subcontractors who provide health care services to the plan's members including, the most vulnerable population, seniors and persons with disabilities or chronic conditions (SPDs), members affected by health disparities, Limited English Proficiency (LEP), and for Children with Special Health Care Needs (CSHCN).
5. All providers participating in the QIHEC or any of its subcommittees, or other QIHE program activities, will be required to sign and annually renew confidentiality and conflict of interest agreements.

D. QIHE Program Description

1. On an annual basis, the BOG and QIHEC will review and approve a comprehensive QIHE Program Description. This description will include at a minimum, the following:
    a. QIHE Program scope, goals and measurable objectives
    b. QIHE Program structure
    c. Organizational chart showing the key staff and the committees and governing bodies responsible for quality improvement activities
    d. Qualifications of staff responsible for QIHE studies and activities
    e. Behavioral health aspects of the program
    f. How patient safety is addressed
    g. Involvement of a designated physician in the QIHE Program
    h. Involvement of a behavioral health practitioner in the mental health aspects of the program
    i. Oversight of QIHE functions by the QIHE Committee
    j. The specific role, structure and function of the QIHE Committee and other committees, including meeting frequency
    k. The resources and analytic support devoted to the QIHE Program
    l. Objectives for serving a culturally and linguistically diverse membership
    m. Objectives for serving members with complex health needs
    n. Objectives for serving the most vulnerable population
    o. Objectives and processes for engaging members and caregivers in the development of QI and health equity activities and interventions
2. The QIHE Program will address the following:
    a. Processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, or health status, and that all covered services are provided in a culturally and linguistically appropriate manner
    b. Processes and procedures to identify, evaluate and implement interventions that focus on reducing Health Disparities, in parallel with the Population Health Management Program and Health Equity Department
    c. Processes and procedure that incorporate data analysis to identify differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to members
    d. Processes and procedures to develop equity-focused interventions to address the underlying factors of identified Health Disparities, including Social Drivers of Health (SDOH)
    e. Objectives to meet disparity reduction targets for specific populations and/or measures as the most vulnerable population and as identified and as directed by DHCS and as directed under Exhibit A.III Subsection 2.2.9.A Mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

E. QIHE Communications

a. The Alliance annually makes information about the QIHE Program and results available to members through the following methods and not limited to, the member handbook, member newsletters, or Alliance website, and providing information to members on how to obtain information about the QIHE Program and results if they are not able to access the website.

b. The Alliance publishes articles about the QIHE program, activities, and outcomes through the following methods and not limited to, the provider bulletin for practitioners, provider manual, provider packets, or the Alliance website.

F. QIHE Work Plan and Evaluation

a. The Quality Department will prepare an annual QIHE Work Plan that addresses the following:

i. An overview QIHE activities, highlighting areas of success and identifying opportunities for improvement. These areas may include data on performance measures and utilization, the results of the Managed Care Accountability Sets (MCAS), CAHPS and HOS survey results, Star measure performance, health equity outcomes, and outcomes/findings from Quality Improvement Projects (QIPs), Chronic Care Improvement Project, DHCS Performance Improvement Projects (PIPs), consumer satisfaction surveys, case management surveys, provider satisfaction surveys, and collaborative initiatives

ii. Addresses clinical quality of physical, behavioral health, access and engagement of providers continuity and coordination across settings and all levels of care, and member experience

iii. Population Health Management activities and findings

iv. Quality of Care

v. Quality of Service

vi. Safety of Clinical Care

vii. Program Scope

viii. Annual Objectives / Goals

ix. Annual Planned Activities

x. Time Frames within which each activity is to be achieved

xi. Staff member responsible for each activity

xii. Monitoring previously identified issues

b. The Quality Improvement Department, made up of Clinical Safety, Quality Performance, Access and Availability, Accreditation, and Population Health & Equity encompassing Health Education and Cultural and Linguistic Services, will prepare an annual written evaluation of the QIHE Program that includes:

i. A description of completed and ongoing QIHE activities that address quality, health disparities and equity and safety of clinical care and quality of service

ii. Trending of measures to assess performance in the quality and safety of clinical care and quality of service

iii. Analysis of the results of QIHE initiatives, including barrier analysis

iv. Evaluation of the overall effectiveness of the QIHE Program, including

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v. progress toward influencing safe clinical practices
vi. Methods to address External Quality Review Organization (EQRO) technical report and evaluation report recommendations.
vii. Methods for equity-focused interventions to identify patterns for over- or under-utilization of physical and behavioral health care services
viii. Member and/or family focused care through member and community engagement, such as review of Community Advisory Committee (CAC) findings and other sources to inform QIHE policies and decision-making

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c. On an annual basis, accreditation status will be reported to QIHEC including copies of reports from independent private agencies for the Alliance, Subcontractors, and Downstream Subcontractors by providing accreditation status, survey type, level, accreditation agency results and recommended actions/improvements, corrective action plans, and summaries, along with accreditation expiration date.

d. The QIHEC and BOG will annually review and approve the QIHE Trilogy documents: Program Description, Quality Improvement Work Plan, and Evaluation, Quality Improvement Project (QIP), and Chronic Care Improvement Project (CCIP). The Model of Care will be reviewed and approved based on CMS ratings and corresponding timelines for re-submission.

e. Model of Care (MOC) Submission and Approval

The Alliance will submit an evidence-based MOC to CMS for NCQA evaluation and approval in accordance with CMS guidance. The MOC will provide the following:

i. Structure for care management processes and systems that will enable the Alliance to provide coordinated care for special needs individuals
ii. Description of the SNP population
iii. Care coordination
iv. SNP Provider Network
v. MOC quality measurement and performance

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Quality Monitoring Activities

The Alliance aligns internal quality and health equity efforts with DHCS' Comprehensive Quality Strategy Report, monitor and report quality performance measures, and also review and act on items identified through DHCS' reports.

The Alliance participates in DHCS mandated statewide collaborations or additional initiatives that may improve quality and equity of care for Medi-Cal members as directed by DHCS. The Alliance will leverage DHCS' Regional Quality and Health Equity teams to support quality and health equity work. The Alliance has assigned a Performance Improvement Lead and a back up contact to participate in these teams and report performance measurements to DHCS.

As applicable, the Alliance uses the DHCS' External Quality Review Organization (EQRO) File Transfer Protocol (FTP) website when sending communications containing patient-level data to DHCS.

1. **Managed Care Accountability Sets (MCAS) and HEDIS**
   a. The Alliance will calculate and report all HEDIS measures and other quality and health equity performance measures as specified by DHCS, DMHC, CMS and NCQA.
   b. The results of these performance measures shall be audited by an external MCAS/HEDIS Compliance Auditor licensed by and listed on NCQA's website. The methodology used is compliant with HEDIS Compliance audit standards, policies and procedures.
   c. Final audit reports from the NCQA-licensed audit firm will be available to CMS as needed.
   d. Medicare Health Outcomes Survey (HOS) will be completed following CMS guidelines using a NCQA certified vendor for administration of the survey.
   e. Medicare CAHPS surveys will be completed following CMS guidelines using an approved MA & PDP (Medicare Advantage and Prescription Drug Plan) CAHPS vendor for administration of the survey
   f. The Alliance is required to conduct additional Quality Improvement and Health Equity improvement projects as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide

2. **Quality Improvement and Health Equity Projects**
   a. Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs)
      i. The Alliance will conduct a minimum of two Performance Improvement Projects (PIPs) or Quality Improvement Projects (QIPs) as mandated by Centers for Medicare and Medicaid or DHCS. One PIP may be a DHCS facilitated statewide collaborative.
      ii. The Alliance reports audited results on the required performance measures to DHCS.
      iii. The Alliance attends, at a minimum, quarterly regional collaborative meetings that may be in person

b. The Alliance shall identify opportunities for QIPs/PIPs through meetings, data analysis, HEDIS assessments, and day-to-day operations.
c. The Alliance will engage with local partners and delegates when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.
d. The Alliance will comply with MMCD All Plan letter 24-004 and subsequent updates and shall use the QIP reporting format as designated by DHCS
e. The Alliance conducts quantitative and qualitative data collection to drive quality improvement and health equity projects
f. The Alliance drives performance improvement projects to exceed Minimum Performance Level (MPL) rates for each required Quality Performance Measures and Health Equity Measure selected by DHCS and DMHC
g. The Alliance leads strategies to achieve benchmarks for DSNP Stars

3. Consumer Satisfaction Survey

The Alliance conducts annual member satisfaction survey in accordance with Consumer Assessment of Health Providers and Systems 5.1H (CAHPS) survey methodology, that comply with DHCS APL17-014, with the DHCS contract, exhibit A, attachment 5, section 1.G., and with Title 42, Code of Federal Regulations, section 423.156. The Alliance conducts the Health Outcomes Survey (HOS) for DSNP members as required by CMS. Refer to policy QI- 117 Member Satisfaction Survey (CAHPS)

4. Network Adequacy Validation

The Alliance participates in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months in compliance with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358. Refer to policy PRV-003 *Provider Network Capacity Standards.*

5. Encounter Data Validation

The Alliance participates in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d), and 438.818.

6. Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Quality Assurance Performance Improvement (QAPI)

The Alliance maintains a comprehensive SNF/LTC QAPI program to comply with APL 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care and described in policy LTC- 001 *Long Term Care Program.* In addition, the Alliance maintains a quality monitoring program to comply with APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities

7. Focused Studies

The Alliance participates in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by Contractor

8. Health Disparities Report

The Alliance references the DHCS' Health Disparities report that describes health disparities in the Medi-Cal and D-SNP populations to inform QIHE activities

9. Preventive Services Report

The Alliance references the DHCS' Preventive Services report that describes preventive services in the Medi-Cal population to inform QIHE activities.

10. Technical Assistance

The Alliance participates in mandatory and optional activities described in 42 CFR section 438.358 and Medi-Cal Contract

11. Site Review

The Alliance conducts site review requirements as described in policy QI -105 *Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Reviews.* Other types of site or medical reviews may be conducted as required by DHCS or for quality monitoring purposes.

12. Potential Quality Issue (PQI)

The Alliance conducts PQI monitoring processes as described in policy QI-104 *Potential Quality Issues*

13. Health Equity and Quality Measure Set (HEQMS)

The Alliance reports health equity and quality measure sets (HEQMS) as required by the Department of Managed Health Care (DMHC) as described in APL 24-013 Health Equity and Quality Program Policies and Requirements

14. Other quality monitoring activities

The Alliance will comply with QIHEC activities as mandated by the BOG or State and Federal laws and regulations

AFFECTED DEPARTMENTS/PARTIES

All Alliance departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Quality Improvement Health Equity Program Description
Quality Improvement Health Equity Work Plan
Quality Improvement Health Equity Program Evaluation
QI-117 Member Satisfaction Survey (CAHPS)
PRV-003 Provider Network Capacity Standards.
LTC- 001 Long Term Care Program
QI -105 Facility site Reviews, Medical Record Reviews, and Physical Accessibility Reviews.
QI-104 Potential Quality Issues

REVISION HISTORY

9/28/2006, 7/13/2007, 1/1/2008, 10/28/2009, 2/26/2010, 9/18/2012, 11/6/2014, 11/10/2016, 10/18/2018, 3/21/19, 3/19/2020, 3/22/2022, 3/31/2023, 6/20/2023, 12/19/2023**, 9/18/2024, 9/25/25**

Red = substantive changes

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment 3
MMCD All Plan Letter 23-004 Skilled Nursing Facilities – Long Term Care Benefit

Standardization and Transition of Members to Managed Care
MMCD APL 23-023 Intermediate Care Facilities for Individuals with Developmental
Centers for Medicare and Medicaid, Medicare Managed Care Manual
Centers for Medicare and Medicaid Services, Code of Federal Regulations Title 42
Alameda Alliance for Wellness D-SNP Model of Care
MMCD All Plan Letter 24-004 Quality Improvement Health Equity Transformation Requirements
DMHC APL 24-013 Health Equity and Quality Program Policies and Requirements

MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	QI-D-001
Policy Name	Quality Improvement Project Selection Criteria
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director Quality Improvement
Lines of Business	D-SNP
Effective Date	1/1/2026
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

Alameda Alliance Wellness (The Alliance) is committed to a robust Quality Improvement Health Equity Program that complies with Centers for Medicare and Medicaid Services (CMS) requirements under 42 CFR §422.152, which mandates those offering a Dual Special Needs Plan implement data-driven quality improvement initiatives. This policy establishes the criteria and process for selecting Quality Improvement Projects (QIPs) to ensure they address high-impact clinical and non-clinical areas, improve health outcomes, and beneficiary satisfaction, reduce disparities in healthcare, and align with CMS priorities such as the 3-year QIP on reducing 30-day all-cause hospital readmission rates. Selection will prioritize evidence-based rationale, measurable potential impact, and integration with the organization's Model of Care, utilizing the Plan-Do-Study-Act (PDSA) model for systematic evaluation and alignment with broader CMS goals like integrated care coordination.

This policy applies to all parties contributing to DSNP including leadership, quality improvement staff, data analysts, interdisciplinary care teams (ICTs), and stakeholders involved in identifying and prioritizing QIPs. This policy ensures QIPs are selected based on opportunities for improvement identified through data analysis, targeting populations with multiple or severe chronic conditions, and addressing unique needs of DSNP members.

PROCEDURE

1. Plan Phase (Basis for Selection, Program Design, and Anticipated Barriers):

Collaboration

1.1. Select the QIP focus based on data indicating high readmission rates impacting member health, quality of life, and costs, aligned with CMS goals for DSNP plans to target chronic conditions and care transitions.
1.2. Define the target population using claims data to identify members with frequent admissions (2 or more in 12 months) or high-risk diagnoses (e.g., heart failure, COPD, diabetes). Apply risk stratification incorporating clinical factors (comorbidities, medication adherence) and SDOH (e.g., housing instability, transportation barriers).
1.3. Automatically enroll high-risk members with opt-out provisions communicated via mail and care coordinator calls.
1.4. Establish an aim statement e.g., (By December 31, 2028, reduce the 30-day-all-cause hospital readmission rate for DSNP members by 10% via targeted care coordination, SDOH interventions, and predictive analytics).
1.5. Anticipate barriers including low member engagement (e.g., due to health literacy or mistrust), data integration challenges, and resource limitations. Develop mitigations such as cultural competency training for staff, interoperable systems for SDOH-clinical data, and community partnerships.
1.6. Integrate with the MOC by incorporating health risk assessments (HRAs), individualized care plans (ICPs), and ICTs.

2. Do Phase (Implementation of Interventions):
2.1. Deploy interventions including:
2.1.1. Enhanced Care Transitions: ICTs to create ICPs within 48 hours of discharge, covering medication reconciliation, follow-up appointments, and home visits or telehealth check-ins.
2.1.2. SDOH Support: Collaborate with community partners to provide transportation vouchers, meal delivery, and assistance for food/housing insecurity.
2.1.3. Patient Education and Technology: Offer tailored self-management education via telehealth/in-person and use predictive analytics to flag at-risk members for proactive interventions.
2.2. Track implementation metrics, such as number of post-discharge ICT activities, community services utilized (e.g., rides, meals), and analytic tool effectiveness in risk identification.
2.3. Ensure interventions are culturally sensitive and accessible, supporting CMS requirements for reducing disparities in DSNP populations.

3. Study Phase (Outcome Measures, Methodology, and Findings Analysis):
3.1. Collect data from claims (readmission rates), EHRs (clinical outcomes), and member surveys (satisfaction/engagement).
3.2. Compute baseline and ongoing rates: (e.g., Number of readmissions within 30 days/Total acute inpatient discharges) x100.
3.3. Monitor trends monthly via statistical process control (SPC) charts and perform quarterly regression analyses, controlling for age, comorbidities, and SDOH.
3.4. Analyze annual results (Years 1-3): Numerator (readmissions), denominator (discharges), progress toward 10% reduction, SPC trends, SDOH intervention impact, and satisfaction percentages (e.g., % satisfied with care coordination).

4. Act Phase (Annual Updates, Barrier Mitigation, Next Steps, Best Practices, and Lessons Learned):
4.1. Prepare annual HPMS updates detailing implemented interventions, barriers (e.g., vendor delays in meal delivery) and mitigations (e.g., alternative partners), findings

(e.g., on-track status), next steps (e.g., in-hospital pre-discharge meetings, additional engagement programs), best practices (e.g., ICT SDOH training, community partnerships), lessons learned (e.g., early engagement criticality, flexible delivery modes).

4.2. If not meeting goals, revise interventions (e.g., enhance predictive models) and document in subsequent updates, per CMS guidance for iterative improvement.

DEFINITIONS

- Quality Improvement Project (QIP): A focused, multi-year initiative under the Quality Improvement Program to address specific areas like readmissions using PDSA for measurable improvements in health outcomes.
- 30-Day All-Cause Hospital Readmission Rate: Percentage of unplanned readmissions within 30 days post-discharge.

AFFECTED DEPARTMENTS/PARTIES

Care Management
Quality Improvement
Utilization Management

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RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

QI 101 Quality Improvement Health Equity Program

REVISION HISTORY

REFERENCES

- Centers for Medicare & Medicaid Services (CMS). 42 CFR §422.152: Quality Improvement Program. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-D/section-422.152.
- CMS. Medicare Managed Care Manual, Chapter 5: Quality Assessment. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf.
- CMS. Medicare Advantage Quality Improvement Program. Available at: https://www.cms.gov/medicare/advantage-quality-improvement-program.
- CMS. Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F). Available at: https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f.
- Department of Health Care Services (DHCS). CalAIM Policy Guide.
- National Committee for Quality Assurance (NCQA). Quality Improvement Standards and SNP Model of Care Requirements.

Collaboration

- CMS. D-SNPs: Integration & Unified Appeals & Grievance Requirements. Available at: https://www.cms.gov/medicare/medicaid-coordination/about/dsnps.

MONITORING

This policy will be evaluated annually for effectiveness and approved at the Quality Improvement Health Equity Committee (QIHEC) .

collaboration

POLICY AND PROCEDURE

Policy Number	QI-D-002~~XX~~
Policy Name	QI Health Outcomes Survey Policy
Department Name	Quality Improvement ~~Health Equity~~
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Lines of Business	DSNP
Effective Date	01/01/2026
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

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POLICY STATEMENT

~~The Alameda Alliance for Wellness (D-SNP) is committed to supporting the successful administration and oversight of the Medicare Health Outcomes Survey (HOS) in compliance with the Centers for Medicare & Medicaid Services (CMS) Title 42, Code of Federal Regulations (CFR), Sections, 422.162, 422.164, 422.166 and 422.252. ,National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards, California's Department of Health Care Services (DCHS DHCS) requirements. The questions on the survey relate to the member's physical and mental health, daily activities, and sleep patterns. The HOS asks members a series of questions that measures how effective the plan is in improving and/or maintaining mental and physical health and about conversations members have with providers about fall prevention, bladder control and physical exercise. This policy supports continuous quality improvement by identifying opportunities to deliver high-quality healthcare services, ensuring safety, and promoting member satisfaction, while incorporating measurable goals for care coordination, transitions, and utilization.~~

Purpose:

This policy outlines the requirements and procedures for administering the Health Outcomes Survey (HOS) for Dual Eligible Special Needs Plans (D-SNPs) enrolled in Alameda Alliance Wellness D-SNP, in alignment with federal Centers for Medicare and Medicaid (CMS) guidelines and the California Department of Healthcare Services (DHCS) California-specific mandates under the CalAIM initiative.

Policy:

Alameda Alliance Wellness must ensure timely and accurate administration of the Health Outcomes Survey (HOS) as part of their Medicare Advantage reporting and quality improvement obligations. The HOS is a critical tool used to assess the physical and mental

health status of enrollees over time and supports care coordination, quality measurement, and compliance with CMS and DHCS requirements.

SCOPE

This policy applies to all staff, vendors, and delegated entities involved in the administration, reporting, and analysis of HOS data for D-SNP members.~~This policy applies to Alliance DSNP members completing the HOS as well as all Alliance departments involved in the care of the DSNP members. all Medicare Advantage and D-SNP lines of business where the HOS is a regulatory or contractual requirement. It includes Health Plan operations, Quality Improvement (QI), and Medicare Compliance. The HOS is a patient-reported outcomes measure that evaluates the physical and mental health status of Medicare beneficiaries over time. This policy ensures that D-SNP members are appropriately included and that survey data is used for quality improvement initiatives.~~

PROCEDURE

Survey Administration

1. **Compliance with CMS Protocols:**
   Alameda Alliance Wellness follows CMS protocols for HOS sampling, survey distribution, data collection, and reporting. This includes adherence to timelines, survey formats, and data submission standards.
2. **Integration with CalAIM Model of Care:**
   HOS results will be incorporated into the Alameda Alliance Wellness Model of Care (MOC) framework, including updates to Individualized Care Plans (ICPs) and Health Risk Assessments (HRAs), as required by CMS and DHCS.
3. **Member Communication and Accessibility:**
   Alameda Alliance Wellness ensures that survey materials are accessible to members with limited English proficiency, disabilities, or other barriers. This includes providing translated materials and alternative formats as needed.
4. **Data Use and Quality Improvement:**
   HOS data is used to inform quality improvement initiatives, care coordination strategies, and population health management. Plans must demonstrate how HOS findings are used to improve member outcomes.
5. **Oversight and Monitoring:**
   Alameda Alliance Wellness maintains documentation of HOS processes and outcomes, in preparation for audits or reviews by CMS and DHCS. Internal monitoring includes vendor performance, response rates, and data integrity.
6. **Training and Education:**
   Staff and providers involved in care coordination must be trained on the importance of HOS, its integration into the MOC, and how to support member participation.

~~The HOS is administered annually (July-November) by a CMS-approved survey vendor, offering surveys in English, Spanish, Chinese, and Russian. to a random sample of eligible beneficiaries. The health plan collaborates with the survey vendor to confirm accurate member eligibility and contact information, including D-SNP members..~~

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- A random sample of 500-1200 DSNP members are selected. The If fewer than 500 members are enrolled, the Alliance is exempt from mandatory participation.
- A mixed-mode protocol is used with two mailings and telephone follow-up for non-respondents. The CMS-approved survey vendor provides summary progress reports.
- For follow-up surveys (two years after baseline), surviving members from the original sample are resurveyed.

Member Inclusion

- The plan ensures all eligible MA and D-SNP members are included in the CMS sampling frame. Members must have been enrolled for at least six months prior to the sampling period to be eligible.

Member Notification and Education

- The plan may provide general information and reminders to members about the importance of completing the survey. Educational materials are developed in a culturally and linguistically appropriate manner, including for D-SNP populations.
- Notify DSNP members of possible HOS selection via newsletters or communications, using CMS-approved language to encourage participation without influencing responses.
- Educate members on the survey's role in improving health and plan quality through general communications, emphasizing voluntary participation and confidentiality; provide contact information to survey vendor to boost response rates.
- For providers, educational materials on provider role in supporting completion of HOS provided via provider portals.

Data Use and Quality Improvement

- Results from the HOS are reviewed annually. Trends in physical and mental health outcomes are analyzed to identify disparities and target interventions. Findings are incorporated into the Quality Improvement Work Plan (QIWP) and the Model of Care for D-SNPs.
- The goal is to see how well health plans help beneficiaries maintain or improve their health over time.
- HOS results are analyzed by the QI Department to identify trends in member health status, functional limitations, and care needs.
- Findings from the HOS are used for the development of targeted interventions:
  - Enhanced care coordination for members with ADL limitations.
  - Chronic disease management programs for prevalent conditions (e.g., heart failure, diabetes).

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Collaboration

- Behavioral health referrals for members reporting poor mental health scores.
- The QI department will use HOS data to develop strategies for improving STAR ratings, such as member education on preventive care.

Reporting

- The QI team prepares HOS results reports for internal leadership
- Quality Committees, and external regulatory bodies as applicable.
- HOS-related performance metrics may be used to support STAR Ratings and NCQA accreditation requirements.
- The CMS approved vendor collects survey responses, ensuring data integrity and compliance with HIPPA and CMS data security requirements.
- The Alliance will provide summarized HOS findings to providers and care coordinators to guide care planning.

Monitoring and Evaluation

- Annual review of vendor performance
- Survey response rates, and result accuracy
- Identification of barriers to participation, particularly among D-SNP members, with corrective action planning as needed.
- Conduct annual audits of HOS processes to ensure adherence to federal and state standards.
- The QI Department conducts quarterly reviews of the survey vendor's performance, including response rates, data accuracy, and member feedback.
- All HOS data is stored in a secure, HIPPA-compliant database with restricted access to authorized personnel.

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DEFINITIONS

- **HOS: Health Outcomes Survey** a CMS required survey that assesses a health plan's ability to maintain or improve its Medicare members' self-reported perception of their physical and mental health functioning over a two-year period. , administered annually to a random sample of beneficiaries.
- **D-SNP: Dual Eligible Special Needs Plan**, a type of Medicare Advantage plan for individuals eligible for both Medicare and Medicaid.
- **Vendor: CMS**- A list of the CMS approved vendors is posted on the HOS Website (https://www.hosonline.org). Once the health plan has selected the vendor, the health plan completes the selection form online. (-https://www.ncqa.org/hedis/measures/hos/survey-vendor-selection-form/)

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Collaboration

~~**DEPARTMENT RESPONSIBILITIES**~~**Affected Departments/Parties**

- Quality Improvement
- Compliance
- Member Services
- Provider Services
- Case Management

~~This policy applies to all departments and business units that contribute data to or use outputs from the Quality Improvement Program for D-SNP members, including but not limited to:~~

- ~~**Quality Improvement:** Oversees the use of HIS for QI activities, defines data needs, validates quality metrics, and ensures data integrity.~~
- ~~**Compliance**: Ensures the system meets federal and state regulatory requirements (e.g., HIPAA, CMS, NCQA).~~

RELATED POLICIES AND PROCEDURES

QI -101 Quality Improvement Health Equity Program
QI-114 Monitoring of Access and Availability Standards

REVISION HISTORY

~~TBD~~This policy shall be reviewed annually and updated as needed to reflect changes in CMS or DHCS requirements, including updates to the CalAIM D-SNP Policy Guide.

REFERENCES

- CMS Medicare Managed Care Manual, Chapter 5, Sections 30.2.1, 30.2.2,
- CMS Health Outcomes Survey (CMS.Gov HOS Survey) https://www.cms.gov/data-research/research/health-outcomes-survey
- Model of Care (MOC) 4 Element C Factor 1 and Factor 2 ~~(pages 225,226)~~
- 42 CFR § 422.162
- 42 CFR § 422.164
- 42 CFR § 422.166
- 42 CFR § 422.252

MONITORING

This policy is reviewed annually for effectiveness and approved at QIHEC.

~~**QUALITY DATA USE CASES**~~

- ~~Monitoring and reporting HEDIS and STAR measures.~~

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Collaboration

- ~~Identifying care gaps and stratifying members for outreach~~
- ~~Evaluating effectiveness of QI initiatives~~
- ~~Tracking grievance and appeal trends~~
- ~~Supporting CMS and state-mandated reporting~~
- ~~Conducting population health analytics to improve outcomes~~

collaboration

POLICY AND PROCEDURE

Commented [LA1]: @Stott, Michelle Hi Michelle - just making sure this on your radar for review.

Policy Number	QI- ~~XXX-NEW~~D-003
Policy Name	Model of ~~O~~Care Annual Evaluation Policy
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Lines of Business	D-SNP
Effective Date	
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

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POLICY STATEMENT

The purpose of this policy is to ensure accuracy and compliance with the Model of Care Annual Evaluation Policy for Alameda Alliance Wellness. All reviewers conduct a review to ensure ~~that all~~ compliance with the National Committee for Quality Assurance (NCQA), the Department of Healthcare Services (DHCS), the Department of Managed Health Care (DMHC) ~~standards~~, and Centers for Medicare and Medicaid Services (CMS) standards.

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PROCEDURE

1. Annual MOC Review Planning

- The Quality Improvement Health Equity (QIHE) program shall lead the MOC review process ~~in Q1~~ of each calendar year to evaluate the MOC Framework's effectiveness in addressing D-SNP members' unique healthcare needs, including complex medical, behavioral, and social determinants of health (SDOH) requirements. The evaluation uses specific quality metrics~~-~~, ongoing data collection, analysis, improvement planning, and remeasurement to assess ~~-~~care quality, service delivery, health outcomes, and member satisfaction.
- The evaluation explicitly assesses fulfillment of previous MOC goals, analyzing reasons for any unmet goals and planning remeasurement to ensure continuous improvement.

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A MOC Review Workgroup, composed of representatives from Case Management, Pharmacy, Utilization Management, Provider Services, Member Services, Compliance,

Behavioral Health, and Population Health, is convened under the oversight of Alameda Alliance Wellness Medical Director, with support from the Senior Director of Quality.

2. Data Collection and Evaluation

- Process for Data Collection:
  - Continuously collect and analyze data to monitor the MOC's effectiveness in meeting members' unique needs, using quantitative (e.g., performance metrics) and qualitative (e.g., member/provider feedback) methods.
- Data Sources may include:
  - Electronic Health Records, Claims and encounters, DHCS Population Health Management Platform (when available, for SDOH and population health data), CAHPS surveys, member focus groups or Community Advisory Committee feedback, provider feedback, CMS Program Audit data, and grievance trends.
  - Clinical Outcomes: HEDIS and STAR Measures
  - Care Coordination: Initial HRA completion within 90 days, annual HRA reassessments, ICP rates, ICT engagement, care coordinator to member ratio (to ensure adequate staffing), documented care goals.
  - LTSS Utilization
  - Behavioral Health Services Utilization

3. MOC Review and Gap Analysis

- The MOC structure is evaluated annually to ensure it effectively accommodates members' unique needs (e.g., chronic conditions, behavioral health, LTSS, SDOH). The process involves:
  - Comparing MOC processes against CMS, NCQA, and DHCS standards.
  - Assessing whether the MOC framework addresses members' needs through risk stratification, care coordination, and equity-focused interventions.
  - Reviewing prior-year goal fulfillment to detect structural deficiencies.
  - Identifying barriers to effective care delivery via member/provider feedback and audit findings.
- Identify any Gaps in these processes or services:
  - Risk stratification and care management, incorporating SDOH data.
  - Communication across care teams.
  - Documentation and reporting.
  - Provider training on CICM, LTSS, palliative care, and dementia care.
  - Cultural and linguistic services for health equity.
  - LTSS coordination.
  - CICM service delivery.

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Commented [LA2]: Can this be more flexible? "May include"

Commented [MT3R2]: May include works

Commented [LA4]: Delete? Will we have access to EHR data?

Commented [LA5]: Ok to include CAC?

Commented [MT6R5]: Yes

Commented [LA7]: Again - do we want to list specific metrics, or describe more broadly -"Assessment completion, care coordination engagement and staffing, …"

Commented [MT8R7]: The 90 day window is what we are measured on so it is the metric

- Palliative and Dementia care access.
- Face-to-Face encounter compliance.

4. Development of Quality Improvement Interventions

- Based on the gap analysis, the Quality Improvement department, in collaboration with stakeholders, will design quality improvement plans.
  - Develop interventions that are measurable, outcome-based using PDSA cycles, ensuring alignment with regulatory standards.
  - Incorporate feedback from members, providers, ICTs, and community partners to address members' unique needs.
  - Focus on high-impact areas based on data-driven priorities.
  - Initiatives are rolled out via the D-SNP QI Work Plan, with assigned responsibilities, timelines, and KPIs.
- Initiatives may include:
  - Targeted member outreach programs (e.g., HRA/ICP completion and preventive screenings).
  - Provider education campaigns
  - Enhancement of ICT workflows
  - Behavioral health integration strategies
  - Health equity improvement initiatives (e.g., telehealth expansion and community partnerships for SDOH).

5. Implementation and Monitoring

- Interventions are tracked via a D-SNP specific QI Work Plan, approved by QIHEC and BOG, aligning with CMS, DHCS, and NCQA requirements.
- Continuous tracking via real-time dashboards.
- Quarterly reviews to evaluate progress, adjusting strategies as needed.
- KPIs include hospitalization/readmission rates, preventive care adherence, and member satisfaction, benchmarked against HEDIS, CMS, and DHCS targets.
- Member/provider feedback via CAHPS, focus groups, and ICT surveys allow for adjustments as needed.
- Corrective Action Plans address unmet goals, revising processes or enhancing outreach.

6. MOC Revision and Submission

- The MOC shall be updated to reflect significant changes based on the review findings.
- Results are disseminated to all stakeholders (leadership, members, providers, caregivers, the general public, and regulatory agencies) at least annually and ad hoc as needed (e.g., significant gaps or corrective actions).
- The QI department, in collaboration with Communications team, is responsible for sharing performance results, lesson learned, and quality improvement actions via newsletters, the Alameda Alliance website, annual reports, and provider/member portals. Materials are culturally and linguistically appropriate.
- Updated MOC documents shall be approved by executive leadership and submitted to regulatory bodies ~~CMS~~ as required.

7. Documentation and Recordkeeping

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Commented [LA9]: Is this a formal CAP, internal or external with providers? If CAP isn't required, I'd use other language - "Action is taken to address unmet goals . . ."

Commented [MT10R9]: CAP is D-SNP language and is only directed at the measures we do not meet internally we would establish a formal corrective action plan to improve - In an audit CMS will ask to see your CAP.

Commented [LA11R9]: Thank you Michelle - this is good to know!

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- Maintain all meeting notes, data analysis, intervention plans, and approvals for audit readiness.
- Documentation shall be retained for a minimum of 10 years in compliance with regulatory bodies.

DEFINITIONS

- **Model of Care (MOC):** The CMS-approved description of how the D-SNP delivers coordinated care to its dual-eligible population.

Quality Improvement Interventions: Activities designed to improve clinical quality, service delivery, or operational processes based on outcome and performance data.

-

AFFECTED DEPARTMENTS/PARTIES

All Departments Supporting the D-SNP Program

RELATED POLICIES AND PROCEDURES

- Model of Care
- QIHE Program Description

REVISION HISTORY

REFERENCES

- Centers for Medicare and Medicaid Services (CMS)
- The Department of Managed Health Care (DMHC)
- The California Department of Health Care Services (DHCS)
- The National Committee for Quality Assurance (NCQA)
- Model of Care (MOC)

MONITORING

- This policy will be reviewed annually to ensure effectiveness and approved at QIHEC.

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POLICY AND PROCEDURE

Policy Number	QI-D-004 Core Measures and Reporting Policy
Policy Name	Quality Metrics: Stars, Quality Workplan, Health Equity and KPIs
Department Name	Quality Improvement ~~Health Equity~~
Department Officer	Chief Medical Officer
Policy Owner	
Lines of Business	D-SNP
Effective Date	
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

I. Purpose

To establish standardized processes for collecting, analyzing, measuring, and reporting key quality metrics. This includes:

1. CMS Stars Program metrics
2. Annual Quality Improvement Work Plan (QIWP)
3. Health Equity reporting and interventions
4. CMS-required KPIs (e.g., HEDIS, CAHPS, HOS, NCQA reporting)

This policy ensures compliance with 42 CFR § 422.152 (Quality Improvement Program) and 42 CFR § 422.101 (Model of Care for Special Needs Plans), relevant DHCS All Plan Letters, and NCQA Quality Improvement and Health Equity standards, supporting continuous performance improvement, chronic care management, and disparity reduction.
~~This policy ensures compliance with 42 CFR §422.152, DHCS All Plan Letters, NCQA standards, and supports continuous improvement and disparity reduction.~~

II. Scope

This policy applies to:

1. Quality Improvement Health Equity Department, Medicare Stars, Healthcare Services and Health Equity staff
2. Delegated entities performing QI reporting functions
3. Committees with oversight of quality (QIHEC, UM Committee, Compliance Committee, Board of Governors)

Commented [MS2R1]: @Stott, Michelle Reviewed. @Cheang, Tiffany Added for review as well

Commented [TM3]: @Lam, Allison @Goradia, Jalal Please review - This one is time sensitive and needs to be complete by 10/7 for 10/15 Committee review

Commented [GJ4R3]: Stars was reviewed by me and @Alagna, Kristen. Edits/updates were added in the Stars Reporting section.

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Commented [CK5]: Recommend a minor rewrite of this sentence: This policy ensures compliance with 42 CFR § 422.152 (Quality Improvement Program) and 42 CFR § 422.101 (Model of Care for Special Needs Plans), relevant DHCS All Plan Letters, and NCQA Quality Improvement and Health Equity standards, supporting continuous performance improvement, chronic care management, and disparity reduction.

III. Policy

Alameda Alliance for Wellness will:

1. Collect, validate, and analyze all required quality metrics.
2. Report results to CMS, DHCS, DMHC, and NCQA per established timelines.
3. Present results and trends to internal committees and governing bodies.
4. Develop and implement CAPs when performance falls below benchmarks.
5. Integrate health equity by stratifying results and addressing disparities.

PROCEDURE

I. Stars Program Reporting

1. Collection
   a. Extract HEDIS measures from claims, encounters, and EHR data.
   b. Collect CAHPS survey results from CMS-approved vendors.
   c. Collect HOS results from CMS-approved vendors. ~~contractors~~.
   ~~c.~~d. Collect pharmacy measures from Prescription Drug Event (PDE) data.
   e. Gather operational measures (complaints, call center metrics, appeals/grievances, CMS administrative data, plan data reported to CMS).
   ~~d.~~f. Individual measure owners ~~to provide~~provide ongoing initiative projects and status towards measure improvement.
2. Analysis & Measurement
   a. Compare performance against CMS benchmarks and national percentiles.
   b. Stratify results by REaL (race, ethnicity, language) and SDOH where data is available.
   ~~b.~~c. Utilize Star dashboard and cut-point projections for progress tracking.~~:~~
   d. Identify measures projecting below the 3-star threshold for immediate review.
   e. Identify measures nearing the next projected Star cut-point for prioritization of potential improvement initiatives.
   ~~c.~~f. Review initiatives for progress, ~~barriers,and~~barriers, and outcomes.
3. Reporting
   a. Monthly Stars performance~~dashboard~~ to be reviewed at the Quality Improvement Health Equity Committee (QIHEC).
   b. Quarterly updates to QIHEC to include key strategies and improvement initiatives for prioritized measures.
   c. Annual summary presented to Board of Governors.
4. Corrective Action Plans
   a. Develop CAPs for underperforming measures, with potential~~h~~ root cause analyses~~is~~.
   b. Assign accountable owners and deadlines.
   c. Monitor progress through the Stars Workgroup~~QI Committee~~ until closure.

II. Quality Improvement Workplan, Quality Improvement Project (QIP), and Chronic Condition Improvement Project (CCIP).

In accordance with 42 CFR § 422.152(c), the Chronic Care Improvement Program (CCIP) is incorporated within the Quality Improvement Work Plan (QIWP) as a multi-year initiative addressing chronic condition management, evaluation, and outcome improvement.

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"II. Quality Improvement Workplan, Quality Improvement Project (QIP), and Chronic Condition Improvement Project (CCIP)"

- Recommended single-line addition:

"In accordance with 42 CFR § 422.152(c), the Chronic Care Improvement Program (CCIP) is incorporated within the Quality Improvement Work Plan (QIWP) as a multi-year initiative addressing chronic condition management, evaluation, and outcome improvement."

What you have is fine and already meets the process detail requirement, but this is just suggested language to tie it all together.

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~~II.~~

1. Collection
   a. QIHE staff compile ongoing projects, performance metrics, and intervention status.
   b. Include regulatory requirements (CMS, DHCS, NCQA).
2. Analysis and Measurement
   a. Review each initiative for progress, barriers, and outcomes.
   b. Evaluate against prior year benchmarks and goals.
3. Reporting
   a. QIWP, QIP, and CCIP reviewed quarterly at QIHEC Committee.
   b. Annual QIWP and Evaluation submitted to CMS and DHCS as applicable and presented to Board of Governors.
4. Corrective Action Plans
   a. CAPs initiated when QIHEC projects are not meeting milestones.
   b. Documentation includes revised timelines, staff assignment, and resource adjustments.

III. Health Equity Reporting

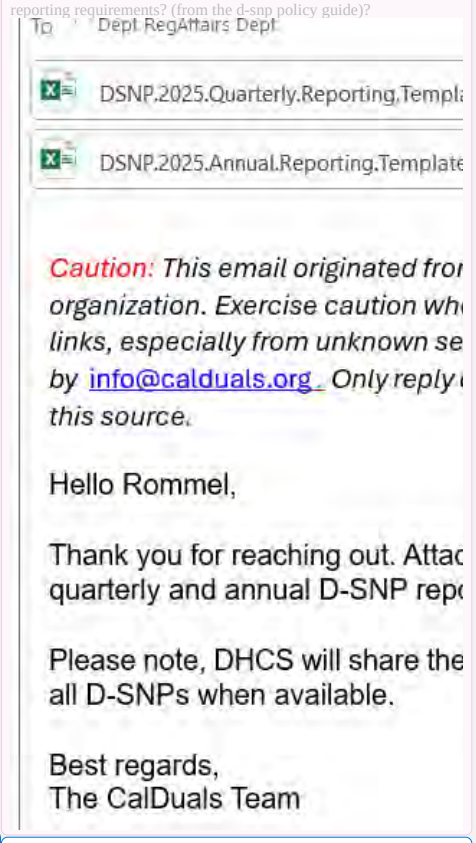
1. Collection
   a. Collect REaL and SDOH data at enrollment, HRA, and ongoing encounters.
   b. Gather stratified results for HEDIS, CAHPS, utilization, and outcomes.
2. Analysis and Measurement
   a. Identify disparities by comparing subpopulations to overall plan performance.
   b. Use dashboards to track trends across multiple years.
3. Reporting
   a. Quarterly disparity reports presented to QIHEC.
   b. Annual disparity analysis included in QIWP Evaluation and DHCS submissions.
   c. Findings integrated into CMS-required Health Equity updates.
4. Corrective Action Plans
   a. Develop targeted interventions (e.g., culturally appropriate outreach, language services).
   b. Monitor outcomes quarterly and revise strategies as needed.

IV. CMS KPIs

1. Collection
   ~~a.~~ CMS-mandated metrics include:
   ~~b.~~a. Timeliness of appeals and grievances
   ~~c.~~b. Prior authorization decision timeliness
   ~~d.~~c. HRA completion and ICP (Individualized Care Plan) timeliness. The Plan implements its CMS/NCQA-approved Model of Care (MOC) encompassing HRAs, Individualized Care Plans, Interdisciplinary Care Teams, and transition management, as required for D-SNP under 42 CFR § 422.101.
   ~~e.~~d. Case/care management documentation
   ~~f.~~e. Stars, HEDIS, CAHPS, HOS
2. Analysis and Measurement
   a. Compare results to CMS thresholds.
   b. Identify variances and root causes.
3. Reporting
   a. Monthly KPI dashboards reviewed by QIHE staff.
   b. Quarterly KPI report submitted to QIHEC, UM Committee, and Compliance Committee.

Commented [CK7]: Consider adding a single line within IV. CMS KPIs - Collection (after "HRA completion and ICP timeliness"). The Plan implements its CMS/NCQA-approved Model of Care (MOC) encompassing HRAs, Individualized Care Plans, Interdisciplinary Care Teams, and transition management, as required for D-SNP under 42 CFR § 422.101.

Commented [AL8]: Do we add the DHCS quarterly and annual reporting requirements? (from the d-snp policy guide)?



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c. Annual KPI report presented to Board of Governors.
~~c.~~d. DHCS quarterly and annually per the D-SNP Policy guide

4. Corrective Action Plans
   a. CAPs required if any KPI falls below threshold.
   b. CAPs documented in QIHEC Committee minutes and tracked until resolution.

IV. Roles and Responsibilities

QIHE Department	Collect, validate, and analyze QIWP, QIP, CCIP, Health Equity, and CMS KPIs.
Medicare Stars	Collect, validate, and analyze Stars
Health Equity Team	Stratify results by demographics and propose disparity interventions.
UM Department	Provide timeliness and appeals/grievance metrics; support KPI reporting.
Data/IT Analytics	Maintain reporting systems, dashboards, and ensure accuracy of submissions.
Compliance	Ensure adherence to CMS, DHCS, and NCQA requirements.
Committees	Review results, approve CAPs, monitor progress.

DEFINITIONS

- **Stars Program:** CMS quality rating system (1–5 stars) based on HEDIS, CAHPS, HOS, and administrative measures.
- **Quality Improvement Work Plan (QIWP):** An annual document outlining QI projects, goals, and monitoring activities.
- **Health Equity Reporting:** Activities that stratify data by race, ethnicity, language, and SDOH to identify disparities.
- **CMS KPIs:** Key metrics required by CMS, including HEDIS, CAHPS, HOS, appeals, grievances, timeliness, and care management KPIs.
- **Corrective Action Plan (CAP):** Structured process to remediate deficiencies and improve performance when benchmarks are not met.

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AFFECTED DEPARTMENTS/PARTIES

Analytics
Stars Strategy and Program Management
Healthcare Services
Grievances & Appeals
Compliance
Health Equity

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

~~ANA-0XX QI Data Collection and Reporting for HEDIS Policy~~
QI – 101 Quality Improvement Health Equity
QI – 117 Member Satisfaction Survey
QI – 118 Provider Satisfaction Survey
QI – 124 Initial Health Appointment
~~ANA-0XX QI Data Collection~~
~~QI – 0XX Stars Annual Workplan and Evaluation~~
~~QI – 0XX QI HEDIS Annual Workplan and Evaluation~~
~~QI – 0XX QI Performance Improvement for HEDIS and Stars~~
~~QI – 0XX QI Core Measures and Reporting Policy~~
QI – D-003~~0XX~~ QI MOC Annual Evaluation Policy

Commented [MS9]: @Thomsen, Michelle @Fiel, Melissa @Reitz, Julie removed the P&s and can add once we have policy numbers and finalized

REVISION HISTORY

REFERENCES

- 42 CFR §422.152 – Quality Improvement Program requirements
- CMS Medicare Advantage Stars Technical Notes
- CMS MOC & Health Equity Guidance (HPMS Memos)
- DHCS All Plan Letters (APL 22-009, APL 21-008, etc.)
- NCQA Health Equity and QI Standards

MONITORING

This policy shall be reviewed and updated annually, or as regulatory requirements change.

~~Approved By:~~
~~[Executive Name]~~
~~Title: Chief Quality Officer~~
~~Date: [Insert Date]~~

POLICY AND PROCEDURE

Policy Number	QI-111
Policy Name	Delegation of Management and Oversight
Department Name	Quality Improvement Division
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	D-SNP, MCAL, IHSS
Effective Date	4/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~7/5/2024~~
Administrative Oversight Committee Approval Date	~~9/18/2024~~

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POLICY STATEMENT

The Alliance ~~and Alameda Alliance for Wellness (D-SNP)~~ is responsible for the oversight of delegated Quality Improvement (QI) responsibilities. The Alliance ensures the delegate has a systematic and effective Quality Improvement Health Equity (QIHE) program for providing and evaluating access to quality healthcare services provided to Alliance members which is consistent with regulatory and contractual standards. Delegated entities are required to have certain QIHE components and functions in adherence to Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS) and the Alliance standards outlined in the Reference section of this Policy and Procedure.

The Alliance has established the appropriate structure and mechanism to perform oversight of delegate's Quality Management and Utilization Management delegation activities to ensure compliance with regulatory and contractual requirements. The Alliance performs a capability assessment prior to delegation, and annually assesses delegates thereafter to monitor performance, corrective actions, and provide recommendations for improvement.

A mutually agreed upon delegated contractual agreement outlines the QIHE responsibilities for the delegate entity and the Alliance. This may include delegation of Quality Management, Utilization Management, Credentialing, and Member Grievances and Appeals.

Preview

The Alliance reserves the right to revoke delegate responsibilities or terminate the delegate's contract if the delegate fails to meet the Alliance's contractual delegation agreement requirement.

review

PROCEDURE

A. The Alliance audits each delegate prior to contracting to evaluate if the delegate's capacity meets DHCS, DMHC, CMS, NCQA, and Alliance requirements. The Alliance reviews the delegate's written policies and procedures, program descriptions, and activities under consideration. The results of the pre-delegation assessment are reviewed by the QI Department and forwarded to the Quality Improvement Health Equity Committee (QIHEC) for determination of delegation status.

B. The Alliance will establish a mutually agreed upon delegation agreement with the delegated entity to include QIHE responsibilities and reporting activities required by the delegate, and the oversight and monitoring responsibilities and process of the Alliance. Additionally, the delegation agreement describes the remedies and actions taken by the Alliance if obligations are not fulfilled by the delegate. This agreement also specifies the semi-annual, or more frequent, reporting requirements of the delegate as deemed appropriate by the Alliance.

C. For delegation agreements in effect for 12 months or longer, the Alliance performs annual delegation oversight audit to verify compliance with the Alliance requirements and their continued ability to perform delegated functions. The Alliance evaluates the following delegation activities, (depending if the areas are applicable to the delegate's contracted responsibilities) annually through the delegation oversight audit, which includes, but is not limited to:

1. QIHE program, work plan and evaluation
2. Utilization Management (UM) program
3. QI and UM policies and procedures
   a) Including but not limited to inpatient hospital services, outpatient care, referral program, prior authorization process, over/underutilization, coordination in care, facility site reviews, medical records, mental health services if applicable
4. QIHE/UM committee meeting minutes
5. Complex case management case file review
6. Authorization denial and appeal case file review
7. Complex case management case file review
8. Access and availability
   b) Timely access to primary care, specialist, ancillary support services, laboratory services, mental health services if applicable
9. Credentialing
10. Preventative health services
11. Member rights and responsibilities
12. Grievances, appeals, and potential quality issues (PQIs)
13. California Children Services (CCS)
14. Cultural and Linguistic Services
15. Member and Provider Health Education
16. Delegation activity reporting
17. Follow-up of any issues found within the last year's delegation reporting and last

year's audit

D. Through the annual delegation oversight audit, the Alliance will assess the delegated activities and score the delegate's performance. The annual review may include a review of files related to the area being evaluated. If there are findings or opportunities for improvement, the Alliance will issue a written corrective action plan (CAP) with recommendations for improvement to the delegate. The delegate will have 30 calendar days to provide responses to the CAP issued by the Alliance. The Alliance will evaluate if deficiencies were corrected, and follow-up on the actions until all deficiencies are resolved. The delegation audits will review past findings to ensure policy and procedure changes have been effective, and evaluate if there are any repeated findings.

E. Focused audits may occur between annual audits if the Alliance determines the need to evaluate the delegate's performance in specific areas. Periodic site visits to the delegate may occur at any time of the year for oversight auditing purposes.

F. Delegates are required to report QI and UM data to the Alliance on a quarterly and annual basis. Delegation reports are reviewed by the Alliance applicable departments to ensure compliance standards are being met. Any deficiencies cited by the Department(s) are communicated to the Delegate through a written CAP. The delegate receives a timeframe to respond to the CAP. Delegation reports are reviewed by the Subcontractor & Delegation Oversight Committee (SDOC) with a summary to the Compliance Committee~~by the Compliance Committee and forwarded to Quality Improvement Health Equity (QIHE) committee for review~~. All delegation oversight activities are reported to the QIHE committee for review and recommendations.

G. As part of its relationship with the delegate, the Alliance provides the following information to the delegate (depending if the areas are applicable to the delegate's contracted responsibilities)~~when requested~~:

1. Member experience data ~~(if relevant)~~ – this information is data that is collected by the Alliance that reflects the member experience with the Alliance and the delegate. This can include surveys and complaint data. This information is used to improve the member experience within the plan and the delegate's services.
2. Clinical performance data – this information is data from claims and other clinical analysis that can be used to assess and improve quality of care and access to preventive and needed care.
3. Delegates may request this information on an ad hoc or routine basis. When possible, the Alliance will share performance data at the quarterly Joint Operations Meetings.

H. Delegated Providers, who consistently fail to meet Alliance standards, as confirmed through annual and/or focused audits, reporting, or other oversight activities, are subject to actions up to and including:

a. Rescission of delegated functions,

b. Non-renewal of the Alliance contract, or

c. Termination of the participation in the Alliance network

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS / PARTIES

Grievance and Appeals
Compliance
Credentialing
Member Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan
CRE-002 Credentialing and Recredentialing of Individual Practitioners
CRE-009 Ongoing Monitoring of Practitioners
QI-101 Quality Improvement Health Equity Program
QI-104 Potential Quality Issues
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

6/16/2016, 3/1/2018, 5/3/2018, 3/21/19, 4/15/2020, 5/21/2020, 6/28/2022, 6/20/2023, 9/18/2024, 6/12/2025, 10/21/25

Commented [nB1]: Update revision date

REFERENCES

DHCS Contract, Exhibit A, Attachment 4, Section 6
Title 28, CCR 1300.70(b)(2)(G)
NCQA ~~201~~ Standards and Guidelines for the Association of Health Plans, Quality Management ~~and Improvement, QI 7, Element A-F~~
Centers for Medicare and Medicaid (CMS)

Commented [nB2]: Update with latest NCQA standards

Commented [GK3]: Removed - QI is not delegated for NCQA.

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Review

MONITORING

This policy will be reviewed annually to ensure effectiveness and compliance with regulatory and contractual requirements.

review

POLICY AND PROCEDURE

Policy Number	BH-XXX
Policy Name	DSNP Behavioral Health Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Behavioral Health
Lines of Business	DSNP
Effective Date	
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

A. Alameda Alliance offers the following Behavioral Health Services:

- Crisis Services
- Mental health evaluation and treatment, including individual, couples, group, and family psychotherapy.
- Outpatient substance use recovery services.
- Outpatient services that include lab work, drugs, and supplies
- Outpatient services to monitor drug therapy.
- Psychiatric consultation
- Psychological and neuropsychological testing to evaluate a mental health condition.
- Transcranial Magnetic Stimulation (TMS)
- Spravato/Esketamine
- Electroconvulsive Therapy
- Intensive Outpatient Programs for mental health and substance use
- Partial Hospitalization Programs for mental health and substance use
- Residential Mental Health Services
- Inpatient psychiatric care
- Inpatient and outpatient detox services

B. Alameda Alliance does not cover residential substance use services. This service is a covered

2025 Proposal

benefit through Alameda County Behavioral Health.

C. Alameda Alliance does not require a referral from a Primary Care Practitioner/Physician (PCP) or Prior Authorization for an initial outpatient behavioral health assessment performed by a contracted behavioral health Provider.

D. Emergency and crisis care does not require prior authorization.

E. Alameda Alliance does not impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), section 438.900.

F. Alameda Alliance Primary Care Practitioner/Physicians (PCPs) shall be responsible for screening and providing Behavioral Health Services within the scope of their practice.

G. Alameda Alliance ensures timely access to Behavioral Health Services as set forth by the Department of Managed Health Care (DMHC) and Alameda Alliance Access and Availability Policy.

H. If Behavioral Health Services that are the responsibility of Alameda Alliance are unavailable to the Member, Alameda Alliance shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with Alameda Alliance's Out of Network Authorization Policy.

I. Alameda Alliance shall follow authorization and case management guidelines in accordance with Alameda Alliance Policies Utilization Review and Case Management policies unless otherwise articulated in this policy.

J. Alameda Alliance shall maintain a twenty-four (24) hour/seven (7) day week direct telephone line for behavioral health emergencies and assistance during non-business hours.

K. Confidentiality: Alameda Alliance shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with Alameda Alliance Policies: Tracking and Reporting Disclosures of Protected Health Information (PHI), Protected Health Information Disclosures Required by Law, Use and Disclosure for Treatment, Payment, and Health Care Operations. (CMP-005 Minimum Necessary Use & Disclosures)

Alameda Alliance shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with Alameda Alliance Policies: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, Member Authorization for the Use and Disclosure of Protected Health Information.

L. Network Adequacy: Alameda Alliance shall maintain and monitor an appropriate provider network and ensure timely access to Behavioral Health Services as set forth by the Department of Health

Care Services (DHCS), Department of Managed Health Care (DMHC) and Alameda Alliance Policy: QI-108 Access to Behavioral Health Services.

M. Out of Network Services: If Alliance network behavioral health services are unavailable to the Member within timely and geographic access standards, Alameda Alliance shall arrange for the provision of Behavioral Health Services outside the network.

PROCEDURE

A. Accessing Alameda Alliance Behavioral Health Services

1 A Member may access Behavioral Health Services directly with any contracted provider. It is the provider's responsibility to seek authorization for any services that require it.

2 Members can identify contracted providers via the plan's provider directory, website or by contacting the Plan's member services or behavioral health department.

3 Members can be referred to the Plan from:

a. Alameda County Behavioral Health.

b. Self-referral.

c. Authorized Representative or caregiver.

d. PCP or another medical provider.

e. Specialty Care provider.

f. Behavioral health providers, including clinical psychologists, clinical social workers, marriage and family therapists, mental health counselors/clinical professional counselors, Opioid Treatment Program (OTP) providers, community mental health centers, and those community-based organizations that regularly furnish or will regularly furnish behavioral health counseling or therapy services.

g. Long-Term Support Services (LTSS) provider.

h. Community-based agency.

i. Internal plan departments including Population Health Management, Case Management, and Customer Services staff or discharge planner.

j. External Enhanced Care Management (ECM) or other Community Support (CS) Providers; and

k. Other Member's identified health care team providers.

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B. Behavioral Health Call Handling Procedures

1. Members may contact the Behavioral Health Department by calling the DSNP member services line.

2. The Behavioral Health Department will:

   a. Maintain 24/7 crisis availability in compliance with Medicare telephone access standards.

   b. Utilize linguistic interpreter services, or the California Relay Service (711) for Members, as necessary to ensure effective communication.

   c. Verify the caller's identity, eligibility, and line of business.

   d. Identify and triage callers based on their initial reason for contacting the Behavioral Health Behavioral Department and clinical needs

   e. Refer the caller to his/her primary health insurance and suggest a community resource for treatment of their described symptoms if the caller is not currently an Alliance member and not in crisis.

3. Screening and determination for emergent and urgent needs. If the member's condition is determined urgent or emergent, behavioral health clinical staff shall immediately complete safety screening.

   a. Emergent: If a member is assessed to be at risk to themselves or others, requiring emergency services, behavioral health staff shall contact Alameda County's Centralized Assessment Team (CAT) and/or contact the other appropriate emergency agencies including the police. Every attempt should be made to keep the member on the line until emergency responders arrive, or a plan to access emergency services is developed with member supports (e.g., member agrees to go to ER or urgent clinic with family member or other support and is assessed as safe to do so).

   b. Urgent: Behavioral health staff will outreach to members with urgent behavioral health needs immediately but not more than two (2) hours after the determination that the member has urgent needs. Behavioral health staff will connect members with urgent mental health needs to services within one (1) business day after making the determination that the member's condition is urgent;

   c. Behavioral health staff must obtain confirmation and document that any caller assessed as requiring Emergency or Urgent Services has been appropriately connected to services and/or the appropriate agencies.

C. **Screening, Assessment and Care Coordination**

1. The behavioral health staff will provide the Member with referrals to appropriate Behavioral Health Services. The behavioral health staff will ensure the Member is

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directed to Providers that are within the DSNP Alliance behavioral health network, are currently accepting DSNP members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to QI-108 Access to Behavioral Health Services;

2. The Alliance and Alameda County Behavioral Health (ACBH) will coordinate services to ensure members receive appropriate care. The Alliance will provide coordination of care to members receiving care in residential substance use treatment or other ACBH programs.

D. Prior Authorization and Out-of-Network Services

1. The Alliance shall process requests for Prior Authorization within the timeframes and processes specified in UM 001: Utilization Management Program, UM-036 Continuity of Care, UM-057 Authorization Service Requests, The Alliance shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

DEFINITIONS

Term	Definition
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both Mental Health and substance use disorder services, as covered by Alameda Alliance.

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Alameda Alliance DSNP Member Services Phone Line	Toll-free telephone numbers that Providers, Members or individuals acting on behalf of Members can call to obtain referrals for all Alameda Alliance Covered Services. Telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services. 2. Can transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

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Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Emergency Services	For purposes of this policy emergency services are indicated when a member experiences an acute disturbance of behavior, thought or mood which left untreated may lead to harm to the individual or others.
Emergent Call	An emergent call is when a member exhibits an acute disturbance of behavior, thought or mood which left untreated may lead to harm to the individual or others.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy, and security of health information, and as subsequently amended.
Medical Necessity	The Centers for Medicare & Medicaid Services (CMS) defines medically necessary services as those that are; proper and needed for the diagnosis and treatment of your medical condition, provided for the diagnosis, direct care and treatment of your medical condition, and meet accepted standards of medical practice in the local area and are not mainly for the convenience of the member or the provider.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

approval

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Behavioral Health provider, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Call or Referral	An urgent call or referral is when a member is experiencing one of the following: • emotional distress • severe depression or anxiety • passive suicidal/homicidal thoughts or actions (non-life-threatening) • experience of a traumatic event • concerns for personal safety or the safety of others • lack of medications that support psychiatric stability (this does not include controlled medications) • physical withdrawal from substances
Urgent Services	Callers in need of Urgent Services shall receive timely Mental Health intervention that shall be appropriate to the severity of the condition.

AFFECTED DEPARTMENTS/PARTIES

:
Behavioral Health
Case and Disease Management
Grievance and Appeals
Utilization Management
Member Services

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning
UM-005 Second Opinions
UM-014 CoC-Identifying Abuse
UM-015 Emergency Services and Post Stabilization Services
UM-016 Transportation Guidelines
UM-025 Guidelines for Obstetrical Services
UM-036 Continuity of Care
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Service Requests
UM-058 Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving Medical Exemption

approval

UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care
CM-001 CCM Identification Screening Enrollment and Assessment
CM-002 Complex Case Management Plan Development and Management
CM-004 Care Coordination of Services
CM-011 Enhanced Care Management – Care Management & Transitions of Care
MBR-062 Referrals and Triage
DSNP CM-004 Care Coordination
DSNP CM XXX Monitoring and Oversight
CMS Managed Care Manual
CY 2026 DHCS Medi-Cal and DSNP Policy Guide

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy

REFERENCES

- California Code of Reg., Title 9, §§ 1810.370(a)(3), 1830.205 and 1830.210
- Welfare and Institutions Code, § 14132.03
- Welfare and Institutions Code, § 14189
- 42 CFR, §§ 438.900-438.930
- 42 CFR, § 438.910, subd. (d)
- California Code, Health & Saf. Code, § 1374.721.

MONITORING

The Compliance, Quality Improvement and Behavioral Health Departments will annually review this policy for compliance with regulatory and contractual requirements. All policies will be brought annually to the Quality Improvement Health Equity Committee (QIHEC), and Administrative Oversight Committee for review and approval.

approval

Policy Number	BH-XXX
Policy Name	Behavioral Health Services_DSNP_Roles and Responsibilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	DSNP
Effective Date	
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

Purpose

This policy outlines the roles and responsibilities of behavioral health staff involved in the Dual Eligible Special Needs Plan (D-SNP) Model of Care to ensure coordinated, high-quality care for members.

Scope

This policy applies to all administrative and clinical staff, including care managers, primary care providers, specialists, social workers, and other members of the Interdisciplinary Care Team (ICT) for members with behavioral health needs.

PROCEDURES

A. Roles and Responsibilities

1. Member and/or Caregiver and/or Family Members

- **Role**: Participate in person-centered care, share self-management goals, and provide personal healthcare preferences.
- **Responsibilities**:
    - Share information about clinical and social needs.

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- Participate in the development and ongoing maintenance of the Individualized Care Plan (ICP).
- Interface with the ICT during meetings or other communications.
- Assist members with access to needed services and supports.
- Support the member in engaging in ICT processes.

2. Behavioral Health Care Manager (RN, LCSW, LMFT)

- **Role**: Serve as the main point of contact for the member and the ICT, assessing clinical needs, providing comprehensive care coordination and psychosocial support.
- **Responsibilities**:
  - **Care Coordination**:
    - Coordinate ICT meetings with the member, PCP, and other ICT members.
    - Ensure information is exchanged and shared during ICT meetings and when creating the ICP.
    - Document ICT minutes and maintain the ICP in the enterprise care management system.
    - Update the ICP as needed.
  - **Psychosocial Support**:
    - Provide insight and support for the member's health needs.
    - Share recommendations with the ICT about psychosocial support and community resources.
    - Identify and partner with community agencies to facilitate the member's ICP.
    - Assist the member with navigating the healthcare system and resources.
  - **Comprehensive Care Management**:
    - In collaboration with the member and ICT, establish care plan goals, interventions and barriers
    - Monitor the accomplishment of ICP goals and work with the member and ICT to achieve these goals.
    - Evaluate the impact of Social Determinants of Health (SDOH) on ICP progression and member outcomes.

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- Provide education and information to the member and/or the member's AOR regarding health conditions and available benefits and services.
- Develop schedules for follow-up and communication with members.
- Coordinate referrals to community services and home-based care.

3. Behavioral Health Treatment Providers

- **Role**: Provide specialized care and support for the member's health needs.
- **Responsibilities**:
  - Collaborate with the Integrated Care Team (ICT) through attendance at meetings and ongoing communications.
  - Share relevant treatment information with the care manager and ICT.
  - Make treatment recommendations and provide input into the development and ongoing maintenance of the Integrated Care Plan (ICP).
  - Incorporate applicable information into the member's treatment plan.

4. Administrative non-clinical staff

- **Role:** Supporting behavioral health clinical staff
- **Responsibilities:**
  - Scheduling ICT meetings
  - Coordinating services and authorizations
  - Managing inbound and outbound calls
  - Communicating with members about services and benefits
  - Escalating callers to clinical staff
  - Documenting all non-clinical activities and interactions in the clinical record.

5. Administrative Staff Roles Supporting Case Managers

- Senior Director of Behavioral Health
  - Oversees Department ensuring adherence to regulatory and contractual requirements.
  - Oversees CM policies and training programs.
  - Oversees case manager performance and reports outcomes to CMS, DHCS, and leadership.
  - Ensures case manager activities comply with regulatory requirements.
  - Reviews CMS and DHCS guidance to update CM roles and responsibilities.
  - Oversees audit-ready documentation in the case management software.

- Behavioral Health Manager

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- Provides operational oversight over the comprehensive case management program.
- Supervision and management of department staff, development of the operational plan, allocation and management of programs resources and accountability for the quality of care and service.
- Develops CM policies and training programs.
- Monitors case manager performance and reports outcomes to CMS, DHCS, and leadership.
- Monitors case manager activities to ensure compliance with regulatory requirements.
- Applies CMS and DHCS guidance to update CM roles and responsibilities.
- Develops audit-ready documentation in the case management software.

- Clinical Team Supervisors
  - Daily oversight and supervision of department clinical staff and allocation and management of program resources
  - Review caseloads weekly and monitor quality metrics.
  - Monthly chart audits are conducted for compliance with CMS/DHCS requirements (e.g., timely and complete assessments, and ICPs)
  - Staff performance is reviewed monthly and more often as needed through evaluations.
  - Supervisors facilitate ICT participation by case managers to ensure effective care coordination.
  - Escalation protocols involve the Case Management Director for unresolved issues.
  - Non-Compliance triggers additional coaching, training, and potential disciplinary action per the company's HR policy.

6. Alliance Departments Supporting Case Management

- Compliance Officer
  - Oversees all compliance within the operations areas of the organization.

- Appeals and Grievance
  - Supports case managers by addressing member appeals and grievances.
  - Collaborates with case managers to resolve care-related complaints.
  - Documents outcomes in Quality Suite for quality improvement.
  - Other Plan Department Roles Supporting Case Management

- Quality Improvement Department
  - Oversees case manager performance metrics (e.g., member satisfaction).
  - Provides feedback to improve program and case management effectiveness.
- IT Department

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- Maintains case management system functionality for case manager documentation.
- Offers technical support for case managers using digital tools.

- Curriculum Designer/Medicare Training
  - Collaborates with the Case Management department to develop training content.
- Utilization Department – Medical
  - Collaborate on medical service approvals, denials, and transitions.
- Medical Case Management
  - Engage in care planning and care coordination for members with medical needs.
- Member Services Department
  - Provide benefit education and respond to member inquiries.

7. Special Training and Ongoing Education

- All behavioral health staff are trained in:
  - CMS Model of Care requirements for case manager roles.
  - Medicare and Medi-Cal coordination training
  - D-SNP regulations, including member rights and appeals processes.
  - Cultural competency for D-SNP populations (e.g., language, ethnicity).
  - Person-centered care and shared decision-making.
  - Case management system usage for documentation.
  - Periodic and annual training including workshops, webinars, and e-learning modules.
  - New case managers complete a D-SNP orientation within 30 days of hire.
  - Refresher training is required annually or upon regulatory updates.
  - Training logs are maintained and audited quarterly.

8. **Licensure and Competency Verification**
   - Human Resources and Clinical Leadership verify licensure at hire and annually thereafter. See HR 0-17 License Verification and Reverification Policy.
   - License must be active, unrestricted, and in good standing in California.
   - Competency assessments are conducted during onboarding and annually, including:
     - Clinical protocols
     - Documentation standards
     - Cultural competency
     - Records of verification are retained in employee files.
     - Annual Interrater Reliability testing for UM processes.

DEFINITIONS

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- Case Management: A collaborative process to assess, plan, coordinate, and monitor services for D-SNP beneficiaries.
- Case Manager: A licensed or certified professional responsible for assessing, planning, coordinating, and monitoring care for D-SNP members.
- Administrative Staff: Non-clinical staff supporting CM operations (e.g., scheduling, documentation, outreach, and reporting for case management operations).
- Interdisciplinary Care Team (ICT): responsible for developing and executing the Individualized Care Plan (ICP).

AFFECTED DEPARTMENTS/PARTIES

- Case Management
- Clinical Services
- Human Resources
- Compliance
- Quality Improvement

RELATED POLICIES AND PROCEDURES

BH XXXX Behavioral Health Services_ DSNP
HR 0-17 License Verification and Reverification Policy
UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning
UM-036 Continuity of Care
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Service Requests
MBR-062 Referrals and Triage
DSNP CM-004 Care Coordination
DSNP CM XXX Monitoring and Oversight

REVISION HISTORY
New policy

REFERENCES

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CMS Model of Care Guidelines
Cal AIM Dual Eligible Special Needs Plan Policy Guide
CM-D-006, DSNP Internal Audit and Monitoring Policy and Procedure
HR 0-17, License Verification and Reverification Policy

MONITORING

- To ensure compliance with CMS, DHCS, and accrediting bodies, Behavioral Health Leadership will audit charts according to CM-D-006 DSNP Internal Audit and Monitoring Policy and Procedure. Non-compliance is addressed through Corrective Action Plans (CAPs) and follow up.
- Case Manager tasks and member satisfaction scores are reviewed monthly and reported to CMS.
- This policy is reviewed annually by the Behavioral Health Department for compliance with regulatory and contractual requirements.

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POLICY AND PROCEDURE

Policy Number	
Policy Name	Behavioral Health Crisis Intervention
Department Name	Behavioral Health
Department Officer	Dr. Donna Carey
Policy Owner	Senior Director of Behavioral Health
Lines of Business	DSNP
Effective Date	
Subcommittee Name	**QIHEC**
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

The Alliance is committed to identifying and responding to behavioral health crises among DSNP members in a timely and clinically appropriate manner. This policy establishes standardized procedures for crisis recognition, immediate safety response, coordination with providers and county services, and ongoing follow-up, in alignment with CMS, DHCS, and NCQA requirements.

Scope: This policy applies to all Behavioral Health Case Management Staff

PROCEDURE

1. Crisis Recognition
    a. Members will be screened using standardized tools such as the GAD-2 or PHQ-9 during intake, reassessments, or routine care by clinical care management staff.
    b. Clinical care management staff may identify clinical and behavioral indicators of crisis, including:
        i. GAD-2 score greater than or equal to 3 or PHQ-9 score greater than10
        ii. Suicidal or homicidal ideation or plan
        iii. Panic attacks, psychotic symptoms, extreme distress
        iv. Caregiver or provider report of danger to self or others
        v. Physical withdrawal from substances that threatens health and safety

2. Assessment of Safety Risks

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a. A safety assessment includes direct questions (e.g., Are you thinking of harming yourself or someone else? Do you have a plan to do so?) If a member states that they have a plan, or intent, the clinical staff will assess for immediate safety risks.
b. Non-clinical staff will warm transfer the member to a BH clinical staff member for full assessment of member's current clinical needs and safety risks. Non-clinical staff will remain on the line until the member is engaged with the clinical staff member and the clinical staff instructs the non-clinical staff that they can exit the call. Clinical staff can be reached on the Emergent Phone queue (ext. 2539).
c. If a member does not have a plan and or intent, the clinical staff will further assessment of their clinical needs and identify an appropriate intervention based on the members needs and preferences.

3. Crisis- Immediate Safety Risks

    a. If a member states or exhibits behavior that indicates that they are in immediate danger, staff are instructed to keep the member on the line.
    b. Staff will contact another staff member to have them call 911. For staff working online, the quickest way to request assistance is via Teams BH Emergent Chat.
    c. Non-clinical staff will advise the member that they are adding a clinical staff person to the call to assist the member. Non-clinical staff will stay on the line with the member and clinician until advised by the clinician to drop off the call. Once the clinician has engaged the member, the non-clinical staff member may provide additional information.
    d. In the event safety personnel are deployed to assist the member, staff will remain on the phone with the member until safety personnel have arrived.
    e. Once safety personnel have arrived, the staff will follow notification/escalation procedures, complete documentation and schedule a debrief with their supervisor.

4. Crisis- No Immediate safety risks

    a. Members presenting with urgent clinical needs without safety concerns may include:
        i. emotional distress
        ii. severe depression or anxiety
        iii. passive suicidal/homicidal thoughts or actions (non-life-threatening)
        iv. experience of a traumatic event
        v. concerns for personal safety or the safety of others
        vi. lack of medications that support psychiatric stability (this does not include controlled medications)
        vii. physical withdrawal from substances which do not pose safety risks

    b. Members in crisis with no immediate safety risks, will be triaged by a clinical staff member to determine the appropriate services needed such as:
        i. Same-day or next-day psychiatric appointment
        ii. Referral to in-network providers for behavioral therapy and medication management

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iii. Detox services if SUD-related
iv. Temporary housing or respite if needed
v. Referral to 988 for crisis and warmline support
vi. Completing a safety plan with member as indicated.

5. Notification and Escalation
    a. Notify
        i. Clinical Supervisor
        ii. Assigned Behavioral Health Case Manager
        iii. Senior Director of Behavioral Health or Medical Director (as needed)
    b. Document in care management system.
    c. Document in individual care plan (ICP) for all DSNP Members
    d. For DSNP members, convene an urgent Interdisciplinary Care Team (ICT) in 24 – 48 hours

6. For DSNP members, update individualized Care Plan (ICP)
    a. Document the crisis in the ICP with:
        i. Date, nature of the event
        ii. Emergency contacts or services used
        iii. Updates to goals or medications
        iv. Plans for stabilization

7. Post-Crisis Follow-Up
    a. Increase care manager engagement (weekly check-ins for 30 days)
    b. Monitor for:
        i. Appointment adherence
        ii. Crisis recurrence
        iii. ED visits or readmissions
    c. Include caregiver support and re-engagement strategies as appropriate

8. Responsibilities
    a. BH Case Manager – coordinate crisis response and services, monitor member engagement with services, update ICT if applicable
    b. Clinical Supervisor – Provide oversight and escalate to leadership
    c. ICT team members – Collaborate on follow-up and stabilization

9. Training and Monitoring
    a. Clinical staff are licensed to evaluate member mental health needs, manage mental health crisis and provide care coordination. Non-clinical staff are trained on crisis workflows, including the identification of a member in crisis.
    b. Adherence to workflows is monitored as part of routine operational activities. In accordance with our goal of continuous quality monitoring, crisis protocols, training and process changes are made based on trends identified in the data.

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Term	Definition
Alameda County Behavioral Health	County Behavioral Health Plan: Responsible entity for Medi-Cal specialty mental health and SUD services for Medi-Cal members in Alameda County
Behavioral Crisis	A situation in which a member is experiencing acute psychological distress, suicidal ideation, or inability to function safely.
Emergency Services	For purposes of this policy emergency services are indicated when a member experiences an acute disturbance of behavior, thought or mood which left untreated may lead to harm to the individual or others.
Emergent Call	An emergent call is when a member exhibits an acute disturbance of behavior, thought or mood which left untreated may lead to harm to the individual or others.
GAD-2	The medical term GAD-2 refers to a self-report measure of anxiety. It consists of two items that assess anxiety. The scores range from 0-6. A total score of 3 or higher indicates the presence of anxiety and need for further clinical assessment.
Interdisciplinary Care Team (ICT)	Interdisciplinary Care Team involved in the member's care plan.
Medical Necessity	The Centers for Medicare & Medicaid Services (CMS) defines medically necessary services as those that are; proper and needed for the diagnosis and treatment of your medical condition, provided for the diagnosis, direct care and treatment of your medical condition, and meet accepted standards of medical practice in the local area and are not mainly for the convenience of the member or the provider.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency. No prior authorization is required for crisis services, including inpatient admissions and emergency room visits.
PHQ-9	The PHQ-9, or Patient Health Questionnaire-9, is a widely used self-administered screening tool designed to identify symptoms of depression. It consists of nine questions that assess the frequency of depressive symptoms over the past two weeks, helping clinicians diagnose and monitor major depressive disorder. This tool is utilized in both clinical and primary care settings to evaluate a person's mental health effectively.

Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Behavioral Health provider, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Call or Referral	An urgent call or referral is when a member is experiencing one of the following: • emotional distress • severe depression or anxiety • passive suicidal/homicidal thoughts or actions (non-life-threatening) • experience of a traumatic event • concerns for personal safety or the safety of others • lack of medications that support psychiatric stability (this does not include controlled medications) • physical withdrawal from substances
rgent Services	Callers in need of Urgent Services shall receive timely Mental Health intervention that shall be appropriate to the severity of the condition.

AFFECTED DEPARTMENTS/PARTIES

Healthcare Services – Behavioral Health Case Management

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

New policy

REFERENCES

CMS Medicare Managed Care Manual, Chapter 5 (Model of Care)
DHCS CalAIM D-SNP Policy Guide CY 2026
NCQA Case Management Standards
42CFR 422.101, 438.208

approval

MONITORING

Policy will be reviewed annually.

approval

POLICY AND PROCEDURE

Policy Number	BH-001
Policy Name	Behavioral Health Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Behavioral Health
Lines of Business	MCAL, IHSS
Effective Date	03/21/2023
Administrative Oversight Committee Approval Date	9/17/2025

POLICY STATEMENT

A. Alameda Alliance for Health (Alliance) shall provide the following Behavioral Health Services when they are provided or ordered by a licensed health care professional acting within the scope of his or her license:

1. Individual/group Mental Health evaluation and treatment (psychotherapy);
2. Psychological testing when clinically indicated to evaluate a Mental Health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation for medication management;
5. Outpatient laboratory, supplies and supplements;
6. Alcohol Misuse Screening and Counseling (AMSC) for Members who misuse alcohol, in accordance with the Alliance Policy UM-013 Coordination of Care-Substance Abuse
7. Family therapy (composed of two (2) or more family members) for adult Members with a Mental Health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
   a. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.

B. Alliance benefits include screenings. These screenings include but are not limited to the following:

- Adverse Childhood Events (ACEs)
- Perinatal and maternal mental health
- Substance use
- Cognitive Health Screenings

C. The Alliance collaborates with Alameda County Behavioral Health (ACBH) and contracted mental health providers to gather and share member's mental health treatment information for the purposes of care coordination. PHI is shared securely to ensure member information is protected and viewed only by authorized staff and treating providers for the purpose of care coordination.

D. The Alliance refers members to the ACBH ODS program for SUD treatment. Alameda Alliance ensures that member privacy and data security for SUD treatment is maintained according to State and Federal guidelines including 42-CFR. Member authorization to release information allowing treatment history, active treatment, and health information to be exchanged in obtained as required by law.

E. For Members under the age of twenty-one (21), the Alliance shall provide Medically Necessary non-specialty Menal Health services listed in Section II A of this Policy, regardless of the severity of the impairment.

F. For Members under the age of twenty-one (21), the Alliance shall provide Medically Necessary Behavioral Health Treatment (BHT) services

1. BHT services are evidenced-based and include but are not limited to Applied Behavioral Analysis (ABA).
2. If diagnosis is complete or there is prior BHT treatment history, the member is triaged by the Alliance ABA Analyst who is a Board-Certified Behavioral Analyst.
3. If the member seeking BHT services does not have a treatment history and has not been evaluated and diagnosed, a referral is made for evaluation with a pediatrician or psychologist to determine the need for the Comprehensive Diagnostic Evaluation and ABA services.
4. The parent or guardian is instructed to submit a copy of the available information from the treating provider that must show that the member exhibits the presence of excessive and/or deficits of behaviors that significantly interfere with home and community activities.
5. The Alliance BCBA reviews the available information and confirms that the member is medically stable and without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.
6. The Alliance BCBA conducts a thorough assessment of the Member's history and may request additional documentation from the parent or guardian to determine specific treatment needs and the number of hours needed for the initial Functional Behavioral Assessment (FBA). This initial assessment completed by the Alliance BCBA may include one or more of the following:
    a. Additional evaluations or diagnostic report.
    b. Release of Information form.
    c. Individual Education Plan (IEP) report for the member.
    d. Reports from therapists providing any other services.
    e. Previous assessments/treatment plans if applicable.
    f. Previous behavior plan if applicable.
7. The Alliance BCBA reviews the information provided by the parent or guardian, diagnostic and assessment information and follows MCG guidelines and the Board of Behavioral Analysis guidelines to refer the member to a Qualified Autism Service Provider for a Functional Behavioral Assessment (FBA) if a current FBA is not already completed.
8. The Alliance BCBA reviews the FBA and provides authorization for 6 months of BHT services utilizing MCG guidelines and the Board of Behavioral Analysis guidelines.
9. The Alliance Behavioral Health Care Managers (Clinicians) and staff assist the Alliance BCBA in responding to member needs throughout the course of BHT treatment and the BCBA reviews subsequent treatment reports submitted by the Qualified Autism Service Provider at 6-month intervals and provides subsequent authorizations for continuing BHT services.

G. The Alliance shall *not* impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by the

Alliance, in accordance with the parity in Mental Health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), Part 438, Subpart K.

H. For Group Care Members the Alliance does not require prior authorization for emergency MH/SUD inpatient admissions but does require prior authorization for residential services, intensive outpatient services, psychological testing, electroconvulsive therapy and transcranial magnetic stimulation.

1. The Alliance will cover behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services without prior authorization.
2. The Alliance will require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system only if the plan's prior authorization requirements comply with Section 1374.721.
3. If there is a disagreement between the Alliance and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan will assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to Section 1374.72 at a level of care consistent with utilization review criteria pursuant to Section 1374.721
4. The Alliance will not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with Section 1374.721.
5. If contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, the Alliance will either authorize post stabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider within 30 minutes of the time the provider makes the initial telephone call requesting authorization for post stabilization care.
6. To the extent permissible under federal law, the plan will not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one post stabilization telephone call to the number provided in advance by the plan.
7. The Alliance will not require the representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the post stabilization telephone call to the plan to be a physician or surgeon.
8. The Alliance will arrange coverage and facilitate scheduling appointments or arranging the admission for out-of-network services for medically necessary treatment of mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards.

I. The Alliance shall use tools mutually agreed upon with Alameda County Behavioral Health (ACBH), administered by Alameda Health System (AHS) to assess the Member's disorder, level of impairment, and needed care.

Behavioral case managers are able to refer Medi-Cal members 12 years and older for a mental initial evaluation without parental or guardian consent. The treating mental health clinician will determine if the member is deemed mature enough to participate without parental or

guardian consent.

J. Through a network of licensed Mental Health care Providers, the Alliance shall provide Behavioral Health Services to Members with Mild to Moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual (except relational problems), individual/group Mental Health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a Mental Health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.

K. The Alliance and its contracted Primary Care Providers (PCPs) shall provide AMSC for Members identified as at-risk of alcohol misuse in accordance with the Alliance Policy.

L. The Alliance and its contracted PCPs shall be responsible for screening and providing Mental Health services within the scope of their practice.

M. The Alliance shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with Alameda Alliance Policies: Tracking and Reporting Disclosures of Protected Health Information (PHI), Protected Health Information Disclosures Required by Law, Use and Disclosure for Treatment, Payment, and Health Care Operations. (CMP-005 Minimum Necessary Use & Disclosures)

N. The Alliance shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with the Alliance Policies: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, Member Authorization for the Use and Disclosure of Protected Health Information.

O. The Alliance shall maintain and monitor an appropriate provider network and ensure timely access to Behavioral Health Services as set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and the Alliance Policy: QI 108 Access and Availability Standards.

P. If Behavioral Health Services that are the responsibility of the Alliance are unavailable to the Member within the network, the Alliance shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with the Alliance Policy: UM-057 Authorization Request.

Q. The Alliance shall not require a referral from a PCP or Prior Authorization for an initial Mental Health assessment performed by a network Mental Health Provider. In addition, Behavioral Health Services do not require Prior Authorization except for Psychological Testing and Behavioral Health Treatment (BHT) Services, in accordance with the Alliance Policies and APL 22-005 (No Wrong Door for MHS) Prior Authorization requirements shall be in compliance with the requirements for parity in Mental Health and substance use disorder benefits in Title 42 CFR section 438.910(d).

R. The Alliance shall provide a direct telephone call center for emergencies during non-business hours for Members to access and for Providers to coordinate care or to access the nearest emergency room during a crisis.

1. The Alliance shall ensure:

   a. Timely access to screening of Members for Mild to Moderate Behavioral Health Services using the age appropriate DHCS approved Screening Tool;
   b. Appropriate staffing levels of the call center; and
   c. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to the Alliance Policy: Cultural and Linguistic Services.

2. The Alliance shall ensure its call center staff have relevant knowledge to:

   a. Provide information regarding Covered Services;
   b. Identify the location, qualifications, and availability of Providers within the Alliance Behavioral Health Provider network;
   c. Inform Members of their rights and responsibilities, in accordance with the Alliance Policy: Member Rights and Responsibilities;
   d. Communicate the procedure for Member Complaints, Grievances, and Appeals, in accordance with the Alliance Policies, Member Grievance and Appeal Process;
   e. Communicate the procedure for Provider Complaints and disputes, Appeals and Grievances in accordance with the Alliance Policies, the Alliance Provider Complaint and Appeal Process;
   f. Access oral interpretation services and written materials in Threshold Languages for Members;
   g. Provide information on other community services or resources available to Members; and

Educate the Member regarding the procedure and department at the Alliance to contact if the Member would like to change their Health Network or has questions about Health Network options.

S. The Alliance will administer DHCS mental health and transition of care tools for members under age 21 (youth) and for Members age 21 and over (adults).

1. The Adult Screening Tool, which includes screening questions that are intended to elicit information about the following:

   a. Safety: information about whether the Member needs immediate attention and the reason(s) a Member is seeking services.
   b. Clinical Experiences: information about whether the Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
   c. Life Circumstances: information about challenges the Member may be experiencing issues related to school, work, relationships, housing, or other circumstances.
   d. Risk: information about suicidality, self-harm, emergency treatment, and hospitalizations.

2. The Adult and Youth Screening Tools are:

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a. Not required or intended for use with Members who are currently receiving mental health services.
b. Not required for use with Members who contact mental health Providers directly to seek mental health services.
c. Must be used by MCPs when a Member, or a person on behalf of a Member under age 21, who is not currently receiving mental health services, contacts the MCP seeking mental health services.

3. The Youth Screening Tool screening questions that are intended to elicit information about the following:

    a. Safety: information about whether the Member needs immediate attention and the reason(s) a Member is seeking services.
    b. System Involvement: information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
    c. Life Circumstances: information about challenges the Member may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.
    d. Risk: information about suicidality, self-harm, harm to others, and hospitalizations.
    e. SMHS access and referral of other services.

4. The Adult and Youth Screening Tools do not replace:
    a. Procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
    b. Protocols that address clinically appropriate, timely, and equitable access to care.
    c. Clinical assessments, level of care determinations and service recommendations.
    d. Requirements to provide EPSDT services.

5. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool determines whether the Member must be referred to the Alliance's non-specialty mental health network or to Alameda County Behavioral Health (ACBH) for clinical assessment and medically necessary services.

    a. Alliance staff must use the scoring methodology and follow the referral determination generated by the score unless a clinical staff member overrides the score consistent with the guidance outlined in APL 25-010.
    b. For all referrals, the Member must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.

6. The Adult and Youth Screening Tools, and the Transition of Care Tool:

    a. Can be administered by designated staff, licensed or unlicensed, who are trained by the Alliance to administer the Screening tools in alignment with Alliance protocols and in accordance with APL 25-010.
    b. May be administered in a variety of ways, including in person, by telephone, or by video conference.

c. Will be administered using the exact wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the Member is able to respond. Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.

7. Alliance clinical staff may override the Screening Tool score when the result is inconsistent with the Member's clinical presentation (e.g., the Screening Tool does not capture the need for SMHS in Members who are unable to respond to the Screening Tool questions due to serious mental health symptoms.

8. Overriding the Screening Tool score must be conducted only by specified clinical staff. The Alliance practitioner types that may override the Screening Tool score include Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, Licensed Physicians, and their waivered, Registered, or Clinical Trainee counterparts. MCPs are responsible for ensuring that all Practitioners deliver services within their scope of practice under California law.

9. The clinical staff must provide ACBH their rationale and information supporting the rationale for overriding the Screening Tool score based on the following:

   a. Additional information was provided during the screening indicating a higher level of services than NSMHS is needed. The Alliance staff will refer the Member to ACBH for a timely assessment.
   b. Additional information was provided during the screening indicating a lower level of services than SMHS is needed. The Member should be referred to the Alliance so the Alliance can coordinate a timely assessment.

10. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference, and is utilized to ensure Members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.

11. The Transition of Care Tool is not considered an assessment and does not replace:

    a. MCP P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
    b. MCP protocols that address clinically appropriate, timely, and equitable access to care.
    c. MCP clinical assessments, level of care determinations, and service recommendations.
    d. MCP requirements to provide EPSDT services.

12. The Transition of Care Tool is used by both adults and youth and intended to document the Member's information and provide information from the entity making the referral to the receiving delivery system to begin the member's care transition?

13. The Transition of Care Tool includes specific fields to document the following elements:

a. Referring plan contact information and care team.

b. Member demographics and contact information.

c. Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications.

d. Requested services and plan contact information.

14. The Alliance is required to administer the Transition of Care Tool to facilitate transitions of care to MHPs for all Members, including adults aged 21 and older and youth under age 21, when their service needs change. The determination to transition services to and/or add services from the Alliance delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with the plan's protocols. Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician. Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.

15. Following the completion of the Transition of Care Tool, MCPs shall:

a. Refer the Member to the MHP

b. Coordinate care.

16. The Alliance staff shall coordinate Member care services with ACBH to facilitate care transitions or additions of services, including ensuring that the referral process has been completed, the Member has been connected with a Provider in the new system, the new Provider accepts the care of the Member, and medically necessary services have been made available to the Member. All appropriate consents must be obtained in accordance with accepted standards of clinical practice.

17. Alliance will coordinate member referrals with Alameda County Behavioral Health (ACBH). Referral coordination must include sharing the completed Adult or Youth Screening Tool, or Transition of Care Tool and following up to ensure a timely clinical assessment has been made available and appropriate consents obtained in accordance with accepted standards of clinical practice.

T. The Alliance shall identify and refer an eligible Member to ACBH for the provision of Medi-Cal Specialty Mental Health Services the Alliance shall identify and refer an eligible Member to the County Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

U. The Alliance will develop an annual outreach and education plan for Medi-Cal members and primary care providers to increase awareness of the non-specialty mental health services (NSMHS) available to Alliance members which is posted on the Alliance website. The outreach and education conducted for Members will meet cultural and linguistic appropriateness standards, incorporate best practices in stigma reduction, and provide multiple points of contact for Members to access NSMHS. The outreach and education plan will be reviewed annually with the Quality Improvement Health Equity Committee (QIHEC).

The Alliance collaborates with Alameda County Behavioral Health and relevant community organizations including tribal liaisons, with the focus on ensuring that members understand how they can "receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption."

The outreach and education plan includes content specifically created for both members and PCPs and it is informed by, but not limited, to the following:

1) The MCP's stakeholders, including the community advisory committee (CAC) established by the MCP and Quality Improvement and Health Equity Committee (QIHEC) which includes tribal liaisons.

2) Most recently approved DHCS Population Needs Assessment as defined by the Population Health Management (PHM) Policy Guide, or the most recently approved National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) Population Assessment.

3) A utilization assessment of provided NSMHS that is, at a minimum, stratified and analyzed by race, ethnicity, language, age, sexual orientation, gender identity, and disability.

4) Regularly scheduled Operational and No Wrong Door Meetings with ACBH are utilized to collaborate with the County Mental Health Plan (ACBH) to coordinate outreach and education efforts for Members to improve access to mental and behavioral health services.

5) Quarterly No Wrong Door Meetings, Joint Operational Meetings and monthly Coordination of Care meetings with ACBH address timely access to services and facilitate and support uninterrupted treatment relationships between members and providers in both the Alliance provider network and the ACBH network of services.

6) Collaboration with ACBH leadership and the ACBH Mental Health Services Act implementation team is ongoing to ensure alignment and awareness of programs and services developed and available through the Mental Health Services Act funding.

V. The Alliance's Behavioral Health Department performs the care management and utilization management functions requiring behavioral health expertise and experience. The Alliance integrates behavioral health into its UM, CM and QI program descriptions, work plans and annual evaluations to ensure parity and enable the Alliance's efforts to provide integrated whole person healthcare services.

W. Grievances are reviewed monthly by Behavioral Health Leadership for monitoring, and the identification of trends and areas for improvement. Process improvements may be implemented by the Behavioral Health Department or in other the Alliance departments (e.g., contracting) . The

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process improvements are monitored for effectiveness in improving member experiences.

X. The Alliance's Behavioral Health Department provides Care Management and Utilization Management for Mental Health and Autism Services. The Behavioral Health Department is overseen by the Senior Director of Behavioral Health and the Senior Medical Director. The Senior Medical Director is an Emergency Medicine Physician and the Senior Director of Behavioral Health is a licensed psychologist. Together, they are responsible for Behavioral Health Care Management and Utilization Management processes and level of care determinations. The Behavioral Health Department is staffed by licensed Mental Health clinicians including LCSWs, LMFTs, BCBAs, RNs and Behavioral Health navigators.

PROCEDURE

A. PCP and Behavioral Health Services
   1. For alcohol misuse, a PCP shall:
      a. Administer the DHCS-approved screening tool for identifying alcohol misuse in accordance with DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care.
      b. Provide behavioral counseling intervention on identified issue(s); and
      c. Refer to ACBH for additional assessment and counseling when indicated.
   2. For Mental Health, a PCP shall:

      a. Screen and provide Mental Health services within the scope of their practice; and
      b. Refer the Member for further Mental Health services through the Alliance's and / or ACBH's Mental Health Provider Network.

B. Accessing the Alliance Behavioral Health Services

   3. A Member may access Behavioral Health Services through the Alliance Member Services Phone Line.

   4. A Member may be referred to the Alliance Member Services Phone Line from the following:

      a. Alameda County Mental Health Plan (ACBH) ACCESS Line;
      b. Self-referral;
      c. Authorized Representative or caregiver.
      d. PCP;
      e. Specialty Care Provider;
      f. Behavioral Health specialist;
      g. Long-Term Support Services (LTSS) Provider;
      h. Community-based agency;

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i. Case manager, Disease Management staff, or discharge planner; and
j. Other Providers of a Member's health care team.

C. The Alliance Member Services Phone Line

5. Call Center requirements shall include:

a. Complying with telephone access standards in accordance with the Alliance Policies: Access and Availability Standards; and Member Services Clinical Referral and Triage Process (MBR – 062)
b. Utilizing linguistic interpreter services, or the California Relay Service for Members, as necessary to ensure effective communication;
c. Verifying the caller's Medi-Cal eligibility and Health Network assignment;

i. If the caller is a the Alliance Medi-Cal Member assigned to Kaiser Foundation Health Plan (Kaiser), The Alliance shall refer and provide the caller the Kaiser phone line to access services.
ii. If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Alameda County Social Services or provide enrollment information and suggest a community resource for treatment of their described symptoms.

d. Determining if the caller is seeking help for a Mental Health concern;
e. Screening for crisis and determining if the call is routine, urgent or emergent. If determined urgent or emergent, call center staff shall immediately complete safety screening;
f. If a caller's needs are indicated as requiring Emergent or Urgent Services including when a caller who potentially presents as a danger to self or others, call center staff shall transfer the caller to the Alliance BH Care Management Team and/or County's Crisis Response services without delay to prevent further deterioration of the caller's condition;
g. Call center staff must link Emergent calls to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than two (2) hours after determining the call is emergent;
h. Call center staff must transfer urgent calls for services to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than within twenty-four (24) hours after making the determination that the call is urgent;
i. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to the Alliance Behavioral Health Care Management Team (Clinician) and:
j. If the Caller is determined to be a Medi-Cal beneficiary assigned to the Alliance with a Mental Health need, the call center staff shall conduct a brief telephone clinical screening tool approved by DHCS to verify appropriate level of services and transfer/refer members meeting the threshold criteria for Specialty Mental Health Services to the ACBH Access Team to initiate appropriate mental health services.
k. The member services staff will use the DHCS approved screening tool to determine the need for a referral to Alameda County Behavioral Health of moderate to severe services. Member services will transfer/refer members to

the ACBH Access Team to initiate appropriate mental health services.

6. As a result of the brief telephone clinical screening using the DHCS approved Screening Tool:

   a. If it is determined the Member meets Mild to Moderate need for Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the Alliance Behavioral Health Network, are currently accepting the Alliance Medi-Cal Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to the Alliance Policy: Access and Availability Standards.
   b. If determined the Member does *not* meet Mild to Moderate need for Behavioral Health Services and rather does meet for Serious Mental Illness (SMI), the call center staff will warm transfer the member to the Alliance BH Care Manager who will complete the DHCS clinical assessment and transition of care form and subsequently transfer the member to ACBH ACCESS where the Member will establish appropriate services consistent with APL 22-005 No Wrong Door for MHS.

      i. Based on screening, member will be referred to ACBH if member has:
         a. An included diagnosis for services with ACBH
         b. A significant impairment in an important area of life functioning or a reasonable probability of deterioration in an important area of life functioning
      ii. Member can also initiate services by self-referring to an Alliance contracted provider. The Alliance contracted provider to complete the initial screening during the first initial assessment appointment. If based on the screening, member meets criteria for Specialty Mental Health Services, current provider to notify Alliance BH department to refer the member to ACBH for services utilizing the DHCS approved Transition of Care Tool.
      iii. Transfer/refer members to ACBH Access Team:
         a. If during clinical review or during the course of treatment the behavioral health provider determines that member meets criteria for Specialty Mental Health Services through the Mental Health Plan, BH Case Manager will coordinate with member and current behavioral health provider to transition member to the ACBH for services. BH Case Manager will ensure successful linkage to ACBH for services consistent with "closed loop" referral requirements.

   c. If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to ACBH for Drug Medi- Cal services.

7. The Alliance shall ensure the following steps are completed during the Member call:

   a. Member's eligibility status and Health Network assignment shall be verified each time the Member contacts the Alliance Member Services Phone Line;

b. A safety screening and an age-appropriate Screening Tool approved by DHCS will be completed, the outcome/results of the screening, and if applicable, any resources/Provider referrals that were provided; and
c. Warm transfer to the Alliance BH Care Management Team for further clinical assessment based on the Safety Screening and protocols for identification of urgent and emergent access to care.

D. Care Coordination

8. The Alliance shall coordinate Mental Health care for Members enrolled in the Enhanced Care Management (ECM)and Community Supports (CS) in accordance with the Alliance polices for ECM and CS.

   a. The Alliance shall ensure compliance with all applicable State and federal requirements related to ECM and all CSS requirements determined by DHCS.
   b. The Alliance shall ensure Members are receiving appropriate and coordinated services.

9. The Alliance shall ensure care coordination with ACBH is addressed in interagency the Alliance/ACBH Collaboration Meetings to ensure:

   a. Provision of all Medically Necessary Covered Services; and
   b. Identification and referral of eligible Members to LTSS based on Member's Plan of Care.
   c. When the Alliance is determined to be responsible for covered Behavioral Health Services, the Alliance shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the ACBH.
   d. Transition of care is provided for Members transitioning to or from the Alliance or ACBH Mental Health services in compliance with APL 22-005 (No Wrong Door for MHS) requirements. ACBH clinical consultation, including consultation on medications, shall be provided to the Alliance's PCPs who are treating Members with mental illness;

10. Coordination of care for Inpatient Mental Health treatment:

    a. ACBH requires that inpatient hospital Providers notify a Member's PCP within twenty-four
    (24) hours of admission and discharge from an inpatient Mental Health treatment to arrange for appropriate follow-up services.
    b. To facilitate transition of care for Members transiting to or from ACBH Mental Health services, the Alliance's PCPs and the outpatient Behavioral Health Providers treating
    Members with mental illness shall receive clinical consultation, including consultation on medication from ACBH.
    c. The Alliance and contracted Health Network PCPs and the outpatient Behavioral Health Provider shall review and update the care plan of the Member as clinically indicated.

11. Services provided Simultaneously by Alliance and ACBH

    a. ACBH and the Alliance will coordinate provision of prescribing psychiatrists and psychiatric NPs who are serving the Alliance members; and
    b. Ensure non-duplicated specialty Mental Health services provided through ACBH, including psychiatric medication management, can be provided simultaneously with Mental Health services provided by the Alliance network providers when clinically appropriate.

12. Emergency Services

    a. The Alliance shall provide emergency room facility and related services (other than Specialty Mental Health Services), home health agency services as described in Title 22 of the California Code of Regulations (CCR) section 51337, Non-Emergency Medical Transportation as defined in the Alliance Policy: Transportation: Emergency, Non- Emergency, and Non-Medical, and Covered Services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical examination required upon admission;
    b. The Alliance shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's Mental Health or medical condition; and
    c. As the County Mental Health Plan, ACBH provides emergency assessment of the Member's Mental Health condition through their Crisis Services Team and designated Emergency Departments throughout Alameda County.

13. Information Exchange

    a. The Alliance shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and Behavioral Health care coordination pursuant to Title 9, CCR, section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.

14. Members receive Specialty Mental Health Services, as well as alcohol and/or substance use disorder treatment while receiving services from a Specialty Mental Health Provider; and

15. Members are receiving services from ACBH and/or Drug Medi-Cal program.

DEFINITIONS

Term	Definition

Appeal	A review by the Alliance of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both Mental Health and substance use disorder services, as covered by the Alliance.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
The Alliance Member Services Phone Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call to obtain referrals for all Alliance Covered Outpatient Mental Health Services. Telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

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Term	Definition
Child with Serious Emotional Disturbance (SED)	Pursuant to Section 1912(c) of the Public Health Service Act and Section 5600.3 of the Welfare and Institutions Code, children with a serious emotional disturbance are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the Alliance program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under the Alliance's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the Alliance Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For- Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi- Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.

Drug Medi-Cal Treatment Program (Drug Medi-Cal)	Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Generally accepted standards of mental health and substance use disorder care	Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

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Term	Definition
Emergent Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.
Grievance	An oral or written expression of dissatisfaction, about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Enhanced Care Management Program (ECM)	This program is required by DHCS to replace the prior Health Homes Program and is designed to provide targeted services and resources for members who meet ECM criteria in order to provide additional support and Care Management services for members with complex needs.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable Alliance policies.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Alameda Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the Alliance program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Plan of Care	An individual written Plan of Care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by the Alliance or Business Associates and relates to: 1. The past, present, or future physical or Mental Health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	**Definition**
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Behavioral Health provider, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Rehabilitation services, which include Mental Health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services. Specialty Mental Health Services may also include: 1. Psychiatric inpatient hospital services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; and 5. Early Periodic Screening, Detection, and Treatment (EPSDT) Specialty Mental Health Services
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely Mental Health intervention that shall be appropriate to the severity for the condition.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews including:

Behavioral Health,
Case and Disease Management,
Grievance and Appeals,
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning
UM-005 Second Opinions
UM-014 Identifying Abuse
UM-015 Emergency Services and Post Stabilization Services
UM-016 Transportation Guidelines
UM-025 Guidelines for Obstetrical Services
UM-036 Continuity of Care
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Requests
UM-058 Continuity of Care for Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Transitioning into Medi-Cal Managed Care
CM-001 CCM Identification Screening Enrollment and Assessment
CM-002 CCM Plan Development and Management
CM-004 Care Coordination
CM-011 ECM Care Management and Transitions of Care
MBR-062 Member Services Clinical Referral and Triage Process
CMP-210 Minor Consent to Medical Care

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 3/21/2023
Revisions: 6/12/2024, **12/18/2024, 9/17/2025**

Blue = material updates

REFERENCES

- Alameda Alliance for Health Contract with Department of Health Care Services (DHCS)
- Memorandum of Understanding with ACBH
- DHCS All Plan Letter (APL) 17-018: Medi-Cal Managed Care Health Plan Responsibilities

approval

for Outpatient Mental Health Services

- DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
- DHCS APL 21-002 Implementation of SB 855, MH/SUD Coverage
- DHCS APL 22-005 No Wrong Door for Mental Health Services
- DHCS APL 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders.
- DHCS APL 22-007 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
- Medi-Cal Provider Manual – Part 2: Psychological Services
- Title 9, California Code of Regulations, §§1810.370(a)(3), 1830.205 and 1830.210
- Title 22, California Code of Regulations, §51337
- AA. Welfare and Institutions Code, §§14132.03 and 14189 BB. Title 42, Code of Federal Regulations, Part 438, Subpart K CC. Title 42 Code of Federal Regulations §438.910(d)

MONITORING

The Compliance, Quality Improvement and Behavioral Health Departments will annually review this policy for compliance with regulatory and contractual requirements. All policies will be brought annually to the Quality Improvement Health Equity Committee (QIHEC), and Administrative Oversight Committee for review and approval.

approval

approval

approval



POLICY AND PROCEDURE

Policy Number	CBAS-001
Policy Name	Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	Outpatient Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~11/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~12/18/2024~~TBD

POLICY STATEMENT

The Alliance follows Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS) as well as for periodic reassessments of eligibility determinations.

Alameda Alliance for Health (The Alliance) ensures the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

A. Ensures appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS is trained by DHCS on using the approved assessment tool.
~~A.~~

B. Conducts the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations include a face-to-face (42 CFR §422.101(f)(1)(iv) or Telephonic review of the Member. The assessment team includes a Registered, ~~d~~ Nurse with level of care experience, either as an employee or as a sub- contractor.
~~B.~~

C. The Alliance shall reassess and re-determine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.
~~C.~~

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D. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, The Alliance may conduct the reassessment using only the Member's Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

E. The Alliance shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. The Alliance's written notice shall be approved by DHCS and include procedures for grievances and appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6, (Member Grievance and Appeal System.)

~~E.~~

F. The Alliance shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

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PROCEDURE

~~The Alliance Out of Plan team receives a CBAS interest call from the following sources:~~

~~a. Self, family and/or caregiver~~

~~b. Primary Care Provider (PCP)~~

~~c. Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management~~

~~d. CBAS provider/center~~

~~e. Home or Community Based Organization (HCBO)~~

~~f. Acute care hospital (see LTS CBAS 0002 Expedited Initial Member Assessment for Community Based Adult Services (CBAS) Eligibility)~~

~~g. Skilled nursing facility, acute care facility (see LTS CBAS 0002 Expedited Initial Member Assessment for Community Based Adult Services (CBAS) Eligibility)~~

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~~The Alliance CBAS Out of Plan RN contacts the member/authorized representative to confirm interest in CBAS services and ascertain administrative eligibility. If member does not meet administrative criteria, a letter is sent informing the member and requester that the member did not meet minimum qualifications. Information regarding the rights to file a Grievance and Appeal, Independent Medical Review (IMR) and/or a State Fair Hearing is also sent to the member.If the member meets administrative eligibility, the Alliance ensures that the member is in touch with the CBAS center of their choice, either through direct contact initiated by the member or through care coordination provided by an Alliance CBAS Out of Plan RN in order to initiate a site visit. If the member cannot make a choice of center, an Alliance CBAS team helps the member select a CBAS center that fits the member's interest, culture and language, health condition and/or geographic location. The Alliance works with the chosen or assigned CBAS center and the member's PCP to obtain medical necessity for CBAS services. Once medical necessity is obtained from the member's PCP, the CBAS center sends a referral to the Alliance for eligibility determination.~~

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1. When the Alliance receives a referral for eligibility determination the following processes

occur, although the ordering of the processes may vary according to individual cases:

a. Alliance CBAS team receives initial referral of a member to CBAS. from the following sources:

i. Self, family and/or caregiver
ii. Primary Care Provider (PCP)
iii. Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
iv. CBAS provider/center
v. Home or Community-Based Organization (HCBO)
vi. Acute care hospital (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)
vii. Skilled nursing facility, acute-care facility (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)

b. Out of Plan RN makes first attempt to schedule Face-to-Face assessment within 5 calendar days of initial referral the RN makes two additional attempts via telephone to schedule between five (5) and eight (8) calendar days of initial referral.

~~i.~~ c. If the RN is unable to contact the member and/or authorized representative by phone within eight (8) calendar days of the initial referral request, s/he makes final attempt in writing, giving the member until day 14 from initial referral to schedule face-to-face or Telephonic.

~~ii.~~ d. If a member does not schedule within 14 days from initial referral, the Alliance will send a follow-up letter to member and requester informing them that if services are still needed, a new referral must be submitted to begin the process again.

~~ii.~~ 2. When an Alliance nurse successfully contacts the member and/or the authorized representative, the nurse confirms:

a. Appropriateness of the referral, i.e., that the member meets the minimum qualifications.

i. If member does not meet administrative criteria, a letter is sent informing the member and requester that the member did not meet minimum qualifications. Information regarding the rights to file a Grievance and Appeal, Independent Medical Review (IMR) and/or a State Fair Hearing is also sent to the member.

ii. If the member meets administrative eligibility, the Alliance ensures that the member is in touch with the CBAS center of their choice, either through direct contact initiated by the member or through care coordination provided by an Alliance CBAS Out of Plan RN in order to initiate a site visit.

iii. If the member cannot make a choice of center, an Alliance CBAS team helps the member select a CBAS center that fits the member's interest, culture and language, health condition and/or geographic location.

iv. The Alliance works with the chosen or assigned CBAS center and the member's PCP to obtain medical necessity for CBAS services. Once medical necessity is obtained from the member's PCP, the CBAS center sends a referral to the Alliance for eligibility determination.

~~i.~~

3. An Alliance Registered Nurse with level of care experience arranges for a face-to-face

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interview with the member within 30 days from initial referral, employing the approved CBAS Eligibility Determination Tool (CEDT) (See Attachment A).

~~3.~~

4. Plan staff, including RN Case Manager, approve or deny CBAS services based on information collected during the face-to-face assessment.

a. Denial of CBAS program:

i. Member does not meet medical necessity criteria or member's need for services is not supported by CEDT.

ii. A denial of CBAS eligibility results in a Notice of Action (NOA,) which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review and a State Fair Hearing. The CBAS provider also receives a copy of this letter. This letter is sent within five (5) working days of the face-to-face assessment.

iii. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

b. Approval of CBAS program:

i. Eligibility determination is communicated to the member and her/his authorized representative within two (2) business days.

ii. Authorization to conduct Individual Plan of Care (IPC) is communicated to the member's chosen CBAS provider within one (1) business day of the decision.

~~ii.~~

5. At this point, the CBAS provider is authorized to conduct a three (3) day multidisciplinary team assessment in order to produce an IPC, within 90 days.

~~5.~~ a. CBAS center staff:

~~a.~~i. Performs three (3) day multidisciplinary team assessment.

~~b.~~ii. Based on the assessment, the CBAS center submits an Individualized Plan of Care (IPC) with level of service recommendation

~~c.~~iii. Submits a Prior Authorization request to the Alliance.

~~6.~~ 6. The Alliance:

~~a.~~ a. Approves, modifies, or denies prior authorization request within five (5) business days in accordance with the standards set in the Health and Safety Code section 1367.01.

i. If the Alliance cannot make a decision within five (5) working days of receiving

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the authorization, the decision may be deferred, and the time limit may be extended no longer than 14 calendar days from the initial receipt of the authorization request. A deferral letter explaining the decision-making extension period is sent to the member and CBAS provider.

ii. If a prior authorization request is denied or level of service is decreased (modified), a Notice of Action is sent to the member within 48 hours of decision, along with information on their rights to file a Grievance and Appeal, Independent Medical Review, and State Fair Hearing. The CBAS provider also receives a copy of this letter. The CBAS provider is notified within 1 Business Day.

iii. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

~~b.~~ b. Approved services are authorized for a six-month period.

~~i.~~ i. Member is notified within 2 Business Days of authorization.

~~ii.~~ ii. Center is notified within 1 Business Day of authorization.

~~7.~~ 7. Reassessment: In order for CBAS services to continue, the CBAS center sends a prior authorization request including an updated IPC with level of service recommendations to the Alliance prior to the expiration of the authorized six-month period.

a. A reassessment and redetermination of a member's eligibility for CBAS is completed at least every six (6) months after the initial assessment or whenever a change in circumstances occurs that may require a change in the member's CBAS benefit.

b. If a member is already receiving CBAS services and requests that services remain at the same level or be increased due to a change in level of need, the Alliance conducts the reassessment using only the member's IPC and any supporting documentation supplied by the CBAS Provider.

c. Reauthorization is an administrative process and may be accomplished without a repeat face-to-face evaluation.

d. If a member no longer requires CBAS, CBAS providers are required to complete a CBAS Discharge Plan of Care. The CBAS Discharge Plan of Care includes:

~~i.~~iii. The Member's name and ID number

~~ii.~~iv. The name(s) of the Member's Physician(s)

~~iii.~~v. If applicable, the date of the Notice of Action denying authorization for CBAS was issued

~~iv.~~vi. If applicable, the date the CBAS benefit will be terminated

~~v.~~ Specific information about the Member's current medical condition, treatments, and

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medications

vii.

~~vi.~~viii. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge

~~vii.~~ix. Contact information for the Member's case manager

~~viii.~~x. A space for the member or Member's representative to sign and date the Discharge Plan of Care.

~~e.~~ e. Communication and Coordination of Care

~~i.~~i. The Alliance will coordinate with the CBAS provider to ensure:

- Timely exchange of the following coordination of care information:
- Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition.
- Clear communication pathways between the appropriate CBAS Provider and staff and The Alliance staff (CBAS RN) responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team.

~~ii.~~ ii. The Alliance will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in The Alliance policies and procedures related to CBAS.

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DEFINITIONS / ACRONYMS

" Out of Plan RN" refers to a professionally trained and licensed Alliance staff member in the Utilization Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems with the aim of improving health status and reducing the inappropriate use of medical services. The nurse provides care coordination and is an essential member of the Interdisciplinary Care Team.

"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi- Cal beneficiaries who meet criteria as defined in the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" is the document which delineates aCBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It is created after a multidisciplinary team assessment and includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Long–Term Care

RELATED POLICIES AND PROCEDURES

CBAS 002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 05/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 9/25/2024, 12/18/2024, 10/28/2025

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

42 CFR §422.101(f)(1)(iv)
California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9
DHCS CBAS Contract, Exhibit A, Attachment 20.4

DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01

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MONITORING

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Monthly monitoring report that tracks volume of CBAS authorizations and processing turn around times.

~~Monthly monitoring report that tracks volume of CBAS authorizations and processing turn around time.~~

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POLICY AND PROCEDURE

Policy Number	CBAS-002
Policy Name	Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	Outpatient Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~TBD
Administrative Oversight Committee Approval Date	TBD~~4/16/2025~~

POLICY STATEMENT

The Alliance follows the Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS). Services are provided according to a six-month individual plan of care (IPC) developed by the CBAS center's multidisciplinary team (MDT) in collaboration with the CBAS participant or authorized representative(s). The services are designed to prevent premature and unnecessary institutionalization and to keep participants as independent as possible in the community. The Alliance has developed and implemented an expedited assessment process to determine CBAS eligibility when the plan is informed that a member is in a hospital or skilled nursing facility whose discharge plan includes CBAS, who is at high risk of admission to a skilled nursing facility or faces an imminent and serious threat to their health.
.

PROCEDURE

1. If Alliance staff receive~~s~~ an initial CBAS referral for a member who is in the hospital or nursing facility and whose discharge plan includes CBAS, or for a member who is at immediate risk of admission to a nursing facility or faces an imminent and serious threat to their health, an expedited CBAS eligibility determination by the Nurse is triggered. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that a Face to Face (F2F) (42 CFR §422.101(f)(1)(iv) will not be

performed:

~~1.1~~ a. Members in a hospital or skilled nursing facility whose discharge plan includes CBAS, who are at high risk of admission to a skilled nursing facility or face~~s~~ an imminent and serious threat to their health or faces an imminent and serious threat to their health will have an expedited authorization within 72 hours of receipt of a CBAS authorization request.

~~1.2~~ b. Written documentation of medical necessity is obtained from the Attending Physician.

c. ~~1.3~~ The Alliance uses the Department of Health Care Services (DHCS) approved CBAS Eligibility Determination Tool (CEDT) tool. The CEDT is completed within 5 business days from initial referral.

2. Eligibility determination is communicated to the member and her/his authorized representative within 2 business days. If the requester and the member has not yet chosen or been assigned to a CBAS provider, the member and/or authorized representative may do so at this time.

a. A denial of CBAS eligibility will result in a Notice of Action which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review, and a State Fair Hearing. The Requester also receives a copy of this letter.

~~2.1~~

3. Approval or denial of eligibility is communicated to the CBAS center within 24 hours of the decision. At this point, if the member is approved for CBAS services, the Alliance authorizes the CBAS center to conduct a three (3) day interdisciplinary team assessment in order to produce an Individualized Plan of Care (IPC).

~~3.~~

4. After the three-day assessment is completed, the CBAS center submits the IPC with Level of Service recommendation and a prior authorization request to the Alliance.

~~4.1~~ a. The Alliance approves, modifies, or denies prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)

~~4.2~~ b. The Alliance notifies the Center within 24 hours of the decision. The Alliance notifies the member within 48 hours of the decision

~~4.3~~ c. If the prior authorization request is approved, CBAS services are approved with specified level of service. Services are authorized for a six-month period and CBAS services begin.

~~4.4~~ d. If prior authorization request is denied, a Notice of Action is sent to the member and requestor along with information on her/his right to file a Grievance and Appeal, Independent Medical Review, and a State Fair Hearing.

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DEFINITIONS / ACRONYMS

"Attending Physician" shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law and who is providing medical care to a Member.

Community Based Adult Services (CBAS): means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the California CalAIM Demonstration, Number 11-W-00193/9 Special Terms and Conditions

"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" a written plan of care developed by a CBAS center's multidisciplinary team which delineates a CBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

CBAS Provider: means an ADHC center that is licensed by the California Department of Public Health to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a CBAS Provider by the California Department of Aging

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Long Term Services and Supports (LTSS)

Utilization Management

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CBAS Eligibility Determination Tool (CEDT)
Community Based Adult Services (CBAS) Standard Operating Procedure

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 3/19/2024, 7/17/2024, **4/16/2025**, 10/25/2025

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REFERENCES

42 CFR §422.101(f)(1)(iv

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Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, amended 4/1/2012
California's Section 1115(a) Medicaid Waiver, entitled Medi-Cal 2020.
DHCS CBAS Contract, Exhibit A, Attachment 20.4
DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01

MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn-around-time.

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POLICY AND PROCEDURE

Policy Number	CBAS-004
Policy Name	Member Assignment to a Community-Based Adult Service (CBAS) Center
Department Name	Outpatient Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD~~2/14/2025~~
Administrative Oversight Committee Approval Date	TBD~~4/16/2025~~

POLICY STATEMENT

1. Alliance supports Member preference in the assignment of Community Based Adult Services (CBAS) center.
   ~~1.~~
2. The Alliance promotes CBAS services as an option for all eligible Members.
   ~~2.~~
3. The Alliance makes every effort to accommodate language, culture, and geographical preferences and to guide Members to a CBAS provider that offers disease/condition specific services appropriate to that Member.
   ~~3.~~
4. The Alliance provides unbundled CBAS services for CBAS-eligible members when CBAS centers are unavailable, limited in capacity, or cannot meet member's geographic, cultural and/or linguistic needs.

PROCEDURE

1. Member accesses CBAS through:
   a. Self or family and/or caregiver
   b. Primary Care Provider
   c. Alliance internal departments: such as, Case Management, Member Services,

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Utilization Management or Long-Term Services and Supports (LTSS) department
d. Skilled nursing facility or acute-care facility
e. Home or Community-Based Organization (HCBO)
f. CBAS provider/center
~~f.~~

2. Eligibility determination and initial assessment is outlined in CBAS-001 Initial Member Assessment and Reassessment for Community-Based Adult Services (CBAS) Eligibility.
~~2.~~

3. After eligibility has been determined, if the referral source was not a CBAS provider and if the member has not selected a CBAS provider prior to eligibility determination, the member and/or authorized representative are given detailed information on the various CBAS centers taking new clients and given the opportunity to make a selection and are offered to have a CBAS Provider contact the member to initiate the intake process.
~~3.~~

4. If the requested CBAS center is closed to new enrollees due to capacity limitations, the Member and/or Authorized Representative may choose to:
   a. Waitlist for an opening at the CBAS center of choice
      i. While on wait list, member may choose to receive unbundled CBAS equivalent services (see Alliance Policy and Procedure (CBAS-005 Provision of Unbundled CBAS Services) while on a CBAS center wait list.
   b. Accept assignment to another CBAS provider that does have openings and meets cultural and linguistic needs of the member and the one-way transportation time between member's place of residence and the CBAS center is reasonable.
   c. Accept unbundled equivalent CBAS services (see Alliance Policy and Procedure CBAS-005 Provision of Unbundled CBAS Services).
   ~~c.~~

5. If a member is unable to choose or does not wish to make the selection, the Alliance's Nurse contacts CBAS providers to determine capacity. The RN will assign the Member to a CBAS site using the following preferential order:
   a. Disease specific
   b. Member's relationship with a previous provider of services similar to CBAS
   c. Language/culture appropriate
   d. Geographically appropriate (closest to member's place of residence~~,~~ and involving reasonable transport~~.~~).~~.~~
   ~~d.~~

6. Member request for a specific CBAS center may be denied by the Alliance for the following reasons:
   a. The requested CBAS Provider is full and not accepting new participants.
   b. The requested CBAS Center~~PCP~~ had previously discharged the Member from his/her CBAS center
   c. The CBAS center is not complaint with their licensing requirements or certification standards

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d. The CBAS center failed to meet DHCS or CMS quality benchmarks
e. The facility has inadequate staffing, facility conditions or service delivery
f. There are any member safety, quality or fraudulent activities against the center documented
~~b.~~

7. The Alliance notifies Members of any termination, breach of contract, or other inability to provide services by the CBAS Provider thirty (30) days in advance when possible. In this event, the Member may continue to receive care from the CBAS center until the Alliance has made provisions for the assumption of health care services by another CBAS center or for the provision of unbundled CBAS equivalent services.

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DEFINITIONS / ACRONYMS

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"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation for eligible Medi-Cal beneficiaries to eligible Medi-Cal beneficiaries.

"Community-Based Adult Services (CBAS) PROVIDER" shall mean a center/place that provides skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Members and is certified by the California Department of Aging.

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"Member" shall mean any person certified as eligible for the Medi-Cal Program, pursuant to Welfare and Institutions Code, Sections 14016 and 14018, whose designated County Code number in the Medi-Cal Eligibility Data System (MEDS) database is 01 and Plan number 300, and whose Aid Code is included for capitation payment in the Alliance's contract with the State of California.

"Primary Care physician" or **"PCP"** shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law. A Member selects or is assigned to a primary care provider who provides primary and preventive medical care and is responsible for coordinating ongoing delivery of specialty medical services. "Primary care physician" may include physician assistant and nurse practitioner within their scope of practice and under the appropriate supervision of the physician.

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

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1. CBAS-001 Initial Member Assessment and Member Reassessment forCommunity-Based Adult Services (CBAS) Eligibility
2. CBAS-005 Provision of Unbundled CBAS Services
3. Community Based Adult Services (CBAS) Standard Operating Procedure

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 5/20/2021, 06/28/2022, 9/19/2023, 7/17/2024, 4/16/2025, 10/28/2025

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

~~REFERENCES~~

~~DHCS Contract, Exhibit A, Attachment 18~~California Health and Safety Code (H&S Code), Division 2, Chapter 3.3
California Welfare and Institutions Code (W&I Code), Division 9, Chapter 8.7
California Code of Regulations (CCR), Title 22, Division 3;
CCR, Title 22, Division 5
Code of Federal Regulations (CFR), Title 42, section 441.301(c)(1-4):
DHCS Contract, Exhibit A, Attachment 18

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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POLICY AND PROCEDURE

Policy Number	CBAS-005
Policy Name	Provision of Unbundled CBAS Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	TBD~~8/21/2024~~

POLICY STATEMENT

The Alliance provides unbundled Community Based Adult Services (CBAS) to Members who have been determined eligible for CBAS services when there is not sufficient and/or appropriate CBAS center capacity available within the timely access requirements. The Alliance does the following to ensure the provisions of unbundled CBAS services are met:

1. Arranges for the provision of unbundled services based on the assessed needs of the Member eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area.

~~1.~~

1. Coordinates care for unbundled CBAS, based on the assessed needs of the member eligible for CBAS, including services beyond those offered as CBAs unbundled services

PROCEDURE

1. Members who have expressed interest in CBAS services and have been determined to meet medical necessity criteria will undergo CBAS eligibility determination (CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility)

~~1.~~

1. When a ~~Member~~member has been determined eligible for CBAS services, the Member may select the CBAS center of their choice or be assigned to a CBAS center by the

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Alliance (see Policy and Procedure entitled CBAS-004 Member Assignment to a Community-Based Adult Service (CBAS) Center).

~~1.~~ 3.

~~2.~~ If an appropriate CBAS center exists in the service area but is at full capacity, the Member may be on a waitlist and contacted when an opening becomes available, at which time that Member will undergo multidisciplinary assessment by the CBAS center (See Policy and Procedure entitled CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility.

4. If there is no appropriate CBAS center available or if the member is placed on a waitlist, the Member may choose to accept a program designed by the CBAS RN as described in California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

. The Alliance follows our Special Needs Plan (SNP) Model of Care which outlines the "Development of the Individualized Care Plan (ICP) for High Risk Members" as well as follow-up action and regularity of Interdisciplinary Care Team (ICT) meetings. These alternative programs are designed to engage services provided by both The Alliance and Community Based Organizations.

a. Goal is to ensure that the members are fully receiving access and engagement with community and services desired by each member.

~~3.~~ 5. The Individualized Care Plan (ICP) outlines a package of unbundled services that might otherwise be provided at a CBAS center. These services are limited to:

a. Professional Nursing Services
b. Nutrition
c. Physical Therapy
d. Occupational Therapy
e. Speech and Language Pathology Services
f. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service provider
g. Non-Specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) that are Covered Services.

~~g.~~

~~4.~~ 6. Coordination of care for unbundled CBAS services, based on the assessed needs of the member~~,~~ may include services beyond those offered as CBAS unbundled services, including but not limited to:

a. Personal Care Services
b. Social Services
c. Physical and Occupational Maintenance Therapy
d. Meals
e. Mental Health Services and Substance Use Services.

~~e.~~

7. Reevaluation of Member needs and update of the ICP occurs annually.

~~5.~~

~~6.~~ 8. If a new CBAS center opens and is appropriate for a particular member's needs, the member is referred to that CBAS center for a multidisciplinary assessment and a service authorization request will progress (see Policy and Procedures entitled CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility)

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DEFINITIONS / ACRONYMS

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"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi-Cal beneficiaries.

"Community-Based Adult Services (CBAS) center" shall mean a Provider that provides skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Members and is certified by the California Department of Aging.

"Core CBAS services" shall mean services that are designed to maintain the ability of a CBAS participant to remain in the community and avoid emergency department visits,

hospitalizations, or other institutionalization and are required on each CBAS attendance day. They include professional nursing services, personal care services and/or social services, therapeutic activities, and meal service.

"Individualized Care Plan (ICP)" is the initial and ongoing document which delineates a Member's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives.

"Interdisciplinary Care Team (ICT)" is a multiagency, multidisciplinary healthcare team which is person centered in its approach, led by a Members primary care Provider.

"Member" shall mean any person certified as eligible for the Medi-Cal Program, pursuant to Welfare and Institutions Code, Sections 14016 and 14018, whose designated County Code number in the Medi-Cal Eligibility Data System (MEDS) database is "41 and Plan number 503", and whose Aid Code is included for capitation payment in the Alliance's contract with the State of California.

"Specialized CBAS services" shall mean services that may be included in a CBAS ICP and are designed to maintain the ability of a CBAS participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization but are not required for every participant on every day of service. They include rehabilitative services, registered dietitian services, and mental health services.

"Special Needs Plan (SNP)" is a specially designed Medicare Advantage health plan. Enrollment is focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, Medicare/Medicaid dual eligible members, and beneficiaries the severe or disabling chronic conditions.

"Special Needs Plan (SNP) Model of Care" refers to a service delivery mechanism required and approved by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage Special Needs Plans. The Model of Care contains the following elements: measurable goals, staff structure and care management roles, interdisciplinary care team, Provider network having special expertise, use of clinical practice guidelines, specialized

training, health risk assessment, communication network, performance, and health outcome measurements.

AFFECTED DEPARTMENTS/PARTIES RELATED POLICIES AND PROCEDURES

CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
CBAS-002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility
CBAS-004 Member Assignment to a Community-Based Adult Service (CBAS) Center

REVISION HISTORY

10/1/2013, 09/06/2018, 04/15/2019, 5/21/2020, 5/20/2021, 06/28/2022, 6/20/2023, 8/21/2024, 10/28/2025

RELATED WORKFLOW DOCUMENTS OROTHER ATTACHMENTS

CBAS Determination of Eligibility Tool (CDET)

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REFERENCES

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9
DHCS/ CMS Model Output Report MOR.0254

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MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn-around-time.

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POLICY AND PROCEDURE

Policy Number	CBAS-006
Policy Name	CBAS Emergency Remote Services (ERS)
Department Name	Outpatient Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	UM Director
Line(s) of Business	MCAL
Effective Date	7/17/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~TBD
Administrative Oversight Committee Approval Date	TBD~~4/16/2025~~

POLICY STATEMENT

California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver, authorized by the Centers for Medicare and Medicaid Services (CMS) now includes the provision of Ce~~o~~mmunity-Bb~~b~~ased A~~a~~dult S~~s~~ervices E~~e~~mergency R~~r~~emote S~~s~~ervices (CBAS ERS) after cessation of Temporary Adult Services (TAS) to ensure each member's needs continue to be met if the member is unable to return physically to a CBAS center for services. The goal is to support Seniors and Persons with Disabilities and their families and caregivers where and when services are needed. This expands access to home and community-based services to support individuals remaining in their homes and communities. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings in the community, the participant's home or via telehealth to allow for immediate response during CBAS participant emergencies.

1. CBAS ERS is available only to CBAS participants. CBAS participant is defined as:
   a. Member eligible for CBAS by the managed care plan (MCP)
   b. Has completed a person-centered care plan
   c. Has an approved authorization on file AND
   d. Signed a CBAS participation agreement at the CBAS Center

2. There are two (2) unique circumstances that may result in need for ERS services. The provision of ERS supports and services is temporary and time-limited, and specifically either:

   a. ~~2.1.~~Short-term: Members may receive ERS for an emergency occurrence for up to three consecutive months. CBAS providers and MCPs must coordinate to ensure duration of ERS is appropriate during the Member's current authorized period and, as necessary, for reauthorization into a new period; or

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b. ~~2.2.~~ Beyond Three Consecutive Months: ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. CBAS providers and MCPs must coordinate on requests for authorization of ERS that exceed three consecutive months.

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3. The two (2) types of circumstances that are eligible for ERS are:

   a. Public Emergencies, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc.

   b. Personal Emergencies, such as serious illness or injury, crises, or care transitions, as defined below. Specific personal emergencies may include serious illness or injury, crises, care transitions such as to/from a nursing facility, hospital, and home.

      i. Serious Illness or Injury means that the illness or injury is preventing the Member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address or prevent significant illness or disability, and/or to alleviate pain.
      ii. Crises means that the Member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises would be the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
      iii. Care Transitions means transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and Member/caregiver needs and not duplicate responsibilities assigned to intake or discharging entities.

4. Members may choose to cease receipt of ERS at any time. The Alliance will cover ERS as part of the CBAS benefit when a member meets the criteria established as outlined above.

5. CBAS providers are required to obtain expanded licensure to add ERS as an Optional Service to their respective center. The Alliance Operations designee will ensure that their contracted CBAS providers meet all operational requirements as outlined in APL 22-020 and the California Department of Aging (CDA) All Center Letters ACL 22-04 Launch of CBAS Emergency Remote Services and completion and licensure approval for these expanded services.

6. The Alliance will collaborate with all CBAS providers to ensure that each member's needs continue to be met, whether through in-person services provided at the CBAS center or through ERS and that the member's needs are documented appropriately on the CDA 4000i form and interdisciplinary plan of care (IPC). For members who choose to discontinue their CBAS services, the Alliance will ensure care coordination occurs for these members and that their continued needs are met.

PROCEDURE

1. The CBAS Center identifies emergency services needs for a member
    ~~a.~~ Public (earthquake, flood, fire, power outages, epidemic/infectious disease outbreak)
    a.
    ~~b.~~ Personal (serious illness, crisis, care transition)
    b. ~~1.1.2~~
    c. Additional circumstances may include: hospitalization, loss of housing, personal health care provider restrictions, loss of caregiver, nursing home admission

2. The CBAS Center completes the CBAS ERS Initial CDA (California Department of Aging) 4000i CBAS ERS initiation form (CEIF) via the Peach Portal within 3 business days from the date of identification of the emergency. Up to 7 business days allowed for completion of the CEIF in cases of widespread emergency affecting the majority (50% or greater) of the participants enrolled at the center at the time of the emergency:

3. The Center submits the completed CDA 4000i CBAS ERS form to the Health Plan within the same time constraints noted above.

4. The CBAS RN will:
    a. Review the request against the criteria outlined in APL 22-020 Community-Based Adult Services Emergency Remote Services
    b. Assess for any case management or care coordination needs in addition to services provided during ERS to ensure that the member's needs are met, and the member is safely managed during their emergency remote period. The Plan will collaborate with the CBAS center to confirm any identified needs and how needs will be managed.
    c. Complete the CBAS ERS note type
    d. Upon decision the nurse will forward the case to the CBAS coordinator for creation of authorization and notification to applicable parties. The authorization represents the Plan's agreement for ERS services as submitted by the Center.

5. The coordinator will:
    a. Add the request to the current active IPC authorization

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b. Attach the completed form to the document section of the members account
c. Notify applicable parties per normal process

6. The member may choose to cease receipt of ERS at any time

7. The initial authorization will be for no more than 90 days with a one-time extension for an additional 3 months if the member continues to meet the ERS criteria for services. Participants will be reassessed by the Center inter disciplinary team and submit and updated plan for continued remote/telehealth delivery of CBAS services. CBAS Centers will submit the extension request via fax for review and re-authorization as outlined above.

8. Ongoing services will be reviewed based on the AAH IPC reassessment policy outlined in CBAS-001

9. Members who are discharged from the CBAS program will have a CBAS Discharge Plan of Care completed by the CBAS Center outlining a member's continued care needs. The MCP CBAS RN will:
   a. Collaborate with the Center to identify any additional CM or care coordination needs for the member
   b. The CBAS RN will work with the MCP CM team to coordinate services with applicable providers to secure the needed services

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DEFINITIONS / ACRONYMS

CalAIM: California Advancing and Innovating Medi-Cal

CMS: Centers for Medicare and Medicaid Services

CBAS ERS: Community-Based Adult Services Emergency Remote Services

CDA 4000i CEIF: California Department of Aging CBAS Emergency Remove Services Initiation Form

IPC: Interdisciplinary Plan of Care

MCP: Managed Care Plan

AFFECTED DEPARTMENTS/PARTIES

Utilization Management

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Case Management

Long-Term Services and Supports (LTSS)

RELATED POLICIES AND PROCEDURES

CBAS -001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

~~New Policy: 7/17/2024~~

Revisions: 7/17/2024, 10/28/2025~~Committee Approvals: 4/16/2025~~

Blue = substantive updates

REFERENCES

1.ACL- 22-04 (Revised 10/2023) Launch of New CBAS Emergency Remote Services (ERS)

~~1.~~2. APL 22-020 Community-Based Adult Services Emergency Remote Services

~~2.~~3. California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver

~~3.~~4. CDA 4000i CBAS ERS form

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MONITORING

1. Internal Reporting development for CBAS/CBAS ERS, reported at Utilization Management Committee (UMC)
2. Quarterly CBAS Departmental Auditing

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POLICY AND PROCEDURE

Policy Number	CHS ~~HCSP~~ - 001
Policy Name	Community Health Worker (CHW) Services
Department Name	~~Housing and Community Services~~Community Health
Department Officer	Chief ~~Operating~~ Medical Officer
Policy Owner	Director, ~~Housing & Community Services~~Community Health Strategy
Line(s) of Business	MCAL/Medicare
Effective Date	11/27/2024
Administrative Oversight Committee Approval Date	11/27/2024

POLICY STATEMENT

Alameda Alliance for Health (Alliance) offers Community Health Worker (CHW) services as a preventive health benefit to members. These services may assist with a variety of concerns including but not limited to, the prevention and management of chronic conditions or infectious diseases, behavioral health conditions, navigation and referral to community resources, and mitigation of health-related social needs. Additionally, CHW services can help Members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services. CHWs tend to be members of the community they serve and link Members to health and social services to improve the overall quality of services delivered.

CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health.

Through their community connection and engagement, CHWs will advance ~~the California~~California

Advancing and Innovating Medi-Cal (CalAIM) initiative's efforts in providing equitable health care through culturally competent services and further promote the Alliance's contractual obligations to meet Department of Health Care Services (DHCS) broader Population Health Management (PHM) strategies, and other Alameda Alliance for Health identified strategic priorities to promote Health Equity to its members.

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The Alliance CHW benefit is guided by Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006.

PROCEDURE

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1 Community Provider Requirements and Minimum Qualifications

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1.1 Alameda Alliance Community Health Worker Program Requires that CHWs must have the following:

1.1.1 CHWs must have lived experience that aligns with and provides a connection between the CHW, and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use disorders, or being a survivor of domestic or intimate partner violence or abuse and exploitation.

1.1.2 Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

1.1.3 Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

1.1.4 Alameda Alliance encourages Supervising Providers (often the organizations employing or otherwise overseeing the CHWs by which the Alliance contracts) to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising Providers must maintain evidence of this experience.

1.1.5 Alliance contracted providers deploying CHW services adheres to DHCS guidance via APL 24-006 and under the following required pathways:

1.1.5.1 CHWs must demonstrate, and Supervising Providers must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the Supervising Provider.

1.1.5.2 The Alliance will audit contracted providers in accordance with APL 24-006, indicating that CHWs demonstrating qualifications through the Certificate pathways must provide proof of completion of at least one of the following certificates:

1.1.5.2.1 CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills

and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity

building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services.

1.1.5.2.2 Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

1.1.5.2.3 Asthma Preventive Services: CHWs may provide CHW services to individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by asthma preventive services providers who have completed either a certificate

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from California Department of Public Health Asthma Management Academy, or a certificate demonstrating completion of a training program consistent with the guidelines of the National Institute of Health's Guidelines for Diagnosis and Management of Asthma (Refer to Asthma Preventive Services (APS) Provider Manual.

Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skill and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completions for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

~~1.1.5.2.2~~

~~1.1.5.2.3~~1.1.5.2.4 Continuing Education: CHWs must complete a minimum of six hours of additional relevant training annually, which can be in the core competencies or specialty areas. The Supervising provider must maintain evidence of this training. Supervising providers may provide and/or require additional training, as identified by the Supervising Provider.

~~1.1.5.2.4~~

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2 Supervising Provider Requirements

2.1 Definition: Supervising Provider is an enrolled Medi-Cal/Medicare Provider employing or otherwise overseeing the CHW, with which the Alliance contracts.

2.2 The Alliance requires that the Supervising Provider ensures that CHWs meet the qualifications listed in this policy guidance and APL 24-006.

2.3 The Supervising Provider oversees CHWs, and the services delivered to Alliance Members and submits claims for services provided by CHWs.

2.4 The Supervising Provider must be a licensed Provider, a hospital (including the emergency department), an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

2.5 The Alliance does not require Supervising Providers to have a licensed Provider on staff in order to contract with the Plan in order to bill for CHW services. The Alliance will work in partnership with the entity to identify billing pathways.

2.6 The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services. Supervising Providers do not need to be physically present at the location where CHWs provide services to Members.

2.7 Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider.

2.8 The Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements by DHCS and the Alliance.

2.9 Supervising Providers must provide direct or indirect oversight to CHWs.

- 2.9.1 Direct oversight includes, but is not limited to:
  - 2.9.1.1 Guiding CHWs in providing services,
  - 2.9.1.2 Participating in the development of a plan of care,
  - 2.9.1.3 Following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
- 2.9.2 Indirect oversight includes, but is not limited to:
  - 2.9.2.1 Ensuring connectivity of CHWs with the ordering entity
  - 2.9.2.2 Ensuring appropriate services are provided in compliance with all applicable

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requirements.

2.9.3 Alameda Alliance works in partnership with contracted CHW Providers to ensure that Supervising Providers or their subcontractors contracting or employing CHWs to provide

covered CHW services to Alliance Members verify that CHWs have adequate supervision and training.

3 Member Eligibility Criteria for CHW Services

3.1. Alliance CHW services require a written recommendation submitted to the Alliance by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

3.2. Other Licensed practitioners who can recommend CHW services to Alliance Members within their scope of practice include:

3.2.1 physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

3.3. The licensed practitioner will submit a written recommendation with the claim to Alameda Alliance for Health.

3.4. The required recommendation can be provided by a written recommendation placed in the Member's record or a standing recommendation by the Alliance based on eligibility criteria for CHW services as described in the Medi-Cal Provider Manual.

3.5. The recommending licensed provider does not need to be enrolled in Medi-Cal/Medicare or be an Alliance Network Provider.

3.6. Alameda Alliance does not require prior authorization for CHW services for the first 12 units as described in the section below on "Billing, Claims and Payments."

3.7. The recommending licensed provider ensures that a member meets eligibility criteria before recommending CHW services according to the following guidelines:

3.7.1 CHW services are considered medically necessary for members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health- related social needs, and/or who would benefit from preventive services.

3.7.2 The recommending provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following:

3.7.2.1. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.

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3.7.2.2. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.

3.7.2.3. Any stressful life event presented via the Adverse Childhood Events screening.

3.7.2.4. The presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.

3.7.2.5. Results of a SDOH screening, indicating unmet health-related social needs, such as housing or food insecurity.

3.7.2.6. One or more visits to a hospital emergency department (ED) within the previous six months.

3.7.2.7. One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.

3.7.2.8. One or more stays at a detox facility within the previous year.

3.7.2.9. Two or more missed medical appointments within the previous six months.

3.7.2.10. Member expressed the need for support in Health Suite navigation or resource coordination services.

3.7.2.11. Need for recommended preventive services, including updated immunizations, annual dental visits, and well childcare visits for children.

3.8. Alliance members are also eligible for CHW violence prevention services.

3.9. Members must meet any of the following circumstances as determined by a licensed practitioner:

3.9.1 The member has been violently injured as a result of community violence.

3.9.2 The member is at significant risk of experiencing violent injury as a result of community violence.

3.9.3 The member has experienced chronic exposure to community violence.

3.10. CHW violence prevention services are specific to community violence (e.g., gang violence), and CHW services can be provided to

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members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

3.11. In addition to recommending providers identifying a member's need for CHW services, the Alliance uses data-driven approaches to determine and

understand priority populations eligible for CHW services, including but not limited to, using past and current member utilization/encounters, frequent hospital admissions or ED visits, demographic and SDOH data, referrals from the community (including provider referrals), and needs assessments, etc.

3.12. The Alliance uses available data sources to help identify members who meet the eligibility criteria for CHW services and attempt outreach to qualifying members and their providers to encourage utilization of CHW services.

3.13. Additionally, the Alliance will utilize available SDOH Z-codes, results of SDOH screening questions, or other appropriate SDOH data sources to help with the identification and assessment of priority populations as specified by DHCS. The Alliance will also use available HRA data sources to help identify members who meet the eligibility criteria for CHW services and attempt outreach to qualifying members and their providers to encourage utilization of CHW services.

3.14. Priority populations are selected based on the unique needs of the Alliance membership, identified health disparities and DHCS Clinical Quality Strategy priorities.

3.15. The Alliance will also explore partnership building with Local Health Jurisdictions, supportive housing providers, local institutional facilities and institute listening sessions to further ensure that priority populations match the unique needs of the Alliance local populations, especially as it pertains to lived experience, and targeting specific communities that are most vulnerable, including but not limited to, populations experiencing health disparities as identified in DHCS' Health Disparities Report and communities residing in Quartiles one and two as defined by the California Healthy Places Index.

3.16. The Alliance may also receive referrals from licensed practitioners for CHW benefits.

4 Covered CHW Services Including Violence Prevention Services

4.1. CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including outpatient clinics, hospitals, homes, or community settings. There are no service location limits. Services include:

4.1.1 Health Education: Promoting a member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a member's health or ability to self- manage their health conditions.

4.1.2 Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This

includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:

4.1.2.1. Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team.

4.1.2.2. Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or

4.1.2.3. Help a member enroll or maintain enrollment in government or other assistance programs that are related to improving their health if such navigation services are provided pursuant to a plan of care.

4.1.3 Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a member with connecting to appropriate services to improve their health.

4.1.4 Individual Support or Advocacy: Assisting a member in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

4.2. CHW services may be provided to a parent or legal guardian of a member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed provider. A service for the direct benefit of the Member will be billed under the Member's Medi-Cal/Medicare ID. If the parent or legal guardian of the member is not enrolled in Medi-Cal/Medicare, the Member must be present during the session.

4.3. CHWs may render street medicine, and the Supervising Provider would bill the Alliance for any appropriate and applicable services within the scope of the CHW benefit.

4.4. Covered CHW services do not include any service that requires a license.

5 Non-Covered CHW Benefits:

5.1. In Accordance with APL 24-006 the Alliance does adhere to the following Non covered CHW Services:

5.1.1 Any services that require a license, including clinical case management/care management that requires a license.

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5.1.2 Childcare
5.1.3 Chore services, including shopping and cooking meals
5.1.4 Companion services
5.1.5 Employment services

5.1.6 Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
5.1.7 Delivery of medication, medical equipment, or medical supply
5.1.8 Personal Care services/homemaker services
5.1.9 Respite care
5.1.10 Services that duplicate another covered Medi-Cal/Medicare service already being provided to a member
5.1.11 Respite care
5.1.12 Services that duplicate another covered Medi-Cal/Medicare service already being provided to a member
5.1.13 Socialization
5.1.14 Transporting Members
5.1.15 Services provided to individuals not enrolled in Medi-Cal, except as noted above
5.1.16 Services that require a license

5.2. Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as these are covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.

6 Provider Enrollment:

6.1. Network Providers, including those who will operate as Supervising Providers of CHW services, are required to enroll as Medi-Cal/Medicare Providers consistent with APL 22-013 Provider Credentialing/ Recredentialing and Screening/Enrollment or any superseding APL if there is a state-level enrollment pathway for them to do so.

6.2. CHWs are not required to enroll as a Medi-Cal/Medicare Providers and are therefore not subject to the requirements in APL 22-013.

6.3. Alameda Alliance established Policies and Procedures (P&Ps) to ensure the following:

6.3.1 Process to ensure that Providers and Subcontractors that serve as CHW Supervising Providers are certifying that their CHWs have the appropriate training, qualifications, and supervision.
6.3.2 Ability to receive referrals from licensed practitioners for CHW benefits.
6.3.3 Ability to receive referrals from licensed practitioners for CHW benefits.
6.3.4 Alliance validating Supervising Providers are appropriately assessing CHWs have sufficient experience to provide

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services.

6.3.5 Supervising Providers have the ability to submit claims or encounters to the Alliance using standardized protocols.

6.3.6 Supervising Providers have business licensing that meets industry standards.

6.3.7 Capability to comply with all reporting and oversight requirements.

6.3.8 Monitoring processes for fraud, waste, and/or abuse of CHW services.

6.3.9 Process for monitoring recent history of criminal activity of Supervising Providers.

6.3.10 Process for monitoring history of liability claims against the Supervising Provider.

7 Documentation Requirements:

7.1. CHWs are required to document the dates and time/duration of services provided to Members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. For example, documentation might state, "Discussed the patient's challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with the Supplemental Nutrition Assistance Program application for 30 minutes. Referred patient to [XYZ] food pantry."

7.2. Documentation must be accessible to the Supervising Provider upon their request.

7.3. Documentation should be integrated into the Member's medical record and available for encounter data report.

7.4. Plan of Care Documentation:

7.4.1 For Members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, with the e*xception of services provided in the emergency department*, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

7.4.2 Care plan must be submitted by providers at the 12unit threshold and is uploaded via SFTP

7.4.3 The Provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers referenced in this section.

7.4.4 The Plan of Care must include:

7.4.4.1. Specify the condition that the service is being ordered for and be relevant to the

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condition;

7.4.4.2. Include a list of other health care professionals providing treatment for the condition or barrier

7.4.4.3. Contain written objectives that specifically address the recipient's condition or barrier affecting their health;

7.4.4.4. List the specific services required for meeting the written objectives; and

7.4.4.5. Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

7.4.5 A licensed Provider must review the Member's plan of care at least every six months from the effective date of the initial plan of care. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

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8 CHW Billing Claims and Payment:

8.1. The Alliance will not establish unreasonable or arbitrary barriers for accessing CHW services.

8.2. CHW Services are preventative Services. The Alliance does not require prior authorization for CHW services for the first 12 units; however, quantity limits after the first 12 units may be applied based on goals detailed in the plan of care.

8.3. CHW services must be reimbursed through a CHW Supervising Provider in accordance with its Provider contract.

8.4. Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual/provider contract.

8.5. Alameda Alliance will not reimburse CHW services that are duplicative to services that are reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit.

8.6. Alameda Alliance will partner with subcontractors and network providers to prevent double billing of CHW services and ECM for the same member for the same time period.

8.7. Tribal clinics may bill the Alliance for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Provider Manual

8.7.1 Pursuant to Welfare and Institutions Code (WIC) 14087.325(d)21, MCPs are required to reimburse

contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that the MCP would make for the same scope of services if the services were furnished by another

Provider type that is not an FQHC or RHC. This requirement applies to CHW services provided to eligible Medi-Cal/Medicare Members consistent with the provisions outlined in this APL.

9 CHW Service Provision, Emergency Room & Encounter Data:

9.1. In accordance with APL 24-006, no later than March 2025, Alameda Alliance will develop and institute operable policies and procedures (P&Ps) to effectuate a billing pathway for Supervising providers including contracted hospitals, to claim for provisions of CHW services to Members during an emergency department visit and/or as outpatient follow-up to an emergency department visit.

9.2. Alameda Alliance will consider billing pathways structures such as a pathway may be structured as a sub-capitated rate, an addon rate to existing payments, or another billing and payment arrangement agreed upon with the Provider.

9.3. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services. The Alliance will report all CHW service encounters to DHCS.

9.4. The Alliance will report all CHW service encounters to DHCS.

9.5. For CHW services rendered in the Emergency Department, the treating Provider may verbally recommend CHWs to initiate services and later document the recommendation in the Member's medical record of the
Emergency Department visit. The required recommendation can be provided by a written recommendation placed in the Member's record or a standing recommendation by the MCP based on eligibility criteria for CHW services as described in the Medi-Cal Provider Manual

9.6. For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, with the exception of services provided in the emergency department, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

10 CHW Billing Pathways Structures & Claims Processes Explained:

10.1. Community Health Worker (CHW) services are provided in various settings, including hospital emergency departments (ED), community-based organizations (CBO), and tribal clinics. Alameda Alliance ensures proper documentation, claim submission, and compliance with established guidelines that align with existing claims procedures to reduce barriers for new and existing contracted providers.

10.1.1 Tribal Clinics (TC) and Community-Based Organizations

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(CBO) billing pathway structures:

10.1.1.1. Tribal Clinics and community-based billing structures and policy follow AAH general claim process as outlined in the Alameda Alliance Provider Manual (pg. 77-88).

10.1.1.2. Alameda Alliance contracts with Tribal Clinics and Community Based Organizations to deploy CHW services in alignment with both population health and health equity frameworks to serve members who may need preventative health services.

10.1.1.3. After contracting, TC/CBOs will either be issued a scope of work pertaining to a specialty area or provide general CHW services to members

10.1.1.4. Both CBOs and Tribal Clinics bill the following CHW service codes in accordance with number of patients and settings when submitting claims:

10.1.1.4.1. **98960** – Individual patient education

10.1.1.4.2. **98961** – Group education (2-4 patients)

10.1.1.4.3. **98962** – Group education (5-8 patients)

10.1.1.5. Modifiers & Telehealth Codes

10.1.1.5.1. Tribal Clinics and CBOS are required to use the Modifier **U2** to denote CHW services

10.1.1.5.2. Telehealth Services: When CHW services are provided via telehealth, the following modifiers must be used.

10.1.1.5.2.1. **Modifier 93** – Audio-only telehealth

10.1.1.5.2.2. **Modifier 95** – Audio and video telehealth

10.1.1.5.3. Place of Service (POS) & Telehealth:

10.1.1.5.4. There are no POS restrictions for either Tribal Clinics or CBOs. However, to distinguish telehealth services the following POS criteria are required by providers to add on their claims submissions:

10.1.1.5.4.1. **02** – Telehealth services provided outside the patient's home

10.1.1.5.4.2. **10** – Telehealth services provided in the patient's home

10.1.1.6. CHW Service Utilization and Authorization:

10.1.1.6.1. Daily & Yearly service units apply.

10.1.1.6.1.1. Daily Limit: 4 units/day without additional authorization.

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10.1.1.6.1.2. Yearly limit: 12 units/year before requiring a care plan submission

10.1.1.6.2. Providers must track and document the units of CHW services delivered

10.1.1.7. Treatment Authorization Request (TAR):

10.1.1.7.1. Is required if a patient/member exceeds 4 units in a single day

10.1.1.7.2. TARS may be submitted retroactively if necessary. The Health Suite system is also configured to allow for later TAR submission

10.1.1.7.3. The CHW Supervising Provider will be notified of missing TARs.

10.1.1.7.4. A care plan must be submitted at the 12-unit threshold and uploaded via SFTP

10.1.1.7.5. If no Care plan is submitted AAH will notify providers and request submittal of missing documentation.

10.1.1.7.6. The Health Suite System will also track units and alert staff when the 12–unit limit is reached. AAH will then notify providers and staff.

10.1.1.7.7. All claims will undergo a final review in the Health Suite system. Claims that meet unit and care plan requirements in accordance with APL-24-006 and AAH Provider Manual will proceed for payment.

10.1.1.7.8. Claims missing information will be flagged for follow up with the provider

10.1.1.8. Quality Assurance:

10.1.1.8.1. Regular testing will be conducted by configuration to ensure proper claim identification and coding. Test cases will focus on identifying claims originating from the hospital and CBO coding.

10.2. ED Providers Billing Pathways Structure

10.2.1.1. Provider Types:

10.2.1.1.1. Two types of CHW providers are recognized in the ED setting:

10.2.1.1.1.1. CHWs hired by Hospital Staff and (Embedded in ED) and Community-Based Organization (CBO) contracted with AAH to deploy CHW services in hospital settings.

10.2.1.1.1.2. The Shift Captain oversees CHWs in the hospital's acute ED setting.

10.2.1.2. Eligibility Verification, starts the process collecting the member ID, establishing eligibility, and confirming coverage.

10.2.1.2.1.

10.2.1.3. Billing Codes, Modifiers & Place of Service

10.2.1.3.1. All CHW providers must use the applicable

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CHW Service Billing Codes: 98960, 98961, 98962.

10.2.1.3.2. For all ED-based CHW services, Place of Service (POS) 23 applies.

10.2.1.3.3. CBO providers in the ED must include the U2 modifier on their claims.

10.2.1.4. Claim Submission Forms

10.2.1.4.1. Hospital CHW Staff use UB04 claim submission forms to file claims with AAH.

10.2.1.4.2. CBO CHWs staff embedded in the ED use 1500 claim submission forms.

10.2.1.5. Health Suite Configuration: AAH configures health suite billing system to account for billing pathways for Supervising Providers, including contracted hospitals, for CHW services provided during ED visits or as outpatient follow-up to ED visits.

10.2.1.6. Billing Structure Options:

10.2.1.6.1. AAH works in partnership with Providers on billing structured options. The billing pathway may be structured as:

10.2.1.6.1.1. Sub-capitated rate

10.2.1.6.1.2. Add-on rate to existing payments

10.2.1.6.1.3. Other agreed-upon billing and payment arrangements with the Provider

10.2.1.6.1.4. Contractual Rates

10.2.1.6.1.5. Claims must be in accordance with contractually established rates.

10.2.1.6.1.6. All ED providers are subject to AAH general claim process as outlined in the Alameda Alliance Provider Manual (pg. 77-88).

10.2.1.7. Units Tracking & Frequency Considerations:

10.2.1.7.1. Units of CHW services rendered in the ED are not recorded in compliance with APL-24-006.

10.2.1.7.2. Frequency requirements do not apply to ED claims. The ED presentation and CHW service are considered separate, although rates may be the same.

10.2.1.8. Quality Assurance:

10.2.1.8.1. Regular testing will be conducted by configuration to ensure proper claim identification and coding. Test cases will focus on identifying claims originating from the hospital and CBO coding.

10.2.1.8.2. AAH conducts quarterly monitoring reports assessing quality in billing, problem-solving errors, evaluating utilization to track trends and identifying additional areas to enhance care delivery.

11 CHW Integration & Access Requirements:

11.1. Member assessment and identification for needed CHW Services:

11.1.1 The Alliance uses a variety of tools to assess member needs and determine priority populations for CHW

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services.

11.1.1.1. Review of the Population Needs Assessment Results

11.1.1.2. Review of Risk Stratification and Segmentation results

11.1.1.3. Member underutilization reports

11.1.1.4. Input from the Alliance Member Advisory Committee

11.1.1.5. Analysis of HEDIS and gap in care results

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11.1.1.6. Trends identified in Appeals/Grievances
11.1.1.7. Disparities identified through health equity analysis
11.1.1.8. Review of assessment results
11.1.1.9. Referrals for CHW services from providers and learning cohorts

11.2. As part of our Network composition, the Alliance will ensure and monitor sufficient Provider Networks within the Alameda County service areas, including for CHW services.

11.3. The Alliance will prioritize usage of CHW services for priority populations as mentioned through partnership building, educational opportunities and through outreach.

11.3.1 Promoting the benefit and requirements with the provider network. Communications are sent by fax, included on the Alliance public website and/or included in quarterly packets mailed to providers.

11.3.2 The Alliance will leverage the skills and assets of external organizations such as providers, health systems, community- based organizations, and local health jurisdictions to support CHWs.

11.3.3 Assessment of the availability, uses and capacities of CHWs in Alameda County

11.3.4 Designing internal dashboards to reflect administered and Care gaps of CHW recruitment and specialties.

11.3.5 Participation in CHW workgroups in Alameda County and statewide to create support for training, hiring and development of CHWs.

11.4. The Alliance will contract with willing and existing CHW Networks serving Medi-Cal populations, especially those in local public health departments; including but not limited to:

11.4.1 Local educational entities (e.g., schools, local education agencies)

11.4.2 Local county behavioral health departments for specialty Mental Health Care and Substance Use Disorder (SUD) Treatment Services (e.g., mental health plans/providers, Drug Medi-Cal Organized Delivery System plans/providers)

11.4.3 Social services

11.4.4 Child welfare departments

11.4.5 Continuums of Care programs

11.4.6 First 5 programs and providers

11.4.7 Regional centers

11.4.8 Area Agencies on Aging

11.4.9 Caregiver resource centers

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11.4.10 Women, Infants, and Children Supplemental Nutrition Programs

11.4.11 Home and Community-Based Services (HCBS) waiver agencies and providers

11.4.12 Justice-involved partners and providers (e.g., jails, probation, CBOs serving this population)

11.4.13 Hospital Partners

11.5. Alameda Alliance CHW Network building strategies are to foster an integrated system of care to support meeting member where they are and include the following intended outcomes:

11.5.1 Support integrated behavioral health models of care, including by increasing screening, brief intervention, and referral to treatment for substance use and mental health conditions for all age groups but especially children, youth, and pregnant/postpartum populations.

11.5.2 Support improvements in access and utilization of children's preventive care services, especially focused on engagement of communities experiencing health disparities and leveraging DHCS-provided reports of Members who have not utilized services to guide the identification and engagement of target populations.

11.5.3 Support improved birth outcomes by improving support of pregnant persons during the prenatal and postpartum period (through 12 months post-partum) in the clinical and home settings, and leveraging Comprehensive Perinatal Services Program perinatal health workers, where appropriate

11.5.4 Eliminate care gaps for members exiting Emergency room care and through establishing follow-ups/resource linkage with primary care to address member needs for medical services.

11.5.5 Supporting member autonomy through Alameda Alliance communications to members about the scope of practice, benefits, and availability of CHW services.

11.5.6 Alignment with DHCS Comprehensive Quality Strategy/Bold Goals (CQS):

11.5.6.1. The Alliance strives to leverage the CHW to address the DHCS CQS clinical priorities.

11.5.6.2. The Alliance will identify, outreach, and collaborate with community partners that work with populations that align with the CQS clinical priorities and have potential to grow the CHW network.

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11.5.7 The Alliance's CHW strategy will include the use of CHWs to help address gaps in member engagement, population health, housing, quality and health equity and program efficiencies.

11.5.8 The Alliance collaborates with provider and community partners to develop a network of CHW providers to meet identified needs including the following outreach.

11.5.9 The Alliance communicates member benefits and services through the evidence of coverage, newsletters, new member orientations, member calls and call center scripts, the provider directory, and the Alliance website and social media.

11.5.10 The Alliance internal teams partner to make available Alliance member communications that are culturally and linguistically appropriate and available in member threshold languages.

Alliance member informing materials also include the 19 language assistance taglines to help members understand how to receive assistance reading the communication in a different language or an alternative format at no cost to the member.

11.5.10.1. Provider communications also include how a provider can bill for CHW services according to Medi-Cal guidelines and how to complete and submit the Supervision Provider Attestation for Community Health Workers Form.

11.5.10.2. During the credentialling process (see P&P CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications) providers supervising CHW services will complete an attestation form informing providers of the DHCS requirements for providing CHW services.

11.5.10.3. Provider communications will be sent by fax, posted to our public website, and included in our quarterly provider packets mailed to providers.

11.6. Alliance Enhanced Care Management (ECM) and Community Supports (CS) programs may use CHWs to provide services. The Alliance ensures non- duplication of services through claims processes safeguards to prevent non- duplication of services.

11.7. Referral pathways to CHW services include, but are not limited to:

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11.7.1 Agreements with community and/or county public health agencies

11.7.2 Alliance care management staff referral, including referrals from ECM, CS, transitional care services, housing, disease management, behavioral health, and complex case management programs.

11.7.3 Provider Referrals

11.7.4 Member Referrals

12 Monitoring:

12.1. DHCS Monitoring Compliance:

12.1.1 DHCS will monitor the Alliance's implementation of CHW requirements through existing data reporting mechanisms, such as encounter data, grievances, and appeals. CHWs are not required to be entered in the 274 Network Provider File. As such, DHCS will obtain the number of CHWs within each Network, initially from the Alliance through the CHW Integration Plan and included later through the PHM readiness submission as well as post-transition monitoring of CHW utilization.

12.1.2 The Alliance will monitor utilization of services and comply with all reporting and oversight requirements stipulated by DHCS. The Alliance will monitor:

12.1.2.1. Utilization including, at the minimum, a quarterly review of claims and encounters for CHW services and grievances related to CHW services.

12.1.2.2. Annual contracted provider monitoring review of CHW documentation/recordkeeping practices, utilization, fraud waste and abuse, opportunities for advocacy and innovation for improved member outcomes.

12.1.2.3. The Alliance will also host, at minimum. annual CHW cohort learning sessions for contracted providers.

12.1.2.4. Compliance with billing requirements.

12.1.2.5. Short term outcomes including:

12.1.2.5.1. The required DHCS BPHM-CHW Integration measure, percentage of members who received CHW benefit.

12.1.2.5.2. Tracking CHW utilization and services among member groups by race/ethnicity, age, location, language, and gender to ensure equitable utilization, access and emerging trends as identified through data analytics.

12.1.2.5.3. Tracking communications and educational offerings to providers in our effort to expand services

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12.1.2.5.4. Tracking of provider network expansion. The Alliance will take

action as needed to ensure sufficient provider networks for CHW services.

12.1.2.6. Long term outcomes, including:

12.1.2.6.1. An analysis of HEDIS measures and utilization goals addressed through CHW services to determine if there was a reduction in the health disparity.

12.2. The Alliance will review contractually required P&Ps to determine if amendments are needed to comply with APL 24-006. If the requirements contained in APL 24-006, including any updates or revisions to this necessitate a change in the Alliance contractually required P&Ps, the Alliance will submit the updated P&Ps to the Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of the update or revision. If no changes are required to the Alliance's P&Ps, the Alliance will notify the MCOD Contract Manager stating that the P&Ps have been reviewed, and no changes are necessary. The email confirmation will include the corresponding APL title and the applicable APL release date in the subject line.

12.3. The Alliance will ensure that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Grievance and Appeal requirements, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. The Alliance will communicate these requirements to all subcontractors and network providers. The Alliance will also maintain effective communication with DHCS partners to identify and advocate as necessary regarding any identified regulatory barriers.

DEFINITIONS / ACRONYMS

Authorized Representative – An individual designated to act on behalf of a beneficiary in accordance with state and federal regulations.
CAP – Corrective Action Plan
CBO – Community Based Organization
CHW – Community Health Worker
CHW Services – Services delivered by a CHW to prevent disease, disability and other health conditions or their progression; to prolong life; and to promote physical and mental health.
ED – Emergency Department
HCSP – Housing and Community Supports Program
Licensed practitioner/provider -For the purposes of the CHW benefit, a licensed practitioner includes physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists,

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registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.
PHM - Population Health Management
SDOH – Social Determinants of Health
TAR - Treatment Authorization Request
TC – Tribal Clinics

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Supervising Provider – An organization employing or otherwise overseeing the CHWs with which the Alliance contracts (additional details are found in CRE-023).
Recommending Provider – the licensed provider who recommends a member for CHW services, and ensures the member meets medical necessity for CHW services.

AFFECTED DEPARTMENTS/PARTIES

Population Health and Equity

Case Management

Behavioral Health

Claims

Credentialing

Provider Relations

RELATED POLICIES AND PROCEDURES

CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications

PH-001 Population Health Management (PHM) Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy: 11/27/2024

REFERENCES

DHCS APL 24-006 Community Health Worker Services
Alameda Alliance Provider Services Manual: https://alamedaalliance.org/providers/alliance-provider-manual/

MONITORING

This policy will be reviewed annually. DHCS may impose a Corrective Action Plan (CAP), as well as administrative and/or monetary sanctions for non-compliance.

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POLICY AND PROCEDURE

Policy Number	CHS - 02
Policy Name	Community Health Strategy – Prescreening Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Community Health Strategy
Line(s) of Business	MCAL, D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement & Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

1. In order to provide Community Health Worker (CHW) services to eligible Alameda Alliance for Health (AAH) Medi-Cal and D-SNP members, AAH contracts with a network of providers to ensure adequate monitoring and network composition within the Alameda County service area.
2. AAH ensures that providers comply with program requirements as outlined in Department of Healthcare Services (DHCS) All Plan Letters (APL) and the Medi-Cal Provider Manual for CHW services and Asthma Preventative Services Manual on CHW services
3. Providers and/or their subcontractors must follow AAH established authorization requirements, adjudication standards, and referral documentation for CHW services.

PROCEDURE

1 Interest in contracting: There are (2) two main pathways that support provider contracting for CHW services at Alameda Alliance:

1.1 **Alameda Alliance Initiated Outreach:** Alameda Alliance CHS team identifies a potential agency through community engagement/direct outreach opportunities.

1.1.1 The Alameda Alliance Community Health Strategy team (CHS) will conduct community outreach to recruit new providers to contract for CHW Services.

1.1.2 Alameda Alliance will provide a general overview of CHW

Services.

1.1.2.1 If the organization is interested in moving forward with steps for further evaluation:

1.1.2.1.1 The Alliance Community Health Strategy team will send the external entity interest packet that consists of:

1.1.2.1.1.1 Community Health Work Entity Interest Link

1.1.2.1.1.2 Community Health Worker Provider Certification Application

1.1.2.1.1.3 Community Health Worker Attestation Forms

1.1.2.1.2 The external entity is provided with instructions on how to complete and submit the CHW Entity Interest Packet (including all supporting documentation)

1.1.2.1.3 The CHS team receives the completed Entity Interest Packet and logs it onto the CHW Entity Interest Tracker.

1.1.2.1.4 The CHS team sends an external CHW Entity acknowledgement letter within 5 business days of receipt of the completed packet.

1.1.2.1.5 The CHS team then notifies the Alliance CHS Prescreening Panel, when new packets are available for review.

1.1.2.2 If the organization is not interested in moving forward with contracting CHW services with Alameda Alliance, the Alliance will capture this decision on the internal Community Health Strategy Recruitment tracker.

1.2 **Organization Initiated Outreach**: A prospective organization directly contacts Alameda Alliance with an interest to contract for CHW services (e.g., using CHW email address CHW@alamedaalliance.org, or contacting Provider Services team)

1.2.1 When an External Entity contacts the Alliance to show interest in becoming a Community Health Work (CHW) contracted provider, the representative receiving the request should provide the organization with the Community Health Strategy department email (e.g., CHW@alamedalliance.org)

1.2.1.1 The Alliance Community Health Strategy team will contact the external entity and send the external entity interest packet that consists of:

1.2.1.1.1 Community Health Work Entity Interest Link

1.2.1.1.2 Community Health Worker Provider Certification Application

1.2.1.1.3 Community Health Worker Attestation Forms

1.2.1.2 The external entity is provided with instructions on how to complete and submit the CHW Entity Interest Packet (including all supporting documentation)

1.2.1.3 The CHS team receives the completed Entity Interest Packet and logs it onto the CHW Entity Interest Tracker.

1.2.1.4 The CHS team sends an external CHW Entity acknowledgement letter within 5 business days of receipt of the completed packet.

1.2.1.5 The CHS team then notifies the Alliance CHS Prescreening Panel, when new packets are available for review.

1.2.1.6 If the organization is not interested in moving forward with contracting CHW services with Alameda Alliance, the Alliance will capture this decision on the internal Community Health Worker Recruitment tracker.

2 CHW Prescreening Process:

2.1 Potential CHW Providers are prescreened by the Alliance's CHW Prescreening Panel. Depending on the needs of Alliance members at the time of submission, entities with complete submission packets may be invited to a "Provider Showcase" meeting with the Prescreening Panel within 90 calendar days of submission.

2.2 The CHW Prescreening Panel consists of the Director, Community Health and at least 1 representative from each of the following teams, but not limited to:

2.2.1 Health Care Services (HCS)

2.2.1.1 Medical Director, Case Management

2.2.1.2 Senior Director, Health Care Services

2.2.1.3 Director of Community Health Strategy

2.2.1.4 Manager, Community Health Initiatives

2.2.1.5 Representative of Health Equity

2.2.1.6 Representative of Population Health

2.2.1.7 Representative of Case Management

2.2.1.8 Representative of Quality

2.3 All representatives on the Panel evaluate potential CHW Providers by reviewing their Entity Interest Packet and completing a CHW Provider Scorecard (see attachments).

2.4 The CHW Prescreening Panel meets at least monthly to review preliminary scorecard results and decide which providers to invite for a "Provider Showcase" meeting.

2.1.1.1 The CHW Provider Showcase meeting provides prospective providers with an opportunity to formally present their program to the Panel and enables the Panel to pose any outstanding questions regarding the provider's CHW program.

2.1.2 After the Provider Showcase meeting, the Panel finalizes Provider Scorecard results and prepares final recommendations for Senior Leadership approval.

2.1.3 CHW providers who are approved by Senior Leadership are notified via email by the Community Health Strategy Team of the Alliance's decision to move forward with the Onboarding Process.

Commented [SJ1]: Change to say representative from XYZ

Commented [SJ2R1]: Medical Director, Case Management
Senior Director, HCS
Director of CHS
Manager CHS
Mgr. Case Mgt
Sr. Dr. BH
Sr. DR quality
Mgr. CS
Direct. Pop Health
Health Equity

Commented [SJ3]: Given that we have a need to build a robust CHW network, quarterly feels to long. What are thoughts about every 60 days(every other month)? If I write this in here, does it give my team limitations to recruit outside of this process?

Commented [JS4R3]: Monthly - application/cadence

Commented [AL5R3]: Agree with monthly @Jones, Shatae

2.1.3.1 Approved providers will be notified within 120 calendar days of submission.

2.1.3.2 Senior Leadership's approval of the Prescreening Panel's recommended provider does not constitute a guarantee of contracting with the Alliance. Only entities that successfully fulfill all Onboarding Requirements will be eligible for contract consideration.

2.1.4 Submissions from external entities not selected for Onboarding will be retained and documented in the Community Health Strategy Recruitment Tracker. Should future network expansion be warranted, these entities will be subject to the standard Prescreening Process.

3 CHW Onboarding Process & Requirements

3.1 CHW – Kick Off Meeting:

3.1.1 The CHS team coordinates and records Kick-Off Meetings with all CHW providers selected for onboarding.

3.1.2 The CHW Strategy team also extends invitations to the following internal departments at the Alliance to participate in the Kick-Off Meetings:

3.1.2.1 Provider Services/Contracting

3.1.2.2 Credentialing

3.1.2.3 Finance

3.1.2.4 Analytics

3.1.2.5 IT/EDI

3.1.3 During the recorded Kick-Off Meeting, providers are given:

3.1.3.1 An introduction to the operational technical team

3.1.3.2 An overview of the onboarding process, requirements (including milestones and timelines to go-live date)

3.1.3.3 **New Provider Forms** (e.g., documentation required by Health Care Services, CHW Resources, Provider Services, Credentialing, Billing/Finance, Electronic Data Interchange (EDI), and Analytics) must be completed and submitted as part of the onboarding process.

3.1.3.4 Alliance's Contact List for CHW Onboarding Support

3.1.4 Following the Kick-Off Meeting, regular check-in meetings are scheduled with the provider and continue through the go-live date. The frequency of these meetings is determined through mutual agreement between Alameda Alliance for Health (AAH) and the CHW provider.

3.1.4.1 Local Health Jurisdictions (LHJ), Emergency Departments (ED) First Five Entity, may be subject to additional requirements and Joint Operations meetings to satisfy DHCS regulations.

3.2 Departmental Responsibilities – Ensuring Successful Onboarding

3.2.1 The following departments are responsible for ensuring each element of the Onboarding Process is successfully executed with the CHW Provider:

3.2.1.1 Health Care Services – Community Health Strategy Department

- Providing programmatic oversite, operational readiness using the Provider Certification form, to guide any areas which the CHW Provider requires support to comply with DHCS regulatory requirements and expectations

- DHCS documentation requirements for CHW providers in alignment with All Plan Letter (Training, Supervising Provider, Care Plans, Treatment Authorization Request, utilization monitoring, care coordination, referrals, Standing recommendations, metrics development scope of work formation)
- Convene CHW providers and appropriate Alliance Departments as needed to ensure progress toward go-live date, care-delivery, care coordination, metrics performance monitoring.
- Monitor and track onboarding milestones, and identify any risks that would compromise implementation
- Ensure any necessary DHCS submissions are completed in time for go-live (i.e. Model of Care updates, Provider Capacity reports)

3.2.1.2 Credentialing Department:

- Supporting CHW providers questions, successful processing of Credentialing Applications, receiving attestation forms from CHS teams, updating Symplr to identify the CHW supervising provider/organization.
- Communicating with the Community Health Strategies Team of changes in Provider Credentialing status (e.g., terminations, timelines)
- Credentialing also cross-references requests to credential new CHW providers who do not have an attestation with the Community Health Strategy Team if there are requests to credential
- Providing monthly credentialing reports to the Community Health Strategy Team as an organizational quality assurance check.
- When a termination is reported credentialing will send the information tp provider services who will create a SR for the changes. SJ will receive the SR notification via CHW department email to track ongoing changes.

3.2.1.3 Provider Services:

- Provider Roster
- Contract Development & Execution in partnership with HCS-Community Health Strategy Team and credentialing.
- Provider Liaison activities (e.g., contractual inquiries, billing and payment coordination)~~, including payment/billing and contractual inquiries~~
- Cross Collaboration notifications to CHW providers who request expansion of existing contract for CHW services or adding/removing staff
- Provider Services also maintains compliance with Provider Data and directories, s~~S~~end Change Request (CR) to claims with agreed upon rates *etc. See policy DAT-001, Provider Data and Directories*

Commented [AL6]: I like the detail here; confirming credentialing team has reviewed & approved of language?

Commented [JS7R6]: I will state no. Credentialing is currently performing these tasks:

New to discuss with Credentialing (identified gaps are:
- Credentialing also cross-references requests to credential new CHW providers who do not have an attestation with the Community Health Strategy Team if there are requests to credential
- Providing monthly credentialing reports to the Community Health Strategy Team as an organizational quality assurance check. (Some departments get a cred report from credentialing, I was not part of that distro group.

Commented [SJ8]: Added by Donna - 08/1/2025

Commented [SJ9]: When a termination is reported XYZ - a termination, they send the information to provider services who will create a SR for the changes. SJ will receive the SR notification via CHW department email # to track changes.

Commented [JS10R9]: agreement made with Provider services and credentialing can close

Commented [SJ11]: I would like to build this in to solve a bottle neck that is happening. - share with allison

Commented [SJ12]: SJ added to Donna Credentialing distribution list (concern of confidentiality)

Commented [AL13]: I like the detail here; confirming provider services team has reviewed & approved of language?

Commented [JS14R13]: No they haven't seen this in writing yet. They are already performing the following tasks:
-Contract Development & Execution in partnership with HCS-Community Health Strategy Team
-Provider Liaison activities, including payment/billing and contractual inquiries
-Send Change Request (CR) to claims with agreed upon rates
-Provider Portal Training for new contracted providers
-JOM facilitation for CHW providers with Memorandum of Understanding

They have not performed:
- Provider Roster collaboration
-Cross Collaboration notifications to CHW providers who request expansion of existing contract for CHW services or adding/removing staff

Commented [JS15R13]: resolved with Provider Services and credentialing

Commented [SJ16]: Ask Allison what this means. For example, PS has not recruited a single provider for CHW services. This has been an effort put in place by Shatae through individual contact/outreach events and referrals from internal teams

Commented [JS17R16]: see template in 02- provider prescreening: https://alamedaallianceorg.sharepoint.com/:f:/s/CalAIMECMandCS/EkhQzMQ6_KhEvx9RAbT9FrIBgFNvi_tEhL2rQt-hh02tbw?e=zWgx6K

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- New Provider Orientation training will occur 30 days following the month of being credentialed JOM facilitation for CHW providers with Memorandum of Understanding

3.2.1.4 Claims Department & Electronic Data Interchange (EDI), Data Analytics and Finance Department

- Configurations: Team supports configuration of the CHW billing shell in accordance with the contract language
- Claims Department: Sends monthly CHW monitoring reports (e.g., Frequency limitations reports, 12+units reports)
- EDI, Claims: Supports claims, SFTP set up, CHW billing reports notification
- Analytics: Data Analytics reporting as requested
- Finance: Payment Set-Up

All contracted CHW providers will be supported by the Community Health Strategy Team and corresponding Alameda Alliance teams, with monthly operational meetings after go-live.

Commented [AL18]: We should remove the RTF verbiage, but are there other reports that involve analytics?

Commented [JS19R18]: We will make analytics request to track disparities

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DEFINITIONS / ACRONYMS

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CHS	Community Health Strategy (Team)
CHW	Community Health Worker
DHCS	Department of Health Care Services
ECM	Enhanced Care Management
RTF	Return Transmission File
MIF	Member Information File
EDI	Electronic Data Interchange
AAH	Alameda Alliance for Health
HCS	Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Services
Credentialing
Claims
Analytics
Information & Technology (EDI)

RELATED POLICIES AND PROCEDURES

CRE - 018 Credentialing and Recredentialing of Community Supports Providers

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CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications

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CHS – 001 Community Health Worker Benefit

Commented [SJ20]: Tag to add in Donna new CRE policies

DAT – 001 Provider Data and Directories

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Health Worker Services – Entity Interest Form
Community Health Worker Services – Provider Certification Application
Community Health Worker Services – Attestation Form
Community Health Worker Services – Score Card
Community Health Worker Services – Provider Prescreening Template

REVISION APPROVAL HISTORY

[List revision dates starting with original effective date – this is the date that revisions were approved at AOC, and is a running list of approval dates from AOC]

REFERENCES

Department of Health Care Services – All Plan Letter **(APL-24-006)**
The CHW Preventive Services Medi-Cal Provider **Manual**
Asthma Preventive Services (APS) Provider **Manual**

MONITORING

-The Compliance and CHS Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC) annually."

Commented [SJ21]: @Lam, Allison you have a hyperlink here that leads to the 02 Provider Screening & Onboarding, Where would you like me to add CHW prescreening folder.

Commented [SJ22R21]: I think we should Add a cool off period to the policy. Like if we deny the provider how many days until that can resubmit?

Commented [AL23R21]: @Jones, Shatae – let's use your link to house all the CHW content: DCHS - Provider Onboarding Materials

Commented [JS24]: Task assigned to Jones, Shatae @Jones, Shatae - include DHCS references here (APL, provider manual, etc.)

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Commented [JS25]: Task assigned to Jones, Shatae @Jones, Shatae - recommended verbiage:
"The Compliance and CHS Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC) annually."
June 25, 2025 at 11:07 PM

Commented [JS26R25]: @Lam, Allison - Task completed.

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POLICY AND PROCEDURE

Policy Number	CM-010
Policy Name	Enhanced Care Management – Member Identification and Grouping
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	8/17/2005
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

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POLICY STATEMENT

1.1. Alameda Alliance for Health (AAH) is responsible for the development, implementation and distribution of requirements for the Enhanced Care Management (ECM) services and related activities to contracted entities, including member identification and risk grouping.

1.2. Member Identification: Members are identified through three methodologies:

1.2.1. ECM Eligibility List: AAH will generate a monthly ECM Eligibility List based on the defined criteria of the ECM Populations of Focus. Verification and analysis of the list will then be completed. The Eligibility List will be distributed to each ECM Provider with their assigned members.

1.2.2. Self-Referrals: Members may self-refer into ECM at any time by contacting AAH Member Services, a contracted ECM Provider, or any AAH Staff.

1.2.3. Newly enrolled MCP Members who were receiving ECM through their previous Med-Cal Managed Care Plan: Members, Member's family or Authorized Representative (AR) may refer into ECM at any time by contacting AAH Member Services, a contracted ECM Provider, or any AAH Staff.

1.3. Risk Grouping: Members confirmed by AAH as eligible for ECM are prioritized for outreach and engagement based on those that present the greatest opportunity for improvement from care management and reduction in avoidable utilization.

Confirmation

1.3.1. Prioritization will be accomplished through application of a tiering logic that risk stratifies the ECM population into two tiers corresponding to their level of priority, where High Tier is highest risk, and Low Tier is a combined medium and low risk.

1.3.2. A rate and payment structure will be developed and implemented that takes into consideration the increased ECM services experienced by the High Tier.

1.3.3. AAH will apply a prioritization framework to the list to help guide the ECM Providers in outreach efforts.

1.3.4. The tiering logic will be assessed by AAH for validity no less than annually and modified and as needed to maximize efficacy.

PROCEDURE

1.1 Member Identification: AAH identifies eligible members through the following mechanisms:

1.2 AAH generates a list of ECM eligible members on a monthly basis.

1.3 AAH verifies AAH Member eligibility and excludes disenrolled Members.

1.4 Data sources used to identify eligible ECM members by Population of Focus include the following:

Data Source	Resourced From
Enrollment data	Member enrollment data from HealthSuite (AAH claims/eligibility system) including member address information, and 1915(c) waiver wait lists when available
Encounter data	Encounter data including pregnant/postpartum data from AAH providers stored in AAH Datawarehouse
Utilization/claims data	AAH claims data from HealthSuite including pregnant/postpartum data; Plan Data Feed
Pharmacy data	AAH claims data from HealthSuite, historical pharmacy data extracts from AAH's Pharmacy Benefits Manager, current pharmacy data extracts from DHCS (Service Dates 1/1/2022 forward)
Laboratory data	Encounter data from AAH laboratory providers stored in AAH Datawarehouse
SMI/SUD data, as available	Alameda County Behavioral Health (ACBH) utilization/encounter data for SMI (Note: SUD data not available without member consent)
Screening or assessment data	AAH Care Management (CM) assessment and Utilization Management (UM) review

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	data from TruCare (AAH care management system)
Authorization data	Authorization data for members enrolled in Community Services (i.e., Transitional Rent.)
Information about Social Determinants of Health, including standardized assessment tools including Protocols for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and International Classifications of Diseases, Tenth Revision (ICD-10) codes	ICD-10 codes from AAH and ACBH encounter/claims data
Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), available data from the education system	HMIS and Targeted Case Management (TCM) data from Alameda County Social Health Information Exchange (SHIE); Minimum Data Set (MDS) assessment
Clinical information on physical and/or behavioral health	CareAnalyzer (AAH population health analytics tool) data for diagnosis groupings based on Johns Hopkins ACG System and risk/utilization measures.
Risk stratification information for Members under 21 years of age in Contractor's with Whole Child Model (WCM) programs	Not Applicable for AAH
Results from any available Adverse Childhood Experience (ACE) screening	Positive results from an Adverse Childhood Experiences (ACEs) screening, when available
School absentee or truancy information	When available

1.4.1 AAH consolidates the data sources into their reporting databases and develops individual criteria/logic for each ECM Population of Focus to identify eligible members. ECM Population of Focus criteria is based on the population definitions provided by the Department of Health Care Services (DHCS) located in the Enhanced Care Management (ECM) Policy Guide.

1.4.2 As new populations are implemented and/or new data sources are identified, AAH will review and evaluate each data source to determine their impact on the identification process. Any new data sources deemed to have an impact on the identification criteria will be incorporated into the existing identification logic.

1.4.3 Any exclusion and/or non-duplication criteria as outlined in the DHCS ECM Policy Guide will be incorporated into the identification logic, when applicable, and pending data source availability.

1.4.3.1 AAH applies tiering logic to the final AAH ECM eligibility list and assignment

Collaborative

logic to match Members with the appropriate ECM Provider. Assignment to ECM Providers will be determined using factors including the Member's past medical and mental health history, location and history of working with the provider. In addition, alignment of specific member needs to ECM Provider expertise and skillset will be taken into consideration. If a member's main driver is Serious Mental Illness (SMI), the member will be assigned to an ECM provider who specializes in SMI. California Children's Services (CCS) Providers are currently contracted to provide ECM. AAH assigns qualifying members to ECM CCS Providers. AAH takes into consideration Provider feedback regarding the appropriateness of the ECM assignment, when requested, and will take action, as necessary. Any feedback received from prospective ECM Provider, PCP, and ECM Member will be incorporated into the appropriateness of the assignment.

1.4.3.2 AAH submits the tiered ECM eligibility list of assigned members via Secure File Transfer Protocol (SFTP) to each ECM Provider within ten (10) days of determining ECM eligibility to conduct outreach and engagement activities.

1.4.3.3 A Provider, health plan staff, ECM staff, other non-provider community entity, the Member him/herself, or a Member's caregiver/family may refer a Member to AAH for ECM services. AAH will then connect the Member with an ECM Provider to evaluate for eligibility for ECM services.

1.4.3.3.1 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929 (TTY) or AAH Case Management at 1-877-251-9612 or 510-747-4512 during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929 (TTY) after hours to inquire about ECM.

1.4.3.3.2 For subcontracted entities (delegates), the same process for referring/requesting ECM authorization applies as directed above.

1.4.3.4 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data, newly enrolled Members who were receiving ECM through their previous MCP will continue to receive ECM services through AAH.

1.4.3.5 When AAH becomes aware of such a request, AAH will automatically authorize the Member for ECM services for 12 months.

1.4.3.6 AAH will outreach to the Member's previous MCP, the Member and/or previous ECM Provider to obtain access to the Member's Care Management Plan to mitigate any gaps in care. AAH will share the Care Management Plan with the new ECM Provider and assist with a warm hand-off between ECM Providers, when necessary.

1.4.3.7 When available, AAH will review historical utilization data using a 90-day look-back period to identify Members who have received ECM.

1.4.3.8 These Members will be reassessed by the ECM Provider, prior to the end of the

Submission

authorized period, to determine the appropriate level of care management or coordination of services, whether ECM or a lower level of care management or coordination. ECM Providers will assess Members using the ECM Graduation Checklist. ~~(See CM 011 Enhanced Care Management & Transitions of Care Attachment A)~~

1.4.3.9 AAH requires subcontracted plans (delegates) use the same process for automatically authorizing newly enrolled members who were receiving ECM through their previous Medi-Cal managed care plan.

1.5 Risk Grouping: AAH will apply a Risk Grouping methodology as follows:

1.5.1 All Alliance members are assigned a risk grouping, including the entire ECM universe..

~~1.5.1 Initial administrative data tiering will be performed on the entire ECM Universe.~~

1.5.2 All current members are defaulted to high risk.

1.5.3 ~~High Tier~~Reimbursement of members will be paid at a rate and payment structure that takes into consideration DHCS' emphasis on in-person interventions with supplemental telephone encounters. ~~the increased ECM services experienced by the High Tier members. ECM Providers are expected to have at a minimum of three (3) encounters and at least one in-person encounter a month to be eligible for the enhanced rate.~~

~~1.5.3~~1.5.4 In-person meetings may be temporarily suspended during a declared public health emergency; however, alternative means of communication with members should be employed to contact members during this time.

~~1.5.4 ECM Providers unable to meet the minimum expectations will be eligible for reimbursement at a lower rate as long as ECM Providers have monthly encounters.~~

~~1.5.5 AAH will provide the High/Low Tiering in the monthly Member Information file. The High/Low Tiers will help guide the ECM Providers in their outreach efforts for their ECM eligible.~~

~~1.5.6 Those members with the highest tier will be placed higher on the priority list within the respective Tiers and ECM Providers will be asked to prioritize outreach to those members.~~

~~1.5.6.1 All members within a Tier will be paid at the same rate.~~

~~1.5.6.2 The tiering logic for the Low Tier will be assessed by AAH for validity at least annually and modified and as needed.~~

~~1.5.7~~1.5.5 Member assignment is documented in the eligibility lists distributed to each ECM Provider. In addition, member assignment is also stored in the AAH databases for reporting, viewing, and historical purposes.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health

Confidential

SNF	Skilled Nursing Facility
TCM	Targeted Case Management
SMI	Serious Mental Illness
PCP	Primary Care Provider
ACG	Adjusted Clinical Groups
RUB	Resource Utilization Band
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
DHCS	Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 03/22/2022, 05/23/22, 06/20/2022 02/03/2023, 02/08/2023, 9/19/2023, 10/19/2023, 12/18/2024, **4/16/2025**

Blue = substantive updates

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

Collaboration

Lease

POLICY AND PROCEDURE

Policy Number	CM-041
Policy Name	Enhanced Care Management – Outreach/Member Engagement
Department Name	Case Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	05/16/2019
Subcommittee Name	`Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~TBD
Administrative Oversight Committee Approval Date	~~9/18/2024~~TBD

POLICY STATEMENT

AAH is responsible for engaging Enhanced Care Management (ECM) eligible members, using state determined, Centers for Medicare & Medicaid Services (CMS) approved criteria.

PROCEDURE

1. AAH links ECM members to one of our contracted ECM Providers.
   - 1.1.1 If the ECM member's assigned primary care provider (PCP) is affiliated with an ECM Provider, the ECM member will be assigned to that ECM Provider, unless the member chooses another ECM Provider or a more appropriate ECM Provider is identified given the member's individual needs and conditions.
   - 1.1.2 AAH and/or the ECM Provider's notification will inform the ECM member that they are eligible for ECM services and will identify both AAH and the ECM Provider. This notification will explain that ECM participation is voluntary, members have the opportunity to choose a different ECM Provider, and ECM members can discontinue participation at any time. It will also explain the process for participation.

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2. AAH has the ability to perform the following duties/responsibilities or delegate to ECM Providers and provide appropriate oversight.

1.2.1 AAH has the capacity to engage and provide services to eligible members, including:

1.2.1.1 Develop an ECM eligibility list ~~including HHP/WPC enrolled members transitioning to ECM or HHP/WPC eligible members actively being outreached by ECM Providers transitioning to ECM;~~including eligibility for ~~specific DHSC programs like Transitional rent.~~

1.2.1.2 Review the members on the eligibility list for homelessness;and other ECM populations of focus groups.

1.2.1.3 Attribute eligible ECM members to ECM Providers. (See CM- 010 Enhanced Care Management: Member Identification, Grouping & Eligibility List Management); ~~For transitional rent, a subset of contracted ECM providers are selected to perform ECM outreach and engagement as defined by Transitional Rent policy.~~

1.2.1.4 When possible, refer eligible members known to have specific eligibility criteria ~~be homeless~~ to appropriate corresponding ECM Providers with expertise in outreach/engagement of people ~~experiencing homelessness~~of this population (i.e., homelessness); ~~Refer members into ECM who will be authorized for Transitional rent.~~

1.2.1.5 For ~~homeless~~ members assigned to ECM Providers without specific expertise in outreaching people ~~who are homeless~~of the specific population, AAH will attempt to coordinate support from service providers (i.e., street outreach or other homeless service providers);

1.2.1.6 Ensure attempts at the engagement of members on the ECM Eligibility List;

~~1.2.1.6~~1.2.1.6.1 For ECM members authorized for Transitional Rent (TR), outreach/engage in accordance with TR rules for ECM outreach/engagement.

1.2.1.7 Secure and maintain record of the member's consent to participate in the program (which can be verbal); and

1.2.1.8 Provide member resources (e.g. customer service, member grievance process) relating to ECM.

1.2.2 AAH has the ability to engage members or delegate proper engagement processes to ECM Providers, including:

1.2.2.1 Identifying, locating, and engaging ECM-eligible members. AAH uses a model outreach protocol as the primary guidance to ECM Providers in locating and engaging members.

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1.2.2.2 The number of contacts and usual progression of steps for various modalities includes five (5) attempt to contact the member within 90 days after the ECM provider receives the ECM eligibility list.

1.2.2.2.1 For members authorized for Transitional Rent (TR), the outreach/engagement will align with the Community Supports Policy Guide for Transitional Rent.

~~1.2.2.1~~1.2.2.3 ~~For members who may be eligible for Transitional Rent, AAH will pre-identify members for ECM in advance of TR authorization where possible. For members who have not been identified for ECM but do have an authorization for TR, ECM will refer members to a pre-selected ECM provider for outreach in accordance with TR rules/policy.~~

~~1.2.2.2~~

~~3. The number of contacts and usual progression of steps for various modalities includes five attempts to contact the member within 90 days after the ECM Provider receives the ECM Eligibility List. For ECM members authorized for TR, the outreach/engagement will align in accordance with the TR rules/policy requirements. Outreach efforts will consist of:~~

~~1.3.1 Assigned Members in High Tier will receive a minimum of every other week outreach contacts/attempts.~~

~~1.3.2~~3. ~~Assigned Members in Low Tier will receive a minimum of monthly outreach contacts/attempts.~~

1.3.1 All attempts to contact will be documented within the ECM Provider's care management record system.

1.3.1.1 For ECM members authorized for TR, ~~AAH~~the ECM provider will communicate timely with the Alliance to ~~will~~ document/record provider attempts to outreach ~~via our HER system to track the outcome of outreach/engagement for members authorized for TR requiring ECM services.~~. Documentation will occur in the Alliance's system of record.

~~1.3.3~~1.3.1.2 Data (including, but not limited to, closed loop referral information) will be shared in alignment with the DHCS guidance as appropriate.

~~1.3.4~~1.3.2 Active outreach strategies may include but not be limited to:

~~1.3.4.1~~1.3.2.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

~~1.3.4.2~~1.3.2.2 Direct communications with Members by letter, email, social media, texts, telephone;

~~1.3.4.3~~1.3.2.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or

~~1.3.4.4~~1.3.2.4 When possible, available data exchange platform to obtain information to help locate and contact the Member; and/or

~~1.3.4.5~~1.3.2.5 Outreach to SNF's and inpatient facilities. The MCP will share ADT feeds and census information with ECM Providers to help direct this outreach;

~~1.3.4.6~~1.3.2.6 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

1.3.3 Active outreach strategies will be done primarily through in-person contact.

1.3.3.1 For ECM members authorized for TR, outreach will be conducted in accordance with ~~TR rules/policy requirements~~the Community Supports Policy Guide for

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Alameda Alliance for Health

Transitional Rent.

~~1.3.5~~1.3.4 Active, meaningful and progressive attempts at member engagement must be shown each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face to face, mail, email, telephone), follow up if the member presents to another partner agency or facility in the ECM network or if able to contact through teleconferencing or telehealth services, or using claims data to identify and contact providers the member is known to use. Examples of acceptable engagement include:

~~1.3.5.1~~1.3.4.1 If member prefers and is available, teleconferencing may be used. Due to public health restrictions, telehealth, teleconferencing could be used to supplement in-person contact.

~~1.3.5.2~~1.3.4.2 Letter to member followed by phone call to member.

~~1.3.5.3~~1.3.4.3 Phone call to member, outreach to care delivery partners and social service partners.

~~1.3.5.4~~1.3.4.4 Street level outreach, including, but not limited to, where the member lives or is accessible.

1.3.4.5 After five (5) unsuccessful attempts, the ECM Provider and the MCP will note and document the challenges with the active outreach and ask the PCP to discuss ECM with the member at the next PCP visit.

~~1.3.5.5~~1.3.4.5.1 For members ~~referred into ECM because they are~~ authorized for TR, ECM providers will be required to communicate ~~weekly~~ regularly with AAH ECM team for timely notification as required for ECM members who are authorized for TR.

~~1.3.5.5.1~~1.3.4.5.2 If the member declines ECM enrollment at the PCP visit, this will be noted in the ECM Provider's system of record and the MCP will be notified.

~~1.3.5.5.2~~1.3.4.5.3 If the ECM Provider or the MCP learns that the member contact information is out of date, efforts will be made to update that information using recent provider records and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations.

~~1.3.5.5.3~~1.3.4.5.4 For members who are homeless, the ECM provider will also review members' housing and utilization history and work with the MCP and appropriate County agencies to determine if that member can be reached at a shelter, alternative housing site or through a community-based organization.

~~1.3.5.6~~1.3.4.6 Establish a process for reviewing and excluding people from the ECM Eligibility list. Those members to be excluded are the following:

~~1.3.5.6.1~~1.3.4.6.1 Members whose condition management cannot be improved because the member is uncooperative;

~~1.3.5.6.2~~1.3.4.6.2 Members whose behavior or environment is unsafe for ECM staff;

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~~1.3.5.6.3~~1.3.4.6.3 Members determined to be more appropriate for an alternate care management program;
~~1.3.5.6.4~~1.3.4.6.4 Members receiving hospice care;
~~1.3.5.6.5~~1.3.4.6.5 Members receiving pediatric palliative care;
~~1.3.5.6.6~~1.3.4.6.6 Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month;
~~1.3.5.6.7~~1.3.4.6.7 Members enrolled in any other program deemed to have duplication of care management/care coordination services;
~~1.3.5.6.8~~1.3.4.6.8 Duplicated Targeted Case Management services (excluding Severe Mental Illness TCM);
~~1.3.5.6.9~~1.3.4.6.9 Members determined through further assessment to be sufficiently well-managed through self-management, or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria. AAH deems members as "well-managed" based upon graduation criteria, i.e. whether the HAP goals have been met; whether the patient was linked with supportive or community services and feels as though there has been improvement; whether the patient has been linked with a housing referral and plan for monitoring if the member is experiencing homeless, and finally, whether there has been evidence of decreasing utilization of emergency services.

~~1.3.5.7~~1.3.4.7 Report Members determined not appropriate for ECM, along with a reason code, to DHCS.

~~1.3.5.8~~1.3.4.8 DHCS will evaluate AAH-enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the ECM Eligibility list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.

~~1.3.5.9~~1.3.4.9 Include housing navigators in the engagement process, at AAH's discretion.

1.3.4.10 Document the member engagement process.
~~1.3.5.10~~1.3.4.10.1 For ECM members enrolled in TR, providers will communicate ~~weekly~~regularly with AAH ECM team to notify timely of outreach/engagement efforts to align with TR rules/policy requirements.

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~~1.3.5.11~~1.3.4.11 Develop a methodology and criteria used by AAH or the ECM Provider to stratify high, low need members.

~~1.3.5.12~~1.3.4.12 Develop educational materials or scripts to engage the member.

~~1.3.5.13~~1.3.4.13 Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma informed care standards.

~~1.3.5.14~~1.3.4.14 Have policies and procedures for the following:

~~1.3.5.14.1~~1.3.4.14.1 Required number and modalities of attempts made to

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engage member AAH's protocol for follow up attempts.

~~1.3.5.14.2~~1.3.4.14.2 AAH's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate.

~~1.3.6~~1.3.5 After AAH has screened people who are inappropriate for ECM from the ECM Eligibility list based on the ECM requirements, AAH will create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

~~1.3.6.1~~1.3.5.1 This group, or members in order or priority rank, would be the first focus for AAH engagement efforts. The criteria and size of the group for priority engagement status will be at AAH's discretion.

DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
AAH – Alameda Alliance for Health
SNF – Skilled Nursing Facility
DHCS – Department of Health Care Services
PCP – Primary Care Provider
MCP – Managed Care Plan
ADT – Admission Discharge Transfer

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
CM-037 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 12/19/2023, 9/18/2024

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

Collaboration

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

collaboration

POLICY AND PROCEDURE

Policy Number	CM-043
Policy Name	Child Welfare Liaison
Department Name	Case & Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director of Social Determinants of Health
Line(s) of Business	MCAL, D-SNP
Effective Date	12/18/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/14/2025
Administrative Oversight Committee Approval Date	~~4/16/2025~~TBD

POLICY STATEMENT

The purpose of this policy is to clarify the intent and objectives of the Medi-Cal managed care plan Child Welfare Liaison. It also provides guidance regarding the requirements and expectations in relation to the role and responsibilities of the MCP Child Welfare Liaison.

The Alliance has designated an MCP Welfare Liaison to ensure the needs of members involved in child welfare and foster care are met.

The Alliance is working to build partnerships with specified entities, including county child welfare agencies, and enter (as appropriate) into Memorandums of Understand (MOUs) to coordinate and facilitate the provision of Medically Necessary services to members, share data, and as applicable, avoid the duplication of services where members are served by multiple parties. The MOUs are intended to clarify roles and responsibilities among parties, support local engagement, and facilitate the exchange of information necessary to enable care coordination and improve referrals. The MOU is binding, contractual agreement between the Alliance and county child welfare agencies and outlines the responsibilities and obligations of the Alliance to coordinate and facilitate the provision of services to members, when they are served by multiple parties. The MOU with county child welfare agencies will, at a minimum include all of the MOU provisions required by the MOU contract including designation of a MCP Child Welfare Liaison to coordinate with county child welfare agencies.

Assembly Bill (AB) 2083 (Chapter 815, Statutes of 2018) requires each county to develop and implement an MOU setting forth roles and responsibilities of agencies and other

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entities, such as regional centers, county offices of education, county child welfare, juvenile probation, and behavioral health agencies, that serve children and youth in foster care who have experienced server trauma as outlines in the All County Letter No. 19-116/Behavioral Health Information Notice 19-053. The purpose of AB 2083 MOU (i.e. Children and Youth Systems of Care (SOC) MOU) is to ensure that children and youth in foster care receive coordinated, timely, and trauma-informed services. While AB 2083 focuses on children and youth in foster care who have experienced severe trauma, it reflects a priority to build a locally governed interagency or interdepartmental model on behalf of all children and youth across California who have similar needs and who interact with and are served by multiple agencies. A component of these SOC MOUs between counties and other local entities that serve children in child welfare/foster care is the implementation of California's Integrated Core Practice Model (ICPM). The ICPM articulates the shared values, core components, and standards of practice expected when serving California's children, youth, and families. The ICPM establishes leadership behaviors and practices that require individuals and organizations to partner and collaborate with one another and the children and families they serve. This ensures an integrated approach to meet the needs of children and families.

These efforts are integral to driving the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). CalAIM is a multi-year DHCS initiative to improve the quality of life and health outcomes of California's most vulnerable populations by implementing broad delivery system, program and payment reforms across the Medi-Cal program, including by establishing Enhanced Care Management (ECM) and Community Supports. Children and Youth Involved in Child Welfare is one of the key Populations of Focus for these efforts.

The BH-CONNECT demonstration is a new Medicaid Section 1115 Demonstration, with an expected effective date of January 1, 2025. It seeks to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT includes several components that required Centers for Medicare & Medicaid Services (CMS) waiver approval, and others that will be accomplished under existing or other authority, including the implementation of a MCP Child Welfare Liaison within the Alliance.

PROCEDURE

1. Overview

Effective January 1, 2024, the Alliance has designated an appropriate number of staff to serve as the Alliance Child Welfare Liaison to meet the health care needs of children and youth involved in child welfare in Alameda County.

1.1. Children and youth involved in child welfare refers to any member eligible for the ECM Population of Focus for Children and Youth Involved in Child Welfare

1.2. Additional Alliance Child Welfare Liaisons will be designated as needed to ensure the health care needs of children and youth involved in child welfare are met and will be commensurate to the number of members involved in child welfare enrolled with the Alliance.

1.3. The Alliance has fulfilled the Alliance Child Welfare Liaison role with adequate staffing, and will reassess staffing levels at regular intervals to ensure effectiveness and their ability to serve children and youth involved in child welfare and the geographical landscape of Alameda County.

1.3.1. This includes ensuring sufficient staffing commensurate with the workload necessary to support the care managers.
1.3.2. The Alliance will report on the staffing designated to the Child Welfare Liaison role.

2. Roles and Responsibilities

2.1.Roles

The Alliance Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these members are met.

2.1.1. The Alliance Child Welfare liaison serves as a leader within the Alliance to advocate on behalf of the children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific systematic and operational obstacles for accessing services.
2.1.2. The Alliance Welfare Liaison provides assistance and resources to staff responsible for the member's care coordination, including ECM Lead Care Managers for the Children and Youth Involved in Child Welfare Population of Focus and county child welfare staff such as Health Care Program for Children in Foster Care, public health nurses, and other staff as needed.
2.1.3. The Alliance Child Welfare Liaison is not intended to duplicate care coordination activities provided to members by other providers and staff members, but rather to support and act as a resource to solve escalated issues regarding Alliance services as they arise.

2.2.Responsibilities

2.3.The roles and responsibilities of the Alliance Child Welfare Liaison include, but are not limited to:

2.3.1. Act as a resource and provide technical assistance for staff involved in the coordination of the member's care to ensure escalated issues are resolved; in that Alliance Covered Services, including Medically Necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (Medi-Cal for Kids and Teens), are closely coordinated with other Medi-Cal programs that are carved-out from the Alliance, such as Specialty Mental Health Services as well as other non-Medi-Cal services and benefits such as County Child Welfare Services overseen by the California Department of Social Services.
2.3.2. Individuals who may request assistance from the Alliance Child Welfare Liaison may include, but are not limited to:
2.3.2.1. The member's designated ECM Lead Care Manager who is responsible for coordinating all aspects of ECM and Community Supports as a part of the

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member's multi-disciplinary care team. The ECM Lead Care Manager serves as the primary point of contact for member and/or parent, caregiver, legal guardian, resource parents, other family member(s) and/or other authorized support person(s) and coordinates with other staff responsible for coordinating the member's care and the Alliance' Child Welfare Liaison, as needed.

~~2.3.2.1.~~2.3.2.1.1. This includes ensuring appropriate ECM staff, including the ECM Lead Care Manager whenever possible to attend the meetings of the child and family teams and ensure the covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services.

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2.3.2.2. County child welfare staff and other county staff responsible for coordinating the member's care including, but not limited to:

- 2.3.2.2.1. Health Care Program for Children in Foster Care public health nurses
- 2.3.2.2.2. County probation officers
- 2.3.2.2.3. County child welfare social workers
- 2.3.2.2.4. County behavioral health providers
- 2.3.2.2.5. California Wraparound care coordinators
- 2.3.2.2.6. County health education specialists
- 2.3.2.2.7. Child and Family Teams facilitators, and
- 2.3.2.2.8. Other county child welfare staff, county staff, secondary case managers, and/or other service providers, as applicable.

2.3.2.3. Other staff who may be responsible for coordinating the member's care, including, but not limited to:

- 2.3.2.3.1. MCP Providers
- 2.3.2.3.2. Indian Health Care Providers
- 2.3.2.3.3. Tribes, in the case of an American Indian member
- 2.3.2.3.4. Community Health Workers
- 2.3.2.3.5. Regional Center staff, and

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2.3.2.3.6. Other secondary case managers and/or service providers, as applicable

2.3.2.4. County Liaisons designated in the MOU between the Alliance and county child welfare agencies, as the county's designated point of contact responsible for acting as the liaison between the county and the Alliance.

2.3.3. Serve as a point of contact for staff to resolve escalated issues in a timely manner when members are experiencing difficulty accessing services, obtaining referrals, changing Providers, or facing operational obstacles to receiving health care services. For example, if a member faces delays in obtaining needed services and supports from the Alliance, such as needed assistance with finding an appropriate Primary Care Provider, the Alliance Child Welfare Liaison may assist staff, such as county child welfare staff in navigating the health care system on behalf of members involved in child welfare.

2.3.4. Collaborate with the Alliance ECM staff to ensure that robust and effective referral pathway exists to ensure all children and youth involved with child welfare are eligible for the ECM benefit are offered and/or enrolled in the ECM program, including but not limited to referral pathways with the entities listed above who are serving these children and youth.

2.3.5. Provide resources and support regarding Alliance member enrollment and disenrollment when they are made aware that the member will move to a different county. Support may include providing information about how to report a change of address to county social services departments and how to contact the Medi-Cal Managed Care Ombudsman as needed to expedite disenrollment from the Alliance in the county from which the member is leaving.

2.3.6. Assist with benefits and services navigation and coordination throughout the Alliance's service area, including but not limited to ECM, Community Supports, Behavioral Health, Transitional Care Services, Health Education, Home and Community Based Services, California Children's Services (CCS), tribal health care and other local service area resources, etc., to provide full-spectrum services to members.

2.3.7. Coordinate with other internal Alliance Liaisons related to specific member populations and services or programs (e.g., liaisons for Long-Term Services and Supports, Transportation, CCS, Regional Center, Dental, and In-Home Supportive Services). In particular, the Alliance Child Welfare Liaison will coordinate with the designated tribal liaison for members who

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are American Indian children and youth involved in child welfare.

2.3.8. If applicable, coordinate with the designated MCP County Liaison, which serves as the Alliance's designated point of contact via the MOU between the Alliance and county child welfare agencies. The MCP County Liaison and the Alliance Child Welfare Liaison roles may be the same individual(s), as appropriate and with proper fulfillment of the respective roles.

2.3.9. Attend quarterly meetings with local county child welfare agencies as required, including subsequent updates, and as outlined in the MOU between the MCP and county child welfare agencies, to address care coordination, quality improvement activities, quality improvement outcomes, systemic and case-specific concerns, and communicate with others within their organizations about such activities.

2.3.10. Participate in and provide input for quality improvement activities associated with the MOU between the Alliance and county child welfare agencies.

2.3.11. As applicable, pursuant to the MOU between the Alliance and county child welfare agencies, collaborate with the MCP County Liaison to ensure compliance with the training and education provisions of the MOU, which includes providing training and/or educational materials to county child welfare agencies on how the MCP's Covered Services, and any carved-out services, may be accessed, including during nonbusiness hours.

2.3.12. Provide resources and support to Alliance staff and providers in understanding the Foster Youth Bill of Rights.

2.3.13. Support Alliance staff and providers with using trauma-informed approaches when interacting with children, youth, non-minor dependents, parents, family members, legal guardians, resource parents, or caregivers.

2.4. Additionally, the Alliance Child Welfare Liaison(s) are committed to the following activities to enhance relationships between the Alliance and county child welfare agencies for members involved in child welfare.

2.5. Participate in the MCP Community Advisory Committee and other Alliance committees and meetings that potentially impact members involved in child welfare and foster care.

2.6. As applicable, collaborate with the county to identify opportunities for coordination of and alignment with the county's Interagency Leadership Team's efforts in implementing the AB 2083 SOC MOU, and participate in the SOC Local Interagency Leadership Team meetings to which the Alliance may be invited.

Solicitation

2.7. Collaborate with the other Alliance Child Welfare Liaisons internally and with MCP Child Welfare Liaisons in other MCPs to discuss best practices, lessons learned, and sharing of information and resources.

The Alliance has designated individual(s) for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities as outlined above.

2.8. Criteria for the Alliance Child Welfare Liaison(s):

- 2.8.1. Have expertise, demonstrable experience, or sufficient training in the following:
  - 2.8.1.1. Child welfare services and county behavioral health services
  - 2.8.1.2. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes.
  - 2.8.1.3. Trauma informed care practices
- 2.8.2. Additional expertise, experience, and training the Alliance may considered to include, but not limited to:
  - 2.8.2.1. Have a master's degree and/or other additional training in social work, public health nursing, or another related field
  - 2.8.2.2. Have familiarity with Medi-Cal enrollment and disenrollment processes as well as county social services agency processes for updating addresses and other eligibility information
  - 2.8.2.3. Have experience or training in coordinating care within child welfare services and juvenile justice systems and have an understanding of the Foster Care Bill of Rights

3. Information Sharing
   - 3.1. In compliance with the requirement set forth in the appropriate APL(s), including subsequent updates, and the County Social Services Agencies for Child Welfare MOU template, the Alliance has policies and procedures for supporting the timely and frequent exchange of member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining member consent.
   - 3.2. The Alliance will share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other state and federal privacy laws. For additional guidance related to sharing members' data and information.
4. Notification

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4.1. In accordance with the MOU between the MCP and county child welfare agencies and the MCP Contract, the Alliance will notify the county child welfare agency and DHCS of a change in the designated MCP Child Welfare Liaison as soon as practicable, but no later than five (5) working days of the change.

4.2. To support collaboration efforts, the California Department of Social Services (DSS) has created a contact list of the County Child Welfare agencies points of contact.

5. DHCS Monitoring

5.1. The Alliance has submitted the MCP Child Welfare Liaison contact information to the "Liaison Directory" section available on the Managed Care Operations Division (MCOD) - MCP Submission Portal.

5.2. With delegated subcontractors that serve children and youth involved with child welfare, the Alliance will submit contact information of the subcontractor's Child Welfare Liaison(s) to the MCOD-MCP Submission Portal.

5.2.1. The Alliance is responsible for ensuring subcontractors' compliance with the requirements.

5.2.2. The Alliance is responsible for ensuring subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

DEFINITIONS / ACRONYMS

MCP – Managed Care Plan
MOU – Memorandum of Understanding
AB – Assembly Bill
CalAIM - California Advancing and Innovating Medi-Cal
BH-CONNECT - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
CMS - Centers for Medicare & Medicaid Services
ECM – Enhanced Care Management
CCS - California Children's Services
SOC - Systems of Care
EPSDT - Early and Periodic Screening, Diagnostic and Treatment
HIPAA - Health Insurance Portability and Accountability Act

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management
Enhanced Care Management

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Adoption

None

REVISION HISTORY

New Policy: 12/18/2024

Committee Approved Updates: 4/16/2025

REFERENCES

APL 24-013

MONITORING

This policy will be reviewed annually.

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Lease

POLICY AND PROCEDURE

Policy Number	CM-D-006
Policy Name	~~Enhanced~~ California Integrated Care Management – Outreach/Member Engagement
Department Name	Case Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	~~MCAL~~DSNP
Effective Date	~~05/16/2019~~TBD
Subcommittee Name	~~-~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~TBD
Administrative Oversight Committee Approval Date	~~9/18/2024~~TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members. ~~AAH~~ Alameda Alliance Wellness (Alliance) is responsible for engaging ~~Enhanced~~ California Integrated Care Management (CI~~E~~CM) eligible members, using state determined, Centers for Medicare & Medicaid Services (CMS) approved criteria.

PROCEDURE

1. ~~AAH~~ Alliance assigns a CICM member to a lead care manager within the Alliance. ~~links ECM members to one of our contracted ECM Providers.~~

~~1.1.1 If the ECM member's assigned primary care provider (PCP) is affiliated with an ECM Provider, the ECM member will be assigned to that ECM Provider, unless the member chooses another ECM Provider or a more appropriate ECM Provider is identified given the member's individual needs and conditions.~~

~~1.1.2~~ ~~AAH~~ The Alliance's ~~and/or the ECM Provider's~~ notification will inform the ~~ECM~~ CICM member that they are eligible for ~~ECM~~ CICM services and will identify ~~both AAH~~the ~~-~~Alliance ~~and the ECM Provider~~lead care manager. This notification will explain that ~~ECM~~ CICM participation is voluntary, members have the opportunity to ~~choose a different ECM Provider, and ECM members can~~ discontinue participation at any time. It will also explain the process for participation.

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1.1.1

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2. ~~AAH~~ The Alliance ~~has the ability to~~ performs the following duties/responsibilities: ~~or delegate to ECM Providers and provide appropriate oversight~~.

~~1.2.1~~ ~~AAH~~ Alliance ~~has the capacity to~~ engages and provides services to eligible members,

1.2.1 including:

1.2.1.1 Develop a~~n~~ ~~ECM~~ CICM eligibility list including ~~HHP/WPC enrolled members transitioning to ECM or HHP/WPC~~ eligible members actively being outreached by ~~ECM~~ the CICM team~~Providers transitioning to ECM;~~

1.2.1.2 Review the members on the eligibility list for homelessness;

~~1.2.1.3 Attribute eligible ECM members to ECM Providers. (See CM- 010 Enhanced Care Management: Member Identification, Grouping & Eligibility List Management);~~

~~1.2.1.4~~1.2.1.3 When possible, refer eligible members known to be homeless to ~~ECM~~ CICM ~~Providers~~ lead care manager with expertise in outreach/engagement of people experiencing homelessness;

~~1.2.1.5 For homeless members assigned to ECM Providers without expertise in outreaching people who are homeless, AAH will attempt to coordinate support from street outreach or other homeless service providers;~~

~~1.2.1.6~~1.2.1.4 Ensure attempts ~~at the engagement~~to engage ~~of~~ members on the ~~ECM~~ CICM Eligibility List;

~~1.2.1.7~~1.2.1.5 Secure and maintain record of the member's consent to participate in the program (which can be verbal); and

~~1.2.1.8~~1.2.1.6 Provide member resources (e.g. customer service, member grievance process) relating to ~~ECM~~CICM.

~~AAH~~ The Alliance ~~has the ability to~~ engages members ~~or delegate proper engagement processes to ECM Providers~~, including:

~~1.2.2~~ Identifying, locating, and engaging~~ed~~ CICM eligible members.

~~1.2.3.2 Providers in [illegible] engaging [illegible] outreach protocol as the primary guidance to ECM~~

3. The number of contacts and usual progression of steps for various modalities includes (but is not limited to) five attempts to contact the member within 90 days after the ~~ECM~~ CICM lead care manager~~Provider~~ receives the ~~ECM~~ CICM Eligibility List. ~~Outreach efforts will consist of:~~

~~1.3.1 Assigned Members in High Tier will receive a minimum of every other week outreach contacts/attempts.~~

~~1.3.2 Assigned Members in Low Tier will receive a minimum of monthly outreach contacts/attempts.~~

1.3.1 The first outreach being within five (5) days of identification.

~~1.3.~~1.3.2 All attempts to contact will be documented within the ~~ECM~~ CICM ~~Provider's~~ care management record system.

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~~1.3.4~~1.3.3 Active outreach strategies may include but not be limited to:

~~1.3.4.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;~~

~~1.3.4.2~~1.3.3.1 Direct communications with Members by letter, secure email, ~~social media, texts,~~ telephone~~,~~; ~~f~~and/or face-to-face meetings

~~1.3.4.3~~1.3.3.2 Outreach to care delivery and social service partners, providers in the ~~AAH~~ Alliance network, and/or specific ~~AAH~~ Alliance personnel, to obtain information to help locate and contact the Member; and/or

~~1.3.4.4~~1.3.3.3 When possible, available data exchange platform to obtain information to help locate and contact the Member; and/or

~~1.3.4.5~~ Outreach to SNF's and inpatient facilities. ~~The MCP will share ADT feeds and~~

1.3.3.4 ~~census information with ECM Providers to help direct this outreach;~~

~~1.3.4.6~~1.3.3.5 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

~~1.3.5~~1.3.4 Active outreach strategies will be done primarily through in-person contact. Active, meaningful and progressive attempts at member engagement must be shown each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face to face, mail, secure email, telephone), ~~follow up if the member presents to another partner agency or facility in the ECM network~~ or if able to contact through teleconferencing or telehealth services, or using claims data to identify and contact providers the member is known to use. Examples of acceptable engagement include:

~~1.3.5.1~~1.3.4.1 If member prefers and is available, teleconferencing may be used. ~~Due to~~In the event of public health restrictions, telehealth, teleconferencing could be used to supplement in-person contact.

~~1.3.5.2~~1.3.4.2 Letter to member followed by phone call to member.

~~1.3.5.3~~1.3.4.3 Phone call to member, outreach to care delivery partners and social service partners.

1.3.4.4 ~~Street level outreach~~In-Person engagement, including, but not limited to, where the member lives or is accessible.

~~1.3.5.4~~1.3.4.4.1 For members experiencing homelessness, CICM will be provided in-person.

1.3.4.5 After (a minimum of) five (5) unsuccessful attempts~~,~~:

1.3.4.5.1 the ~~ECM~~ CICM ~~Provider and the MCP~~lead care manager will note and document the challenges with the active outreach and ask the PCP to discuss ~~ECM~~ CICM with the member at the next PCP visit.

1.3.4.5.2 The member will not be enrolled in CICM and instead, enrolled in a lower intensity program, Supportive Services.

~~1.3.5.4.1~~

~~1.3.5.4.2~~ If the member declines ~~ECM~~ CICM enrollment, ~~at the PCP visit,~~ this will be

1.3.4.5.3 noted in the ~~ECM~~ CICM ~~Provider's~~ system of record ~~and the MCP will be notified~~.

~~1.3.5.4.3~~ If the CI~~E~~CM lead care manager ~~Provider or the MCP~~ learns that the member contact information is out of date, efforts will be made to update that information

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using recent

1.3.4.5.4 ~~recent~~ provider records and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations.~~on~~

~~1.3.5.4.4~~ For members who are homeless, the ~~ECM~~ CICM ~~provider~~ lead care manager will also review members' housing and utilization history and work with the ~~MCP and~~ appropriate County agencies to determine if that member can be reached at a shelter,

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alternative housing site or through a community-based organization.

~~1.3.5.5~~1.3.4.6 CICM is a program to enroll members who are open and willing to engage in a higher level of care for a period of time. There are situations where members can be excluded, disenrolled or transitioned to a different level of case management. This includes, but is not limited to: ~~Establish a process for reviewing and excluding people from the ECM Eligibility list. Those members to be excluded are the following:~~

~~1.3.5.5.1~~1.3.4.6.1 Members whose condition management cannot be improved because the member is uncooperative;

~~1.3.5.5.2~~1.3.4.6.2 Members whose behavior or environment is unsafe for ~~ECM~~ CICM staff;

~~1.3.5.5.3~~1.3.4.6.3 Members determined to be more appropriate for an alternate care management program;

~~1.3.5.5.4~~1.3.4.6.4 Members receiving hospice care;

~~1.3.5.5.5~~1.3.4.6.5 Members receiving pediatric palliative care;

~~1.3.5.5.6 Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month;~~

~~1.3.5.5.7~~1.3.4.6.6 Members enrolled in any other program deemed to have duplication of care management/care coordination services;

~~1.3.5.5.8 Duplicated Targeted Case Management services (excluding Severe Mental Illness TCM);~~

~~1.3.5.5.9~~ Members determined through further assessment to be sufficiently well-managed through self-management, or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria. ~~AAH~~ Alliance deems members as "well-managed" based upon graduation criteria, i.e. whether the HAP goals have been met; whether the patient was linked with supportive or

1.3.4.6.7 community services and feels as though there has been improvement; whether the patient has been linked with a housing referral and plan for monitoring if the member is experiencing homeless, and finally, whether there has been evidence of decreasing utilization of emergency services.

~~1.3.5.6 Report Members determined not appropriate for ECM, along with a reason code, to DHCS.~~

~~1.3.5.7 DHCS will evaluate AAH enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the ECM Eligibility list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.~~

~~1.3.5.8~~1.3.4.7 Include housing navigators in the engagement process, at ~~AAH's~~Alliance's discretion.

~~1.3.5.9~~ Document the member engagement process.

~~1.3.5.10~~1.3.4.8 ~~Develop a methodology and criteria used by AAH or the ECM Provider to stratify high, low need members.~~

~~1.3.5.11~~1.3.4.9 Develop educational materials or scripts to engage the member.

~~1.3.5.12~~1.3.4.10 Have ~~policies and procedures~~standard operating procedures to provide culturally appropriate communications and information that meet health literacy and trauma informed care standards.

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~~1.3.5.13~~1.3.4.11 Have ~~policies and procedures~~standard operating procedures for the following:

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~~1.3.5.13.1~~1.3.4.11.1 Required number and modalities of attempts made to engage member
~~AAH's~~ Alliance's protocol for follow up attempts.

~~1.3.5.13.2~~1.3.4.11.2 ~~AAH's~~ Alliance's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate.

~~1.3.6 After AAH has screened people who are inappropriate for ECM from the ECM Eligibility list based on the ECM requirements, AAH will create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.~~

~~1.3.6.1 This group, or members in order or priority rank, would be the first focus for AAH engagement efforts. The criteria and size of the group for priority engagement status will be at AAH's discretion.~~

DEFINITIONS / ACRONYMS

~~ECM~~ CICM – ~~Enhanced~~ California Integrated Care Management

Alliance~~AAH~~ – Alameda Alliance Wellness~~for Health~~

SNF – Skilled Nursing Facility
DHCS – Department of Health Care Services PCP – Primary Care Provider
MCP – Managed Care Plan
ADT – Admission Discharge Transfer

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-001 ~~Enhanced~~ California Integrated Care Management (CICM) – Program Infrastructure
CM-D- 002 ~~Enhanced~~ California Integrated Care Management (CICM) – Member Identification and Grouping
CM-D-003 California Integrated~~Enhanced~~ Care Management (CICM) – Care Management
CM-D-004 California Integrated~~Enhanced~~ Care Management (CICM) - Staffing
CM-D-005 California Integrated~~Enhanced~~ Care Management (CICM) – Member Notification
CM-D-~~037~~ 007 California Integrated~~Enhanced~~ Care Management (CICM) – IT/Data Sharing CM-D-010 California Integrated~~Enhanced~~ Care Management (CICM) – Oversight, Monitoring, & Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

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Collaboration

REVISION HISTORY

~~05/20/2021, 01/20/2022, 03/22/2022, 12/19/2023, 9/18/2024~~

REFERENCES

~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

ECM Policy Guide

CalAIM Dual Eligible Special Needs Plan Policy Guide

MONITORING

CM-D-010 ~~Enhanced~~ California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

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collaboration

POLICY AND PROCEDURE

Policy Number	CM-D-008
Policy Name	California Integrated Care Management – Continuity of Care
Department Name	Case Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, SDOH
Line(s) of Business	DSNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members.

This policy describes continuity of care (CoC) guidelines for members receiving Enhanced Care Management (ECM) from their Medi-Cal MCP who were enrolled in a EAE D-SNP plan or who were receiving CICM from a EAE D-SNP plan.

PROCEDURE

1. For members who join Alameda Alliance Wellness (DSNP) on or after 1/1/26 are already receiving Medi-Cal ECM from their managed care plan (MCP), Alameda Alliance Wellness will provide ongoing continuity of care with existing Medi-Cal ECM providers, when possible, for up to 12 months.
2. Alameda Alliance Wellness may offer a longer continuity of care period.
3. UM Process
    a. Alameda Alliance Wellness follows UM-036 Continuity of Care for Terminated and Non-Participating Providers for further guidance.
4. CM Process
    a. The Alliance will work collaboratively with appropriate parties to ensure each member receives appropriate care, including ongoing care or transitioning the member to an in-network provider.

Collaboration

i. Collaborative work, includes, but is not limited to:
    1. Timely communication
    2. Warm hand-off of information between parties
    3. Closed loop communication

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Commented [AL3]: @Hunter, Lily - I started to make edits, but in reading further, I'm not exactly sure if this is what you were trying to get at? There's reference to 1/1/2024 throughout the remainder of the document…

Can you please clarify – you were intending to document the CICM COC expectations for when we become a D-SNP on 1/1/2026, correct?

I paused on further edits until I receive your clarification..

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness
CICM California Integrated Care Management
HAP Health Action Plan
ECM Enhanced Care Management

AFFECTED DEPARTMENTS/PARTIES

Information Technology
Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-009 California Integrated Care Management (CICM) – Infrastructure
CM-D-010 California Integrated Care Management (CICM) – Member Identification and Grouping
CM-D-011 California Integrated Care Management (CICM) – Care Management & Transitions of Care
CM-D-013 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls
CM-D-014 –Integrated Care Management (CICM) - Operations Non-Duplication
CM-D-016 California Integrated Care Management (CICM) – Staffing
CM-D-018 California Integrated Care Management (CICM) – Member Notification

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

REFERENCES

CalAIM Enhanced Care Management Policy Guide: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

MONITORING

CM-D-013 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

collaboration

POLICY AND PROCEDURE

Policy Number	CM—D-101002
Policy Name	DSNP Care Coordination Expectations
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) ensures that it provides comprehensive medical case management and basic population health management (BPHM) to all members in accordance with 42 CFR section 438.208. BPHM and comprehensive case management include care coordination for medically necessary services provided to members within and outside of the Alliance's provider network, based on the member's individual needs. The Alliance is the primary provider of such medical services except for those services that have been expressly carved out.

The Alliance prioritizes seamless and comprehensive care coordination to ensure that all members receive the services and follow-up care necessary to maintain or improve their health outcomes.

review

1. Delivery of Primary Care
   a. The Alliance ensures that members have a source of care that is appropriate, ongoing and timely to meet the member's needs. Primary care services will be available according to the health plan's established access and availability standards. Members will also have access to needed services including care coordination, navigation, and referrals to services that address members' developmental, physical, mental health, substance use disorder (SUD), dementia, long-term services and supports (LTSS), palliative care, vision, oral health, and pharmacy needs.
   b. The Alliance also ensures efficient care coordination and continuity of care for members who may need or are receiving services and/or programs from out-of-network providers. All services will be delivered in a culturally and linguistically competent manner that promotes health equity for all members.

2. Primary Care Provider (PCP) Role
   a. Establishment of an ongoing relationship between the member and their chosen PCP is crucial to the member achieving an optimal health status. Members are encouraged to make an appointment with their primary care practitioner immediately upon selection of their PCP.
   b. The Alliance ensures that each member is engaged with their assigned PCP, who plays a key role in coordination and continuity of care.
   c. The PCP has the responsibility and authority to direct and coordinate the members' services. These responsibilities include:
      i. Act as the primary case manager for all assigned members
      ii. Assist the acute, chronic, and preventive needs of each member
      iii. Ensure members receive all needed preventive services
      iv. Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes.

3. Coordination of Services
   a. The Alliance partners with primary care and other delivery systems to coordinate health and social services between settings of care; across other managed care health plans, delivery systems, and programs; with external entities outside of the provider network; and with other community-based resources, even if they are not covered services, to guarantee members' needs are addressed and to mitigate impacts of social determinants of health (SDOH).
   b. Member are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance use problems, co-existing conditions and chronic illnesses, or those members at the "end of life". Members who are unable to fully participate in their treatment decisions (i.e., minors, incapacitated

review

adults) may be represented by parents, guardians, other family members or conservators, as appropriate, and in accordance with the member's wishes.

c. The PCP has primary responsibility for evaluating the member's needs before recommending and arranging the services required by the member and facilitating communication and information exchange among the different providers/practitioners treating the member.
d. The PCP communicates to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons, all care coordination provided to members, as appropriate.
e. The Alliance assists members, members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons, with navigating health delivery systems, including subcontractor networks, to access services. (Please see P&P, *CM-D-102 DSNP Case Management Care Coordination Activities* for more information.)
f. The Alliance offers care coordination services, including the following:
    i. Coordination of Services with Out-of-Network Providers/Letter of Agreement (LOA)
        1. The Alliance identifies members who may need or who are receiving services from out of plan providers and/or programs to ensure coordinated service delivery, meet time and distance and timely access standards, and efficient and effective joint case management. This includes establishing a LOA to ensure that the member receives necessary care that meets the time and distance and timely access standards.
            a. The LOA is agreed upon by the Alliance and the provider and is made within the most recent year and is intended to ensure providers/specialists meet time, distance and timely access standards.
            b. Members are provided information on how to obtain out-of-network care in the Member's Handbook/Evidence of Coverage.
                i. When an authorization request for care by an out of network provider is approved, the member is informed in the Approval Letter.
                ii. When an prior authorization request with an out-of-network provider is denied because there is an available in-network service within the time and distance requirements, a referral is made to case management to assist with coordination of care in-network.
    ii. Coordination of Behavioral Health Care
        1. Internal to the Alliance collaboration occurs between the case management, utilization management and behavioral health teams to identify opportunities to improve coordination of behavioral health care with general medical care that may include (but is not limited to) collaboration between the organization and behavioral health specialists. The P&P, *BH - 005 Care Coordination –*

review

Behavioral Health describes the process of care coordination for behavioral health services.

iii. Coordination of Alcohol and Substance Use Disorder Treatment Services
   1. PCPs are responsible for identifying members with active or potential substance use problems. Once members are identified, PCPs are responsible for providing services for the substance use problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance use problem.
   2. PCPs are also responsible for referring members with substance use problems to an appropriate treatment practitioner or county department. The P&P, *BH – 005 Care Coordination – Behavioral Health*, describes the process of care coordination for alcohol and substance use disorder treatment services.

iv. Services for Persons with Developmental Disabilities (Regional Center)
   1. Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/behavioral health disorders outside their scope of practice.
   2. The Alliance implements and maintains systems to identify members with developmental disabilities that may meet requirements for participation in a Home and Community Based Services (HCBS) Waiver program and ensures that these members are referred to the appropriate HCBS Waiver program administered by the State Department of Developmental Services. P&P, *CM-D-106 Developmental Disabilities* describes the process of care coordination with the Regional Center.
   3. The Alliance is also responsible for authorizing a member's stay in an Intermediate Care Facility for the Developmentally Delayed (ICF/DD) homes following P&P, *LTC – 002, LTC Authorization Criteria*.

v. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver Program
   1. Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer members to an HIV/AIDS waiver program if they meet criteria. P&P, *CM-033 Home and Community Based Services (Waiver Programs) – DDS* describes the process of care coordination for these services.

vi. Dental Services
   1. For provider information and to assist with coordination of dental benefits the case management team can contact smilecalifornia.org for more information.
   2. To support coordination, the team can submit an online Medi-Cal Dental Care Coordination form. (https://dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/CareCoordinationReferra

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lForm) for the member or call the Dental Business Operation (DBO) customer telephone service center line at, 1-800-322-6384: TTY 1-800-735-2922.

3. A representative is available Monday through Friday, 8:00 AM to 5:00 PM to help assist.
4. The DBO will then create a profile for the member within one business day and reach out to the requester within two business days to assist with care coordination, including finding a dental provider.
5. Medi-Cal dental also offers an online Case Management Referral. (https://dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Provider_Forms/CaseMgmtReferralForm) This program is designed for Medi-Cal members (including D-SNP members) with special health care needs who are unable to schedule and coordinate complex treatment plans, such as a need for general anesthesia required in a hospital setting that involves one or more medical and dental providers.

vii. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
   1. PCPs will assess the risk of noncompliance with drug therapy for each member who requires placement on anti-tuberculosis therapy. P&P *UM-023 Communicable Disease Reporting and Services* describes the process of care coordination for treatment of TB.

viii. Women, Infants, and Children (WIC) Supplemental Nutrition Program
   1. The Alliance PCP, Obstetrical (OB), and Pediatric practitioners will inform members of the availability of WIC services and make appropriate referrals to the local WIC program for their assigned members who are potentially eligible. *CM-044 Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)* describes the care coordination for these services.

ix. Waiver Programs
   1. Members who may qualify for one of the Waiver Programs will be identified by the PCP with Alliance support, based on their diagnosis and need for a specific level of care. P&P *CM-033 Home and Community Based Services (Waiver Programs) – DDS* describes the process of care coordination with these waiver programs.

x. Transportation Services
   1. The Alliance will assist members to obtain transportation services as needed to ensure that members can obtain care within the time and distance and timely access standards.

xi. Community Based Adult Services (CBAS)
   1. CBAS services will be coordinated for members requiring Long-Term Services and Supports outside of facilities to meet their care needs in the least restrictive environment. See CBAS policies for more information.

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Authorization of Services

Services should be medically necessary and recommended by the PCP or the Specialty Care Provider (SCP). Members have the right to request any covered services, whether or not the service has been recommended by the PCP/SCP. The services must be approved through a utilization management system based on medical necessity.

PROCEDURE

1. Coordination Process
    a. The member's medical record is designated to receive and contain documentation of all care and services rendered to the member by the PCP, specialists, inpatient care, and ancillary services. This includes, but is not limited to:
        i. Documentation:
            1. Of care/services provided regarding mental health and/or substance use, providing the member has authorized the mental health/ substance use provider to disclose that information
            2. Of referral/receipt of Long-Term Services and Supports
            3. May be direct or consist of summary, consultation letters, discharge and progress notes submitted by outside providers.
        ii. When a member chooses a new PCP within the same network, the medical records are transferred to the new provider in a timely manner.
    b. Continuity of care
    c. Any specific continuity of care issues identified by the Alliance are communicated to the PCP with suggested resolution(s), when indicated (i.e., prior authorization; assess member for poly-pharmacy issues; member on non-formulary drug (suggest X drug), etc.)
        i. issues may include (but are not limited to):
            1. Ongoing DME in use in the member's home by the member (i.e., wheelchair, hospital bed, oxygen, etc.)
            2. Open authorizations to specialty or diagnostic testing services (i.e., MRI, PT, Specialty consultation/follow-up visits, etc.)
            3. Specialty care being provided to the member on an ongoing basis (i.e., member with HIV under the care of Infectious Disease Practitioner; ESRD member undergoing dialysis, pregnant member under an OB's care, etc.)
            4. Disease management goals, interventions, and outcomes.
            5. Pharmacy utilization issues (i.e., non-formulary medications, poly-pharmacy issues; contraindicated medications, etc.)
            6. Other issues (i.e., member out of area 3 months out of the year, member resides in a custodial care facility, etc.)

Review

d. Urgent and Emergency Care Services
   i. If the member is outside the service area, the PCP may recommend an appropriate level of care, but the final decision as to where to obtain services for the urgent care needs will reside with the member or responsible adult.
   ii. Emergency services are available through the Emergency Medical Services system (911) or through an emergency room either within or outside the service area, and without prior authorization.

e. The PCP will ensure that all referrals contain sufficient clinical information for the specialist/diagnostician to make a decision regarding the treatment of the member.
   i. All specialty consultation reports received by the PCP are to be filed in the member's medical record. Information from other treating providers will be requested as necessary.
   ii. Each practitioner participating in the member's care will provide information on available treatment options (including the option of no treatment) or alternative courses of care and other information regarding treatment options in a language that the member understands.
   iii. This information should include (but is not limited to):
      1. Member's condition
      2. Any proposed treatments or procedures and alternatives
      3. The benefits, drawbacks, and likelihood of success of each option
      4. The possible consequences of refusal or non-compliance with a recommended course of care
   iv. Members who are unable or unwilling to participate in their own care will be assessed through case management, appropriately counseled and given all of their health care options to be referred to the most appropriate long-term services and supports, and other community agencies.
   v. The areas where members need to be able to fully participate in their include, but are not limited to:
      1. Self-care
      2. Medication management
      3. Disease management
      4. Use of medical equipment
      5. Potential complications and when those should be reported to providers
      6. Scheduling of follow-up services
      7. Member education, especially as it relates to discharge planning
   vi. The Alliance implements information-sharing processes and referral support infrastructure. All member information is kept confidential. The Alliance:
      1. Ensures that providers furnishing services to members maintain and share, as appropriate, member's medical records in accordance with professional standards and state and federal law.

Review

2. Facilitates exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuance to 45 CFR parts 160 and 164, subparts A and E, to the extent applicable.

vii. The Alliance maintains processes to ensure no duplication of services occurs.

viii. Care coordination consists of healthcare professionals with appropriate experience and/or special education related to the targeted population.
   1. Health navigators serve as a resource both internally and throughout the provider network.
   2. Education on health promotion and preventative services is prepared for distribution to members and their providers on an ongoing basis.
   3. Disease management programs integrate the full range of services available from the plan within the community.

ix. Whenever possible, services are coordinated through both contracted and non-contracted providers in the service area to ensure continuity of care and integration of services with long-term supports and services and other community and social service programs.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness
CM Case Management
DHCS Department of Health Care Services
BPHM – Basic Population Health Management
CBAS – Community-Based Adult Services
DDS – Department of Developmental Services
HCBS – Home and Community Based Services
LOA – Letter of agreement
LTSS – Long-term services and supports
OON – Out of network
PCP – Primary care provider
SDOH – Social Determinants of Health
SSI – Supplemental Security Income
SUD – Substance Use Disorder
WIC – Women, Infants and Children (WIC)

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

Review

Analytics

RELATED POLICIES AND PROCEDURES

CM-D-106 Developmental Disabilities
CM-033 Home and Community Based Services (Waiver Programs)-DDS
CRE-009 Ongoing Monitoring of Practitioners
Provider Manual Sections 5, 6, 8 and 11
QI-111 Delegation Management and Oversight
UM-010 Coordination of Care - Long Term Care
BH-005 Care Coordination - Behavioral Health
UM-016 Transportation Guidelines
UM-023 Communicable Disease Reporting and Services
UM-024 Care Coordination – Dental Services
CM-044 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

Commented [LH11]: Are any of these changing for DSNP?

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

42 CFR Section 438.208
45 CFR Sections 160 and 164(a) and (e)

MONITORING

review

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

review

POLICY AND PROCEDURE

Policy Number	CM-~~—~~D-102~~001~~
Policy Name	DSNP Case Management Care Coordination Activities
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

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POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) prioritizes seamless and comprehensive care coordination to ensure that all members receive the services and follow-up care necessary to maintain or improve their health outcomes.

The care coordination process is designed to effectively manage referrals, schedule procedures or tests, and provide ongoing support for both members and their caregivers. The goal is to minimize barriers to care and ensure that members are well supported throughout their care journey.

PROCEDURE

1. Identification

collaboration

a. Care coordination activities begin when a member's care needs are identified through any of the following:
   i. Initial or ongoing health assessments (e.g., Health Risk Assessment (HRAs), care plan reviews)
   ii. Clinical evaluations by primary care providers (PCPs), specialists or other healthcare professionals
   iii. Interdisciplinary Care Team (ICT) meetings – members, caregivers, and healthcare professionals discuss the member's health status and unmet needs
   iv. Member or caregiver self-reports during outreach or the Face-to-Face meeting conducted in-person primarily at the member's home or virtually via tele-health capabilities.
b. Once a need for additional care or services is identified, it is documented in the member's individualized care plan and prioritized based on urgency and potential impact on the member's health and well-being.

2. Actions Taken
   a. The care team, led by the member's assigned care manager takes responsibility for managing all follow-up activities to ensure timely and appropriate care. This includes, but is not limited to:
      i. Referral Management
         1. Specialists – when a need for specialty care is identified, the case management team will:
            a. Identify in-network specialists and confirm availability.
               i. If an in-network specialist is not available, out-of-network specialists will be leveraged.
            b. Coordinate and communicate with member's primary care provider and specialist to ensure a smooth handoff of medical information.
            c. Facilitate the referral process, including submitting necessary documentation (e.g., referral forms, prior authorizations, medical records, etc.)
            d. Follow up with the member to confirm that the specialist appointment has been scheduled and ensure transportation, if needed.
         2. Community and Social Services – For non-clinical services (e.g., transportation, housing support, nutrition services), the case management team will:
            a. Identify appropriate community resources or service providers
            b. Make referrals to social services or community-based organizations as needed, including long-term support services.
               i. When necessary warm handoffs will be conducted to ensure alignment of care and services
            c. Ensure members and caregivers are connected to the resources and understand how to access them.

Collaboration

ii. Scheduling Procedures, Tests and Appointments
    1. Diagnostic Tests and Imaging: if required, the case management team will:
        a. Ensure that orders are submitted to the appropriate facility or laboratory.
        b. Contact the members to explain the importance of the tests and help them schedule the procedure.
        c. Confirm the member is aware of any preparation required for the test (e.g., fasting) and assists with any logistical needs (e.g., transportation, language services, etc.)
    2. Medical Procedures:, if required, the case management team will:
        a. Collaborate with the member and healthcare provider(s) to schedule the procedure.
        b. Provie pre-procedure education to the member and caregiver, ensuring they understand what to expect.
        c. Coordinate post-procedure follow-up care, such as home health services, medication management, or physical therapy, to ensure a smooth recovery process.
    3. Appointment scheduling: for all scheduled services, the case management team will:
        a. Confirm the date, time and location of the appointment with both the provider and member.
        b. Ensure the member has access to transportation services, if needed.
        c. Provider reminders to the member and caregiver about the appointment to prevent missed visits.

3. Communication and Documentation
    a. To facilitate effective care coordination, the following communication and documentation processes are followed:
        i. Communication with Members and Caregivers
            1. The care manager communicates directly with members and caregivers to provide clear instructions on the next steps for their care, including (but not limited to) appointment times, preparation instructions and transportation arrangements (if needed).
            2. The case management team maintains open lines of communication to answer questions and address concerns about any part of the follow-up process. Members are encouraged to reach out with any issues related to referrals, scheduling, or care delivery.
        ii. Communication with Providers
            1. Care managers work closely with all members of the Interdisciplinary Care Team (ICT), including physicians, specialists, pharmacists, and social workers to ensure that follow-up care is well-coordinated.

Collaboration

2. Information is shared across the team to avoid duplication of services and ensure that all providers are aware of the members' ongoing care needs. Information may be shared using multiple modalities including (but not limited to) emails, portals, facsimiles and phone calls.
3. The case management team will facilitate timely exchange of medical records, test results, and treatment updates between providers to support continuity of care.

b. Documentation in the Care Plan
   i. All care coordination activities, including referrals, scheduled procedures, and follow-up actions, are documented in the member's individualized care plan (ICP).
      1. This ensures that all members of the care team have access to up-to-date information on the members' care needs and actions taken.
   ii. The case management team tracks the completion of referrals, test, and procedures to ensure that services are provided in a timely manner.
      1. Any delays or barriers to care are documented and addressed promptly.

4. Monitoring and Follow-Up
   a. After services are provided or care is delivered, the case management team will:
      i. Follow up with the member and caregiver to ensure they have received the necessary care of services.
         1. This may involve confirming the outcome of a specialist visit, verifying that a test was performed, or checking on recovery after a procedure.
      ii. Evaluate the effectiveness of the care provided and adjust the care plan as needed.
         1. If further interventions are required, the case management team will initiate new referrals or schedule additional services.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-101 Case Management Care Coordination Expectations

Collaboration

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CMS Managed Care Manual
CalAIM D-SNP Policy Guide
Alameda Alliance Wellness Model of Care
NCQA Case Management Standards

MONITORING

The care coordination process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sought to improve the care coordination process and address any barriers to accessing services.

collaboration

POLICY AND PROCEDURE

Policy Number	CM—D-1043
Policy Name	Individualized Care Plan ~~Components~~ Process
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) Case Management team provides care management to all members in the dual eligible special needs plan. The case management team assists members to optimize their health potential.

An Individualized Care Plan (ICP) is developed for each member regardless of their level of engagement in the program. The ICP process and components, at a minimum, meet Federal and State regulatory requirements. The degree of the ICP's complexity varies depending on the member's risk level and identified goals, when applicable.

The care plan represents the framework for care management activities and focuses on care coordination activities and other interventions to achieve specific goals that are intended to resolve barriers, problems or other issues members may face.

Collaboration

PROCEDURE

1. Health Risk Assessment
    a. The information in the Health Risk Assessment (HRA) provides the foundation of the Individualized Care Plan (ICP).
    b. The case management team is responsible for:
        i. Developing the ICP and working with the member and/or the member's representative when available along with the Interdisciplinary Care Team (ICT) to develop an ICP.
        ii. Collaborating with community-based organizations and palliative care teams supporting members to develop an ICP that is comprehensive and specific to the members' unique and complex needs.
    c. The ICP is initiated by the completion of the HRA.
        i. If the member's Agent of Record (AOR) is unable to be reached or declines completion of the HRA, the ICP can be generated by using other data elements such as risk stratification, claims (medical, behavioral, and/or dental), or data collected through internal and community partner programs.
        ii. When there is no data available and the member contact was unsuccessful, the case management team sends the member a care plan around the following elements:
            1. Problems, goals and interventions focused on informing the members that the care management team has tried to reach them for the ICP discussion.
                a. Encouraging the members to contact the Alliance Case Management team to include them in their care plan development.
                b. Members are encouraged to contact their PCP and their assigned care manager at the Alliance to discuss healthcare, services and supply needs.

2. Communication
    a. The care management process and ICP includes communication and regular meetings with the Interdisciplinary Care Team (ICT).
        i. The ICT is made up of:
            1. The member
            2. The members' Agent of Record (AOR)
            3. The member's primary care provider
            4. Community partners and other disciplines involved in the member's care delivery including palliative care teams
3. Components
    a. The following components are included in the ICP process:
        i. Development and status of member-directed goals, including prioritized goals
        ii. Review of the HRA and the information collected through the HRA process

collaboration

iii. Review of the clinical assessment completed by the care manager
iv. Evaluation of the member risk stratification results
v. The member's personal health care preferences
vi. Description of the services specially tailored to the members' needs
vii. The role of the Interdisciplinary Care Team (ICT)
viii. The role of the member, member's AOR, or the member's caregiver
ix. Identification of barriers to meet the goals and complying with the plans
x. Development of schedules for follow-up and communication with members
xi. Development and communication of member self-management plans
xii. Assessment of progress against plans and goals, and modifications as needed

b. Additional components addressed in the ICP include:
   i. Medical
   ii. Social determinants of health (SDOH)
   iii. Psychosocial
   iv. Functional
   v. Cognitive needs
   vi. Mental and medical health history

c. Overall the ICP:
   i. Person-centered
   ii. Sensitive to disability, cultural, religious and linguistic preferences
   iii. Specific to the amount, frequency, duration of services and the type of provider rendering services
   iv. Includes strategies to address health and safety risks, offering members options to manage their risks and contingency plans for emergencies

4. Engagement
   a. Initial Process
      i. Three (3) outreach attempts to engage the member and/or the member's AOR
   b. Interdisciplinary Care Team
      i. Meetings are scheduled regularly with the member and other members of the care team
      ii. Invitation to the meeting and given appropriate notice of the time and date of the meeting occurance:
         1. The member
         2. The member's AOR
         3. Other members of the ICT

5. Individualized Care Plan (ICP)

Collaboration

a. The member and/or the member's representative is made aware that the ICP is separate and distinct from the medical and/or behavioral health plan of care developed and maintained by their primary care or specialty care provider.
b. Updates occur by the case management team when a change in the plan occurs
    i. This may occur after a meeting with the member and/or the member's AOR, any change in the member's health status, and after each ICT meeting
    ii. Documentation of the ICP is completed within the enterprise care management system.
        1. Case notes are used to document additional information discussed in meetings with the member and during ICT meetings.
        2. Care goals discussions are captured in the enterprise care management system.
c. Copies provided
    i. The Initial and updated ICP are sent to (as appropriate):
        1. The member
        2. PCP
        3. Specialist
        4. Community-based resources
        5. Palliative care teams
        6. Other members of the ICT
    ii. Sent by using multiple modalities, including, but not limited to, mail, secure email, portals, and facsimile.
d. The care plan is reviewed and updated by the case management team at least annually.

6. Data sources
    a. Multiple data sources are utilized in evaluating Individualized Care Plan (ICP) goals, interventions and outcomes. Sources include, but are not limited to:
        i. Medical, behavioral health, pharmacy, and dental claims
        ii. Emergency department and inpatient utilization
        iii. Member provided inputs, assessments, and other information
        iv. Documentation provided by community partners
        v. Case management assessments and documentation
        vi. Annual Health Risk Assessments (HRAs)
        vii. Risk stratification outcomes

    b. All available health data, including medical, prescription drug, and behavioral health claims, emergency department and inpatient utilization, member inputs, and community resources are used to assess ICP goals and objectives. Analysis occurs during ongoing ICT meetings and through interactions with providers and the case management team.

Collaboration

7. ICP Modifications
    a. If member directed goals are not met, the ICP is reassessed including goals and interventions.
        i. The member, the member's AOR, and the ICT are involved in adjusting the goals and providing an updated plan, including alternative interventions.
    b. Additional modifications can occur under the following circumstances:
        i. Lack of goal progress – the case management team will collaborate with the member or representatives to identify and address barriers, adjusting goals as necessary. This may include increasing the frequency of touch points with the member as needed.
        ii. Significant change in health status: based on internal data, proactive steps are taken to coordinate services and minimize unplanned transitions and health declines. Changes are recognized by an ICT participant may also prompt a care plan review.
        iii. Annual review – the ICP is evaluated and updated at least annually regardless of whether changes have occurred or not.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-103 Individualized Care Plan Components

CM-D-105 Individualized Care Plan Documentation, Maintenance, Updates and Notifications

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Collaboration

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Code of Federal Regulations, 422.101

MONITORING

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

collaboration

POLICY AND PROCEDURE

Policy Number	CM-D-~~006~~109
Policy Name	DSNP Internal Audit and Monitoring
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	~~MCALD~~-SNP~~/Medicare~~
Effective Date	~~01/04/2018~~TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

In connection with any of its product lines, Alameda Alliance for Health (The Alliance) Case Management Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state statutory, regulatory, contractual, and National Committee for Quality Assurance (NCQA) accreditation requirements. It is the responsibility of the entire management team to ensure ongoing auditing and monitoring is properly executed, documented, and evidenced.

The Alliance must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, to evaluate internal compliance with regulatory, contractual and accreditation requirements and the overall effectiveness of the compliance program.

The Alliance will establish a monitoring process to rapidly detect potential issues and establish and implement an effective system to identify compliance risks. This includes:

- Routine internal monitoring of compliance risk areas
- Routine internal monitoring
- ~~Periodic internal auditing to confirm results of monitoring~~

The Alliance will maintain processes to perform monitoring of key reporting requirements

and assist in identifying areas that may qualify for “self-reporting” due to over or under performance metrics.

collaboration

The Alliance Health Care Services Department ~~is responsible~~is responsible for the oversight of the monitoring and auditing efforts for ~~Utilization Management and~~ Case Management (CM). The Alliance's Compliance Committee ~~is responsible~~is responsible for the compliance activities of the organization and will receive reports regarding performance, updates to processes through the Utilization Management Committee to the Compliance Committee

PROCEDURE

1. ~~Health Care Services (HCS)~~Case Management staff will participate with Compliance in ~~the~~ annual and ad-hoc audits of Alliance ~~delegated~~ Providers delegated for Case Management (CM). ~~HCS~~ CM will audit and monitor the Providers' compliance with state and federal laws and regulations, The Alliance policies, procedures, contractual requirements, and NCQA accreditation requirements related to functions including but not limited to case management and utilization management.

2. Case Management leadership staff will develop and maintain a monitoring plan for the Case Management Department. The monitoring plan details monitoring reports, performance indicators, monitoring methods and monitoring frequency.

3. Monitoring reports will be identified based on internal, regulatory, contractual and accreditation standard requirements. At least annually, and as needed, reports will be identified along with the applicable performance metrics:
   3.1 Case Management Leadership will assess the various types of reports required for Case Management.

4. Case Management will identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations, and company policies. Examples of possible performance indicators include initiation of assessment, completion of assessment, completion of care plan, etc.

5. Monitoring methods are determined by the type of report and the performance indicators. Examples include risk assessments, data reviews, charts, graphics, spot checks, random sampling, staff interviews, etc.

6. Monitoring frequency is defined by regulation, contract or department policy but should be appropriate to the nature of the process and relative risk it represents. Examples:
   6.1 ~~Weekly~~ Monthly to ensure compliance is met for ~~Complex~~ Case Management assessment timeframes.
   6.2 Monthly ~~or quarterly~~ to determine compliance with Case Management ~~assessment~~ outreach completion with required timeframe.
   ~~6.2~~6.3 Monthly to determine compliance with quality of cases, including call monitoring and reviewing documentation in the system of record
   ~~6.3 Quarterly for Health Risk Assessment completion within the required timeframes.~~
   6.4 Annually for programmatic reporting.

Commented [AL1]: Broaden to include any assessment timeframe (including the HRAs)

Commented [HL2R1]: we monitor HRAs monthly even if TATs are longer than 30 days, so keep as is?

Commented [AL3]: Included in 6.1 because we need to monitor the HRA timeframes more frequently than quarterly

~~For Complex Case Management (CCM)~~

~~HCSFor Complex Case Management (CCM)~~

~~7. Staff will randomly select 5 complex CCM files per reviewer~~

~~7.1 If 5 files are unable to be selected, all CCM files are selected per reviewer~~

~~i. 100% of the files are reviewed using the NCQA worksheet or approved CCM file review tool~~

~~ii. CCM cases review for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the *CM-001- Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment* policy.~~

~~For Health Risk Assessment~~

~~8. Each month Case Management Leadership will randomly select up to 2 HRA files per staff person..~~

~~i. 100% of the files are reviewed using directions identified in the most recent All Plan Letter (APLs) for HRAs for SPD beneficiaries. File review will be completed using an approved HRA assessment Tool.~~

~~ii. HRA files are reviewed for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the APL and CM-008, Policy and Procedure, *SPD HRA – Survey and Interventions* policy. If member is noted as High Risk, the file should contain the assessment by a clinician, individualized care plan, care team discussions and communication with the PCP.~~

Staff Productivity Monitoring and Quality Auditing by CM Staff

Goals and scores are established in standard operating procedure (SOP) *CM – Productivity and Quality Monitoring SOP*.

7. CM Coordinator
   - 7.1 Productivity – CM Non-Clinical Supervisor to monitor volume of inbound calls answered by CM Coordinator each month ensuring meeting monthly baseline volume goal met.
   - 7.2 Quality – Audit three (3) phone call recordings per staff per month for appropriate charting and call handling ensuring passing quality score.

8. HRA Coordinator
   - 8.1 Productivity – CM Non-Clinical Supervisor to monitor volume of Health Risk Assessments (HRA) and HIF/METs processed by HRA Coordinator each month ensuring monthly baseline volume goal met.
   - 8.2 Quality – Audit two (2) HRA cases/programs and two (2) HIF/MET cases/rpgorams per staff per month for appropriate processing of HRA and HIF/MET ensuring passing quality score.

9. Case Management Lead
   - 9.1 Productivity – CM Supervisor to monitor volume of referrals processed

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Commented [AL4]: Will need to reference oversight/monitoring activities for the HRA vendor, when available

Commented [MT5R4]: @Vallejo, Yani this one is not ready for leadership review until information is added.

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Collaboration

(referred out) by CM Lead, ensuring monthly baseline volume goal met.

9.2 Quality – Audit daily assignment completed and send out to department timely by CM Lead each month, ensuring passing monthly score.

10. Health Navigator

10.1 Productivity – CM Non-Clinical Supervisor to monitor volume of phone calls and notes for CM case/program types including but not limited to care coordination and transitional care services. CM Non-Clinical Supervisor ensures monthly baseline phone calls and case note goal met.

10.2 Quality – Audit three (3) care coordination cases/programs and three (3) transitional care services cases/programs per staff per month for appropriate processing of case/program ensuring passing monthly score.

11. Medical Social Worker

11.1 Productivity – CM Supervisor to monitor volume of phone calls and notes for CM case/program types including but not limited to care coordination cases/programs. CM Supervisor ensures monthly baseline phone call and case note goal met.

11.2 Quality – Audit three (3) care coordination cases/programs per staff per month for appropriate processing of case/program, ensuring passing monthly score.

12. Registered Nurse

12.1 Productivity – CM Supervisor to monitor volume of phone calls and notes for CM case/program types including but not limited to care coordination, transitional care services, and complex. CM Supervisor ensures monthly baseline phone call and case note goal met.

12.2 Quality – Audit three (3) care coordination cases/programs, three (3) transitional care services cases/programs per staff per month for appropriate processing of case/program ensuring passing monthly score. Audit all Complex Case Management (CCM) cases open over 30 days for charting and up to three (3) CCM cases per staff per month for phone call quality

Follow up and corrective actions

13. Any monitoring result indicative of a potential issue, problem or noncompliance must be adequately and timely addressed.

~~9.~~13.1 All monitoring is discussed routinely with staff individually.

~~10.~~14. Case Management Leadership Staff is responsible for identifying issues/problems found in the monitoring activities and reporting it to the Director, Social Determinants of Health for recommendations/corrective actions.

~~11.~~15. Non-compliance monitoring results may be reported to the Sr. Director, Health Care Services. Based on the scope and severity of the issues, the Sr. Director, Health Care Services may notify the Compliance Officer for recommendations of the next appropriate steps.

a. Non-compliance monitoring results may trigger a targeted or focused audit

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b. When there are severe monitoring results (repeat deficiencies or Immediate Corrective Action required), the Compliance Officer and Sr. Director, Health Care Services will follow action recommendations as defined in Compliance policies.

~~12.~~ Monthly reports of the monitoring activities will be reported to the ~~Dr~~Sr. Director, Healthh~~h~~

collaboration

16. Care Services and governing committees, including Utilization Management Committee.

~~13.~~17. Repeat deficiencies or Immediate Corrective Actions Required are identified which impact member safety and are reported expeditiously to the Chief Medical Officer for recommendations.

DEFINITIONS / ACRONYMS

Auditing: Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures.

CCM: Complex Case Management

CM: Case Management

HIF/MET: Health Information Form/Member Evaluation Tool

HRA: Health Risk Assessment

Internal Audits: Internal Audits are audits of the Alliance or delegates conducted by an employee or by an affiliate of the Alliance.

Monitoring Activities: A process of regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Oversight: Oversight means monitoring and directing a set of activities, resulting in a desired outcome.

SOP: Standard Operating Procedure

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

Case Management

Compliance Department

RELATED POLICIES AND PROCEDURES

CM-D-~~001~~101 –DSNP ~~Complex Case Management (CCM) Identification, Screening, Enrollment and Assessmen~~Case Management Care Coordination Expectations

CM-D-102 – DSNP Case Management Care Coordination Activities~~t~~

CM-D-~~008~~108, DSNP HRA Policy and Procedure~~, SPD HRA – Survey and Interventions~~

CMP-019 Delegation Oversight

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Commented [AL6]: Add reference to the compliance P&P related to Delegation Oversight

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Commented [HL7]: Is Compliance creating separate P&Ps for DSNP, if so. . . this will need to be changed/updated

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REVISION HISTORY

~~01/04/2018, 04/16/2019, 05/21/2020, 3/22/2022, 6/20/2023, 6/12/2024~~

REFERENCES

- CMS Managed Care Manual
- CalAIM D-SNP Policy Guide
- Alameda Alliance Wellness Model of Care
- NCQA Case Management Standards

~~APL 17-001~~
~~DHCS Two Plan Model Contract~~

MONITORING~~NG~~

~~Monthly monitoring report for UM authorizations and processing turn-around-time. Mo~~Monthly monitoring HRA

Monthly monitoring ~~Complex Case Management~~of all case management case/program types

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POLICY AND PROCEDURE

Policy Number	CM-D-~~032~~110
Policy Name	Care Coordination – Local Education Agency Services
Department Name	Case and Disease Management Department
Department Chief	Chief Medical Officer
Department Owner	Director, Social Determinants of Health
Lines of Business	~~Medi-Cal~~D-SNP
Effective Date	~~12/4/2007~~TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Services provided by Local Education Agencies (LEA) are not covered benefits under Medi-Cal Managed Care but are covered under Medi-Cal Fee-For-Service. LEA services are reimbursable by Medi-Cal Fee-For-Service for Alliance Medi-Cal Members pursuant to Title 22, CCR, §51535.5.

LEA services are provided to Members who meet LEA Program eligibility and are specified in Title 22, CCR, §51360 (b):

- Health and mental health evaluation.
- Physical therapy (PT), which consists of PT services as set forth in Title 22, CCR, §51309 (b), when provided by an LEA practitioner for an LEA eligible Member.
- Occupational therapy (OT), which consists of OT services as set forth in Title 22, CCR, §51309 (c), when provided by an LEA practitioner for an LEA eligible Member.
- Speech pathology or therapy (ST) and audiology services, which consist of ST services as defined by Title 22, CCR, §51096, and audiology services as defined by §51098 when provided by an LEA practitioner for an LEA eligible Member.
- Psychology and counseling services, consisting of diagnosis and psychological counseling of LEA eligible Members with identified mental health, substance abuse, behavioral adjustment, or social problems.
- Nursing services, consisting of preventative and medically necessary nursing services rendered at the school site.

Commented [AL1]: @Thomsen, Michelle @Hunter, Lily - do we foresee coordination with the School Districts for D-SNP members?

Commented [MT2R1]: We will need to have the benefit available because it is up to 22 years of age. It is more of establishing a relationship and coordinating with the district because this is billed under Medicare FFS and not within our MediCal network.

Commented [CD3]: Can you lease clarify the request? Are you asking if PS would be responsible for providing education of these services to LEAs or advising PCPs of responsibilities by guiding them to the provider manual?

Commented [TM4R3]: It just needs to be in the provider guide. It should be there today for Medi-Cal because this is an existing policy for Medi-Cal

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- School health aide services, consisting of the direct provision of specialized physical health care services rendered at the school site.
- Medical transportation, which consists of medical transportation as described in §51323.

LEA services are administered by local school districts and are provided to Alameda Alliance Wellness (D-SNP) and Medi-Cal Members who are under 22 years of age, enrolled in a school within an LEA in California, and who meet LEA Program eligibility.

PCPs are required to assist LEAs with the development of Individual Education Plans (IEP) for children 3 years of age and older or Individual Family Service Plans (IFSP) for children 0-3 years old, if needed.

Alliance ~~Medi-Cal~~ Members receiving LEA services remain enrolled in the Alliance and the Alliance and PCPs remain responsible for all other medically necessary covered health care.

PROCEDURE

A. Provider Services Department will educate PCPs of their responsibilities related to LEA services through the Provider Manual and other periodic communication as needed:

1. Identification of Members Potentially Eligible for LEA Services
   a. LEA services are provided primarily to those Members with an identified developmental disability which affects school performance.
   b. A Member's need for LEA services are determined primarily by the Member's PCP. The need for LEA services may also be identified by the Member, the Member's parent or other family members, or through a Member's encounter with a health care practitioner.
   c. If a PCP, specialist, or Member identifies the need for LEA services, the local school district must be contacted directly.
   d. Many school districts recommend that the referring practitioner provide medical records or a letter documenting the identified developmental disability and recommendations for treatment.
   e. The Member's local school district determines whether the Member is eligible for LEA services based on the Member's medical condition, with input from the PCP or referring practitioner.
2. Care Coordination Services
   a. Continuing all medically necessary health care other than the LEA services.
   b. Cooperating and collaborating with LEAs in the development of the IEP or IFSP, if needed.
   c. Ensuring the provision of covered medically necessary diagnostic, preventative and treatment services identified in the ICP or IFSP, with Alliance participation as needed.

B. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

Commented [TM5]: @Barrera, Soledad please verify this is included in the DNSP Provider Manual? @Vallejo, Yani

Commented [SB6R5]: @Gomez, Cecilia @Crowder, Darryl deferring to you for confirmation of the education of PCPs related to LEA svcs.

Commented [SB7R5]: @Gomez, Cecilia bringing this back up to the top of your mailbox. Please advise if this area is included in the Provider Manual?

Commented [VY8R5]: @Barrera, Soledad can you raise at one of your upcoming meetings?

Commented [SB9R5]: @Thomsen, Michelle In speaking with Ceci, HCS has received a copy of provider manual to review and make any edits needed for all LOB including DSNP. This is an activity in flight and all business areas have until 6/30 to provide their updates. @Vallejo, Yani @Gomez, Cecilia

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DEFINITIONS

Local Education Agency (LEA) is the governing body of any school district or community college district, the county office of education, a state special school, A CSU campus, or a UC campus. To participate as an LEA provider, the LEA must apply to the Medi-Cal program. LEAs employ or contract with qualified medical practitioners to provide health assessments and medical services, within their scope of practice, to Medi-Cal eligible children and, where appropriate, to their family members.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

1. DHCS Contract Exhibit A, Attachment 11
2. Title 22, CCR, Sections 51190.1, 51360 (b), and 51535.5
3. Education Code, Section 56340 et seq.
4. Government Code, Section 95020
5. CMS Managed Care Manual
6. CalAIM D-SNP Policy Guide
7. Alameda Alliance Wellness Model of Care
8. NCQA Case Management Standards
5. ~~DHCS MMCD Policy Letter 00-06~~

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

~~12/4/2007, 1/1/2008, 10/28/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 6/12/2024~~

REFERENCES

None

MONITORING

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee, and Administrative Oversight Committee annually.

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POLICY AND PROCEDURE

Policy Number	CM-D-111
Policy Name	Case Management (CM) Staff Roles and Responsibilities
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (The Alliance) is committed to delivering high-quality, person-centered care to D-SNP members through an organized structure that is well equipped to support its Case Management (CM) program. This policy aims to define the roles and responsibilities of case managers, including clinical and administrative staff, and outlines oversight, license and competency verification, and special training requirements to ensure compliance with the regulatory requirements of CMS, DHCS, and accrediting bodies.

PROCEDURE

1. Clinical Case Managers
   - 1.1. Registered Nuse (RN) Case Manager:
     - 1.1.1. Conduct health risk assessments (HRAs) to evaluate medical, functional, and behavioral health needs annually or upon changes.
     - 1.1.2. Develop, implement, and revise interdisciplinary care plans (ICPs).
     - 1.1.3. Facilitate interdisciplinary care team (ICT) meetings and clinical consultations.
     - 1.1.4. Perform clinical assessments, coordinate transitions of care, and monitor treatment adherence.
     - 1.1.5. Coordinates medical and behavioral health services, ensuring timely access to providers.

Collaboration

1.1.6. Monitors member health status and escalates complex cases to the ICT or physician consultant.
1.1.7. Communicate with members, families, providers, and behavioral health.
1.1.8. Documents all interventions and contacts in the care management system for compliance and audit purposes.
~~1.1.9.~~

2. Administrative Case Management Support
2.1. Health Navigator (Non-Clinical):
2.1.1. Facilitates communication between members, ICT, and providers to support care plan implementation.
2.1.2. Schedules assessments and ICT meetings.
2.1.3. Schedules appointments.
2.1.4. Manage inbound and outbound calls.
2.1.5. Track HRA and ICP completion deadlines, notifying clinical case managers of pending tasks.
2.1.6. Maintain records and submit required reports.
2.1.7. Assist with facilitating authorizations, transportation, and coordination of ~~non-clinical~~ services.
2.1.8. Assists with member education on Medicare and Medi-Cal~~caid~~ Benefits.
2.1.9. Documents non-clinical interactions in the case management system, ensuring audit readiness.
~~2.1.9.~~

3. Administrative Staff Roles Supporting Case Managers
3.1. Case Management ~~Director~~Manager
3.1.1. Oversees case managers, ensuring adherence to regulatory requirements.
3.1.2. Develops CM policies and training programs.
3.1.3. Monitors case manager performance and repots outcomes to CMS, DHCS, and leadership.
3.1.4. Ensures case manager activities comply with regulatory requirements.
3.1.5. Reviews CMS and DHCS guidance to update CM roles and responsibilities.
3.1.6. Maintains audit-ready documentation in the case management system

3.2. Case Management ~~Manager~~Supervisor
3.2.1 Provides daily oversight over the comprehensive case management program
3.2.2 Supervision and management of department staff, development of the operational plan, allocation and management of programs resources and accountability for the quality of care and service

~~3.3 Case Management Supervisor~~
3.3.1Supervision of department clinical staff and allocation and management of program resources
~~3.1.3.~~

~~3.2. Compliance Officer~~
~~Oversees all performance within the operations areas of the organization~~
~~3.2.1. Ensures case manager activities comply with regulatory requirements.~~
~~3.2.2. Reviews CMS and DHCS guidance to update CM roles and responsibilities.~~
~~3.2.3. Maintains audit-ready documentation in the case management system.~~

~~3.3. Appeals and Grievance Specialits~~Specialist
~~3.3.1. Supports case managers by addressing member appeals and grievances.~~

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Commented [AL1]: @Williams, Mollie @Hunter, Lily - include managers and supervisors?

Commented [MT2R1]: Added. @Vallejo, Yani

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Commented [AL3]: @Williams, Mollie – need to verify this with Compliance Director (Stephen Smythe), because our CM team typically does this oversight

Commented [MT4R3]: Removed from Compliance officer and added to CM Director. @Lam, Allison @Vallejo, Yani

Collaboration

~~3.3.2. Collaborates with case managers to resolve care-related complaints.~~

~~3.3.3. Documents outcomes in the case management system~~Quality Suite ~~for quality improvement.~~

~~4. Specific Department Roles Supporting Case Managers~~

~~4.1. Quality Improvement Department~~

~~4.1.1. Analyzes~~ ~~Oversees case manager performance metrics (e.g., timeliness of HRAs, member satisfaction).~~

~~4.1.2. Provides feedback to improve case manger~~manager ~~effectiveness.~~

~~4.2. IT Department~~

~~4.2.1. Maintains case management system functionality for case manager documentation.~~

~~4.2.2. Offers technical support for case managers using digital tools.~~

~~4.3. Curriculum Designer/Medicare Training~~ ~~Training and Development Department~~

~~4.3.1. Collaborates with the Case Management department to develop training content.~~ ~~Delivers D-SNP specific training for case managers.~~

~~4.3.2. Tracks Training completion and certifications.~~

~~4.4. Utilization Department~~

~~4.4.1. Collaborate on service approvals, denials, and transitions.~~

~~4.5. Behavioral Health Department~~

~~4.5.1. Engage in care planning for members with mental health/SUD needs.~~

~~4.6. Member Services Department~~

~~4.6.1. Support scheduling and member inquiries.~~

~~5.~~4. Oversight Responsibilities

~~5.1.~~4.1. Clinical supervisors review caseloads ~~weekly~~regularly and monitor quality metrics.

~~5.2.~~4.2. Monthly chart audits are conducted for compliance with CMS/DHCS requirements (e.g., HRA completion and ICPs)

~~5.3.~~4.3. Staff performance is reviewed monthly and more often as needed~~semi-annually~~ through evaluations.

~~5.4.~~4.4. Supervisors facilitate ICT participation by case managers to ensure effective care coordination.

~~5.5.~~4.5. Escalation protocols involve the Case Management Director for unresolved issues.

~~5.6.~~4.6. Non-Compliance triggers ~~corrective action plans, documented in the case management system.~~ additional coaching, training, and potential disciplinary action per the company's HR policy

~~6. Special Training and Ongoing Education~~

~~6.1. Mandatory Training Topics~~

~~6.1.1. CMS Model of Care requirements for case manager roles.~~

~~6.1.2. Medicare and Medi-Cal coordination training~~

~~6.1.3. D-SNP regulations, including member rights and appeals processes.~~

~~6.1.4. Cultural competency for D-SNP populations (e.g., language, ethnicity).~~

~~6.1.5. Person-centered care and shared decision-making.~~

~~6.1.6. Case management system usage for documentation.~~

~~6.2. Training Delivery~~

~~6.2.1. Annual training includes workshops, webinars, and e-learning modules.~~

DEFINITIONS

Commented [AL5]: @Williams, Mollie - verify preferred language with G&A team (Alma Pena), because G&A doesn't document in our care management system today

Commented [MT6R5]: Updated to quality suite @Vallejo, Yani @Lam, Allison

Commented [AL7]: @Williams, Mollie - The QI department doesn't directly analzye CM performance metrics (our CM department does that internally), but we do report out to the QIHEC. Perhaps the correct verbiage is "oversees"? @Hunter, Lily , your thoughts?

Commented [MT8R7]: Updated to oversees @Vallejo, Yani

Formatted: Indent: Left: 0.85", No bullets or numbering

Commented [AL9]: @Williams, Mollie @Thomsen, Michelle - can we confirm with Tome whether this is still true? My understanding is that we'll work with Indy to develop content in a "train the trainer" fashion, and our own CM team will be responsible for delivering the training?

Commented [MT10R9]: Updated please review @Lam, Allison @Vallejo, Yani

Commented [AL11]: @Williams, Mollie is this referring to our annual organization-wide performance evaluation, or specific to the CM department?

If specific to the CM department, we evaluate staff performance monthly, and more often, as needed.

Commented [MT12R11]: Updated @Lam, Allison @Vallejo, Yani

Commented [AL13]: @Williams, Mollie Corrective action is not documented in the case management system. Would recommend a more general statement: "non-compliance triggers additional coaching, training, and potential disciplinary action per the company's HR policy" - @Hunter, Lily , your thoughts?

Commented [MT14R13]: Updated @Lam, Allison @Vallejo, Yani

Commented [MW15]: Part of the orientation you already have in place- just need to make sure there is a specific piece/time devoted to D-SNP

Commented [AL16R15]: @Hunter, Lily - please confirm current orientation/onboarding process for our new CMs are aligned with this.

Commented [AL17R15]: @Hunter, Lily

Collaboration

- Case Management: A collaborative process to assess, plan, coordinate, and monitor services for D-SNP beneficiaries.
- Case Manager: A licensed or certified professional responsible for assessing, planning, coordinating, and monitoring care for D-SNP members.
- Administrative Staff: Non-clinical staff supporting CM operations (e.g., scheduling, documentation, outreach, and reporting for case management operations).
- Interdisciplinary Care Team (ICT): responsible for developing and executing the Individualized Care Plan (ICP).

AFFECTED DEPARTMENTS/PARTIES

- Case Management
- Clinical Services
- Human Resources
- Compliance
- Quality Improvement

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

REFERENCES

CMS Model of Care Guidelines
CalAIM Dual Eligible Special Needs Plan Policy Guide
CM-D-006, DSNP Internal Audit and Monitoring Policy and Procedure
HR 0-17, License Verification and Reverification Policy

MONITORING

- To ensure compliance with CMS, DHCS, and accrediting bodies, Case Management Leadership will audit charts according to CM-D-006 DSNP Internal Audit and Monitoring Policy and Procedure. Non-compliance is addressed through Corrective Action Plans (CAPs) and follow up.
- Case Manager tasks and member satisfaction scores are reviewed monthly and reported to CMS.
- This policy is reviewed annually by the Compliance and Case and Disease Management Departments for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.

collaboration

POLICY AND PROCEDURE

Policy Number	CM-D-112
Policy Name	DSNP Care Transitions Protocols
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) ensures seamless coordination and delivery of care during transitions between healthcare settings by facilitating communication across providers, services and care settings.

These efforts are focused on meeting the needs of our most vulnerable members, including older adults, individuals with disabilities, and other at-risk groups who are susceptible to fragmented care. Our care transitions protocols are designed to provide continuous support before, during and after transitions, whether care is received from in-network or out-of-network providers.

PROCEDURE

1. Planned and Unplanned Transitions

Preview

a. The Alliance supports both planned and unplanned transitions, such as elective procedures or scheduled discharges, and unplanned transitions, such as emergency hospitalizations.
    i. Planned Transitions
        1. The care coordination team works closely with the facility staff, including discharge planners, to ensure that all necessary resources and support are in place prior to the transitions
    ii. Unplanned Transitions
        1. A designated nurse or care manager monitors the member's care throughout their stay, collaborating with facility staff to facilitate a safe and timely transition to the appropriate care setting, such as a skilled nursing facility (SNF) or back home.

2. Care Coordination Team
    a. The Alliance ensures that care coordination efforts extend beyond high-risk populations, encompassing all members experiencing a care transition and is not limited to only members involved in a care management program.
    b. The process involves a multidisciplinary team, including care managers, social workers, and community support specialists, who work collaboratively to manage care transitions.
    c. Coordination occurs across all care settings and integrates input from both medical and community-based providers to ensure comprehensive support.
    d. Follow up care is provided for all transitions to prevent readmissions and address any ongoing challenges post-discharge.
3. Timely and Proactive Response
    a. The Alliance is committed to promptly responding to authorization requests and coordinating necessary services to ensure a smooth transition for members and between discharging and receiving facilities
4. Member and Provider Communication
    a. Timely communication with members and their representatives is a key component of our transition protocols. (For example: 3 outreach attempts within 30 days)
    b. Members and caregivers are educated about the care transition process and the team ensures that they understand how to access post-discharge services, fill prescriptions and recognize early warning signs of health deterioration.
    c. PCPs will be notified of admissions and discharges to facilitate ongoing care coordination to include appropriate and timely follow-up appointments.
        i. The goal of appropriate and timely notification of providers is to make sure the Alliance meets the goals of the HEDIS TRC Notice of Inpatient Admission and Receipt of Discharge Information Stars measures.
5. Monitoring and Evaluation

Preview

a. The Alliance collects and monitors data related to care transitions, including readmission rates, member engagement, and the timeliness of follow-up care.

6. Community Integration and Support Services
    a. The care transitions protocols include coordination with community resources.
    b. This ensures members have access to necessary support such as durable medical equipment, home modifications, and caregiver assistance, enabling successful transitions back into their community settings.
7. Information sharing
    a. The Alliance complies with California State Medicaid Agency Contract requirements for information sharing
        i. Processes have been implemented to support data utilization throughout its many programs and initiatives including, but not limited to, care transitions, care coordination, care management and quality improvement.
        ii. The Alliance has or is in the process of implementing data sharing agreements with acute care hospitals, physician organizations, skilled nursing facilities and laboratories.
    b. The Alliance complies with all existing federal and state privacy regulations, ensuring the protection of individual health information.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-113 DSNP Care Transitions Personnel

CM-D-114 DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process

CM-D-115 DSNP Planned Care Transitions Process – Member Personal Health Information

CM-D-116 DSNP Planned Care Transitions Process – Member Self-Management Activities

CM-D-117 DSNP Planned Care Transitions Process – Notification and Point of Contact

review

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Code of Federal Regulations, 422.101

MONITORING

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sought to improve the care transition process and address any barriers to accessing services.

review

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-D-113
Policy Name	DSNP Care Transitions Personnel
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

review

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) supports members as they navigate through various healthcare settings. The team collaborates with providers, specialists, and community resources across all healthcare settings to ensure a safe transition for every member.

PROCEDURE

1. Notification
    a. Upon notification of an emergency department visit, inpatient admission, or any other transition between healthcare settings, the case management team begins engagement with the member, if possible, during their emergency department visit or hospital

admission within an appropriate timeframe after the emergency department visit, hospitalization, or care transition if applicable.

b. The discharge plan is reviewed, and special attention is paid to any medication changes, so that care managers can make corresponding updates to the Individualized Care Plan (ICP) as well as manage all referrals and coordination needs.
c. The case management team assists members in scheduling timely post-discharge follow-up appointments with the PCP or specialists as appropriate.
    i. This includes arranging transportation for medical appointments, planning appropriate care and post-discharge needs,
    ii. The care manager confirms the member's PCP completes medication reconciliation during the post-discharge visit, and shares available discharge planning documentation with the PCP, as needed.
        1. If there is no documentation of PCP completing post-discharge medication reconciliation, care manager reviews member's discharge medication list compared with their current list of medications and identifies any discrepancies, duplications or missing medications.
        2. Outcome of care manager's medication review is documented in the member's record and sent to PCP, requesting PCP to engage member to complete a full medication reconciliation.
        3. Care manager continues follow-up with PCP to ensure medication reconciliation was complete.
    iii. The care manager remains highly engaged and contacts the member before, during and after a transition of care, including:
        1. Making updates to the Interdisciplinary Care Team (ICT) of the transition
            a. This team assists with the coordination and delivery of services
        2. Additional case conferences are scheduled to discuss:
            a. any further supportive measures needed
            b. changes to the Individualized Care Plan (ICP)
            c. actions and interventions to prevent future emergency department visits or inpatient admissions.
        3. Ongoing communication with facilities, providers, specialists, and community support providers to monitor the members' needs and services that are provided to them

2. Roles and Responsibilities of Care Transition Personnel
    a. Care Manager
        i. Primarily responsible for managing the care transition process
        ii. Responsibilities include:
            1. Comprehensive assessment: conducting pre-discharge survey to identify care needs and creating a detailed transition plan

Review

2. Coordinated care planning: working closely with healthcare providers, facilities, and family members to ensure a seamless transition based on the members' needs
3. Follow-up services: ensuring that follow-up appointments and services are scheduled and monitoring their completion

b. Utilization Management (UM) Nurse
   i. Plays a critical role in authorizing care and managing transitions
   ii. Responsibilities include:
      1. Authorization management: processing and reviewing requests for services, ensuring that care transitions align with medical necessity criteria
      2. Care coordination: Identifying members who may need additional support and referring them to appropriate case management or care coordination services.

c. Health Navigator
   i. Support staff assist with the administrative aspects of the transition process.
   ii. Responsibilities include:
      1. Information management: gathering and documenting important details, such as discharge information, follow-up appointments, and other care-related data.
      2. Post-transition follow-up: reaching out to members to confirm that they understand their follow-up care plan and that all necessary steps have been taken.

3. Transition Process Workflow
   a. Pre-Transition planning:
      i. The care manager conducts a comprehensive assessment to develop a personalized transition plan that meets the member's needs
   b. Collaboration and engagement:
      i. The care manager works closely with the members, caregivers, and providers to align the transition plan with the member's health and social needs.
   c. Follow-up and monitoring:
      i. The care manager tracks the completion of scheduled follow-up services and monitors the member's status after discharge, adjusting care plans as needed.
   d. Documentation and reporting:
      i. All activities related to care transitions are documented in the member's record within the enterprise care management system, with regular reviews to ensure the process adheres to established guidelines.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
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RELATED POLICIES AND PROCEDURES

CM-D-112 DSNP Care Transitions Protocols

CM-D-114 DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process

CM-D-115 DSNP Planned Care Transitions Process – Member Personal Health Information

CM-D-116 DSNP Planned Care Transitions Process – Member Self-Management Activities

CM-D-117 DSNP Planned Care Transitions Process – Notification and Point of Contact

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Code of Federal Regulations, 422.101

MONITORING

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sought to improve the care transition process and address any barriers to accessing services.

review

POLICY AND PROCEDURE

Policy Number	CM-D-114
Policy Name	DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) supports members as they navigate through various healthcare settings. The team collaborates with providers, specialists, and community resources across all healthcare settings to ensure a safe transition for every member.

PROCEDURE

1. Roles and Responsibilities
    a. Inpatient review nurse and care manager:
        i. Are responsible for managing the Individualized Care Plan (ICP) transfer and transition process.

review

ii. Key responsibilities include:
    1. Before the transition:
        a. The Inpatient Review Nurse collaborates with the discharging facility to gather the member's discharge plan.
        b. The care manager reviews the member's Individualized Care Plan (ICP) and ensures that all necessary elements are updated and ready for transfer to the next setting.
    2. During the transition:
        a. The Individualized Care Plan (ICP) is securely transferred by the care manager to the receiving provider along with any relevant updates, such as physician transfer orders, medication lists, and treatment plans.
        b. The care manager ensures that any pertinent details are communicated clearly to the receiving team.
    3. After the transition:
        a. Follow-up communication with the member, their caregiver, and the receiving provider is conducted to confirm that the Individualized Care Plan (ICP) has been received and implemented.
        b. Any necessary adjustments to the care plan are made based on feedback and the member's evolving needs.

b. Utilization Management (UM) Nurse:
    i. Supports the process by ensuring that any required authorizations are in place and the transition is coordinated smoothly.
    ii. The role includes:
        1. Before the transition: collaborating with the appropriate individuals (internal and external care managers as appropriate) to confirm that all service authorizations for the new care setting are completed.
        2. During the transition: communicating with the receiving facility to ensure that the member's care needs, as outlined in the Individualized Care Plan (ICP) are understood, and planned for.
        3. After the transition: monitor for member's care to assess if additional services or adjustments to the Individualized Care Plan (ICP) are necessary.

c. Care Management Support Staff:
    i. Health navigators facilitate the administrative aspects of the transition.
    ii. They are responsible for:
        1. Before the transition:
            a. Organizing and preparing documentation, including discharge notes, checklists, and updated care plans, for secure transfer to the receiving facility
        2. During the transition:
            a. Ensuring that all documentation is securely transferred and confirming receipt by the receiving provider

review

3. After the transition:
    a. Updating member records and verifying that all communication channels remain open between care providers, the member, and caregivers.

2. Transition Process Workflow
    a. Before the transition:
        i. The care manager and Inpatient Review Nurse review the member's Individualized Care Plan (ICP) and update it with any relevant changes needed for the new care setting.
            1. This includes essential elements such as care goals, medications, and treatment plans
        ii. The UM Nurse ensures all necessary service authorizations are in place.
            1. Support staff prepare all documentation and coordinate logistics for the transfer.
    b. During the transition:
        i. The Individualized Care Plan (ICP) is securely transferred to the receiving facility, and communication is maintained to confirm the care plan is understood and accepted by the new care team.
        ii. The health navigator and care manager are in direct contact with both the member and the receiving provider to manage any immediate concerns or needs
    c. After the transition:
        i. Follow-up assessments are conducted with the member and/or caregiver to evaluate if the transition was successful and if the Individualized Care Plan (ICP) requires further adjustments.
            1. This may involve reviewing access to necessary services such as home health, DME, medications, and follow-up visits
        ii. The Individualized Care Plan (ICP) is updated as needed, and the care manager continues to monitor the member's status.
        iii. Regular communication is maintained with the Interdisciplinary Care Team (ICT) to ensure ongoing alignment with the member's care needs.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

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RELATED POLICIES AND PROCEDURES

CM-D-112 DSNP Care Transitions Protocols

CM-D-113 DSNP Care Transitions Personnel

CM-D-115 DSNP Planned Care Transitions Process – Member Personal Health Information

CM-D-116 DSNP Planned Care Transitions Process – Member Self Management Activities

CM-D-117 DSNP Planned Care Transitions Process – Notification and Point of Contact

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Code of Federal Regulations, 422.101

MONITORING

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sought to improve the care transition process and address any barriers to accessing services.

review

POLICY AND PROCEDURE

Policy Number	CM-D-115
Policy Name	DSNP Planned Care Transitions Process – Member Personal Health Information
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) supports members as they navigate through various healthcare settings. The team collaborates with providers, specialists, and community resources across all healthcare settings to ensure a safe transition for every member.

PROCEDURE

1. Identification
    a. Each Inpatient Review Nurse is responsible for identifying planned transitions by consistently reviewing and tracking elective admissions at their assigned facilities.
    b. This is achieved through:

review

i. Daily Hospital/SNF Census reports: keeping up to date with daily reports on patient admissions at hospitals and skilled nursing facilities (SNFs)
ii. Daily Admission Face Sheets: reviewing face sheets provided by hospitals and SNFs that summarize patient admissions.
iii. Approved Elective Inpatient Prior Authorization requests: Monitoring requests for elective inpatient admissions that have been approved

2. Communication
    a. Once identified, the Inpatient Review Nurse ensures that:
        i. The assigned care manager is informed:
            1. This allows the care manager to collaborate with the member and/or their caregiver/Agent of Record (AOR) to update the goals of care as needed
                a. The care manager makes updates to the Individualized Care Plan (ICP) as needed and these are shared with both the member and their Primary Care Provider (PCP)
                    i. Updates are shared at the Interdisciplinary Care Team (ICT) meetings and copies of the Individualized Care Plan (ICP) are shared with other members of the Interdisciplinary Care Team (ICT) as appropriate.
            2. The care manager coordinates with the discharging facility to ensure that all necessary documentation such as discharge instructions and a discharge summary is provided to the receiving setting within one (1) business day of the member's discharge.
            3. Timely notification of the member's PCP is attempted to meet the corresponding HEDIS metric:
                a. The health navigator is responsible for notifying the member's PCP about the member's admission on the day of admission if possible, and no later than 2 days following admission.
                b. The health navigator is responsible for notifying the member's PCP about the member's discharge on the day of discharge if possible, and no later than 2 days following discharge.
                c. The health navigator also ensures that all necessary communication and care transition details are documented in the enterprise care management system.

3. Post-Discharge
    a. The care manager conducts a post discharge assessment and additional follow-up contact with the member and caregiver/AOR
        i. The care manager ensures that the member and/or AOR have access to and can effectively use the member's personal health information including any post discharge instructions and medication list to coordinate ongoing care.
        ii. The member is also assessed for any barriers to accessing needed care, such as challenges with technology, literacy, or care coordination.

1. Where barriers are identified, additional support is provided, including connecting members with resources, facilitating access to necessary equipment, and offering alternative modalities.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-112 DSNP Care Transitions Protocols

CM-D-113 DSNP Care Transitions Personnel

CM-D-114 DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process

CM-D-116 DSNP Planned Care Transitions Process – Member Self-Management Activities

CM-D-117 DSNP Planned Care Transitions Process – Notification and Point of Contact

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

review

MONITORING

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sough to improve the care transition process and address any barriers to accessing services.

review

POLICY AND PROCEDURE

Policy Number	CM-D-116
Policy Name	DSNP Planned Care Transitions Process – Member Self-Management Activities
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) supports members as they navigate through various healthcare settings. The team collaborates with providers, specialists, and community resources across all healthcare settings to ensure a safe transition for every member.

The Alliance has established a structured approach that provides education and support to members and their caregivers, helping them manage and understand their condition while emphasizing self-care.

PROCEDURE

1. Education Process

review

a. Care transitions are a primary mechanism to educate members and caregivers about indicators that their condition has improved or worsened.
b. Care managers and inpatient review nurses collaborate with Interdisciplinary Care Team (ICTs) to discuss the member's health status, review medical records and coordinate care planning.
    i. These interactions are critical opportunities to educate members and caregivers about changes in their condition and appropriate self-management strategies.
c. Education is delivered through multiple channels, including:
    i. Initial assessments
    ii. Routine care plan reviews
    iii. Structured post-discharge follow-up
d. The care management team provides customized education materials tailored to the member's literacy level, primary language and health condition.
    i. Materials include information on recognizing signs of improvement or worsening and clear steps for when and how to seek medical assistance or contact their care team.
e. The care coordination process ensures that referrals are efficiently documented within the enterprise care management system, and that care managers assess each member's eligibility and service needs promptly.
    i. Referrals can originate from various sources and are categorized by urgency to ensure timely follow-up.
f. Care managers conduct follow-up phone calls within 7 days post-discharge, or sooner depending on complexity of needs.
    i. These calls reinforce the education provided, assessing the member's condition, and addressing any questions or concerns.

2. Demonstrating Understanding
    a. To verify that members can recognize and respond to changes in their condition, care managers use the teach-back method.
        i. During interactions, members and caregivers are asked to explain in their own words what signs to look for and how they would respond.
    b. Members are also provided with symptom tracking tools such as checklists.
        i. These tools help them monitor their daily health status and are reviewed during follow-up appointments.
            1. Care managers use this information to assess adherence to the self-management plan and to provide ongoing coaching and support.
        ii. The care coordination process includes ongoing documentation of member interactions, assessments and interventions within the enterprise care management system.
            1. This allows care managers to monitor progress continuously and adjust care plans as needed.

Review

2. Collaboration occurs across departments to avoid duplication of services and to ensure that all interventions align with the member's Individualized Care Plan (ICP)
3. Self-management education also includes setting SMART goals that are specific, measurable, achievable, realistic and time bound.
    a. The care manager works with the member to set realistic health goals, track progress and address any barriers or challenges.

3. Education Content
    a. Educational interventions are customized based on the member's specific health needs, diagnoses and circumstances.
    b. The case management team ensures that all education is accessible and actionable, utilizing methods like printed materials, referrals to disease management programs, and in-home assessments.
        i. Special attention is given to coordinating care across multiple settings, including ensuring that necessary equipment is acquired and home environments are safe.
    c. Efficient communication is emphasized across providers and services to maintain continuity of care during transitions.
    d. Members are educated on the importance of timely follow-up appointments, medical self-management, and home safety.
        i. Education is reinforced during structured follow-up calls and face-to-face visits.
        ii. Care managers discuss medication changes and ensure that members have received any necessary equipment and assess the safety of the member's home environment, especially in preventing falls.
        iii. Referrals to additional resources are made as needed, including disease management programs, behavioral health support, wellness coaching and medication therapy management.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

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CM-D-112 DSNP Care Transitions Protocols

CM-D-113 DSNP Care Transitions Personnel

CM-D-114 DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process

CM-D-115 DSNP Planned Care Transitions Process – Member Personal Health Information

CM-D-117 DSNP Planned Care Transitions Process – Notification and Point of Contact

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Code of Federal Regulations, 422.101

MONITORING

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sough to improve the care transition process and address any barriers to accessing services.

review

POLICY AND PROCEDURE

Policy Number	CM-D-117
Policy Name	DSNP Planned Care Transitions Process – Notification and Point of Contact
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) supports members as they navigate through various healthcare settings. The team collaborates with providers, specialists, and community resources across all healthcare settings to ensure a safe transition for every member.

The Alliance has established a structured approach that provides education and support to members and their caregivers, helping them manage and understand their condition while emphasizing self-care.

PROCEDURE

1. Assignment and Notification of the Point of Contact

review

a. For each care transition, a designated care team member (e.g. care manager, inpatient review nurse, or health navigator) is assigned as the point of contact (POC) based on the member's specific needs and the type of care setting involved.
b. The POC is responsible for ensuring coordination of all aspects of the transition, including care planning, communication and service arrangements.
c. The assigned POC initiates contact with the member and/or caregiver as soon as the transition plan is developed.
    i. The POC will introduce themselves, explain their role and provide direct contact information, including phone numbers and hours of availability.

2. Communication Methods and Continuity
    a. The POC ensures members and caregivers receive clear information through various communication channels, such as, phone calls, emails, and printed materials.
        i. Members are also provided with a Transition Care Information Packet which includes the POC's contact information, important health resources, and a personalized care plan overview.
    b. The POC conducts initial outreach to discuss the transition process, provide an overview of what to expect and shares direct contact information for any ongoing support.
3. Ongoing Support and Engagement During Transitions
    a. The POC remains actively involved during the transition period, regularly checking in with the member and coordinating services such as transportation, follow-up appointments, and home care needs.
        i. The POC also works closely with the member's PCP and other healthcare professionals to ensure all necessary medical information is transferred seamlessly.
    b. The POC is responsible for assessing the member's medical, behavioral health and social needs during the transition and communicating any updates or changes in the care plan to all involved parties.
4. Post-Transition Follow-Up and Reconnection
    a. Following the transition, the POC conducts a follow-up call within 24-72 hours to confirm that the member has safely transitioned and that all services have been initiated as planned.
    b. The POC also ensures that any pending authorizations, referrals, or services are completed and documented.
5. Documentation and Accessibility
    a. All interactions, communications and care coordination activities are thoroughly documented in the enterprise care management system.

DEFINITIONS / ACRONYMS

Preview

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-112 DSNP Care Transitions Protocols

CM-D-113 DSNP Care Transitions Personnel

CM-D-114 DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process

CM-D-115 DSNP Planned Care Transitions Process – Member Personal Health Information

CM-D-116 DSNP Planned Care Transitions Process – Member Self-Management Activities

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Code of Federal Regulations, 422.101

MONITORING

review

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sought to improve the care transition process and address any barriers to accessing services.

review

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POLICY AND PROCEDURE

Policy Number	CM-D-118
Policy Name	Face-to-Face Encounters
Department Name	Case Management Department
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (The Alliance) provides personalized, high-quality care to every D-SNP member through annual face-to-face (F2F) encounters. These visits are designed to understand each member's unique health needs, build trust with their care team, and create tailored care plans that reflect their goals and cultural preferences. By meeting members where they are, whether in person or virtually, the Alliance aims to improve health outcomes which comply with Centers for Medicare and Medicaid Services (CMS) and California Department of Health Care Services (DHCS).

This policy covers all members enrolled in the D-SNP plan as well as the Alliance's care management staff, contracted providers, delegated partners and members of the Interdisciplinary Care Team (ICT) who schedule, conduct, document, and monitor F2F encounters, whether held in-person at a member's home, a clinic, or a community setting, or via secure telehealth.

PROCEDURE

1. Each Alameda Alliance Wellness member will be monitored for an annual face-to-face (F2F) encounter. These F2F encounters can occur:
   1.1. With a member of the Interdisciplinary care team:
      1.1.1. PCP
      1.1.2. Care manager
      1.1.3. Social worker
      1.1.4. Specialty and behavioral health provider(s)
      1.1.5. Dementia care specialist

review

1.1.6. Palliative care specialist
1.1.7. Physical/Occupational and/or Speech therapist
1.1.8. Dietician

1.2. Alameda Alliance Wellness case management and coordination staff, or
1.3. Contracted plan healthcare providers

2. Monitoring will include, but is not limited to, reviewing Analytics reports to determine if a F2F encounter has already occurred.
3. In the event a F2F encounter has not occurred the Case Management team will proceed with the following:
   3.1. Consent for F2F Encounters
   3.2. Prior to the F2F encounters members are asked to consent to the visit. Consent is documented for F2F visits in the care management platform for all visits conducted by Alameda Alliance Wellness staff. Providers document consent for visits with member within their systems of record.

4. Timing of F2F Encounters
   4.1.1.
   4.2. The Alliance provides an opportunity for every member to participate in a face-to-face encounter beginning within the first 12 months of enrollment and annually thereafter.
   4.3. Upon enrollment, information is placed in the care management system for each member, which include enrollment date. The engagement team will use this date to prioritize outreach attemps to the member to ensure every member can schedule a face-to-face visit within the first 12 months.
      4.3.1. Annually thereafter, visits will be scheduled based on the completed date of the face-to-face for the prior year as documented.

Monthly, the Alliance Analytics team will run a report to track who is due (and who has completed) the face-to-face requirement.

   4.4. For missed visits, the ICT will work with the member to reschedule within 30 days and work to address any barriers, like transportation or scheduling conflicts.

5. Scheduling of F2F Encounters
   5.1.
   5.2. With the monthly Analytics Report, the CM team will review to see which members have yet to complete the annual face-to-face requirement and begin outreach to the member.
   5.3. The CM team will make at least three (3) attempts via phone, mail, or text/email (if the member agrees to digital contact).
   5.4. The care manager will discuss the member's preferences for visit timing, location, language and needs (like mobility support or telehealth access) to make the process smooth. The care manager will also work with the ICT to schedule F2F visits alongside other care needs like specialist appointments, for convenience.
6. Staff/Provider Qualifications
   6.1. All Alliance staff are required to complete yearly training on F2F protocols, cultural sensitivity, person-centered care, trauma-informed care, and safety during home visits.
   6.2. Alliance case management staff serve as ICT members, helping with assessments, care plan updates, and coordination.
   6.3. Quarterly reviews performed on contracted providers to ensure standards are being met.

7. Role of F2F in the ICT process

review

7.1. Care managers and PCPs team up with the ICT to create and update ICPs during F2F visits, ensuring plans reflect member needs.
7.2. Care managers handle scheduling, conduct HRAs, and follow through on care plan goals.
7.3. PCPs perform health exams, review medications, and arrange specialist referrals.

8. Refusals and Unable to Reach
   8.1. If a Member Refuses a F2F visit:
      8.1.1. The Alliance care manager will record the refusal in the care management system as soon as possible, and no later than 1 business day after contact, noting the date, reason (if known), and how they were contacted (i.e., phone, mail).
      8.1.2. The Alliance care manager will explain the importance of the F2F and offer other options for completion if the member is willing.
      8.1.3. The process will start again, with the Analytics report depicting a member's status of a face-to-face visit, and additional case management follow-up as needed, if the member is unable to be seen.
      8.1.4. The case management direct involvement will begin nine (9) months after the date of refusal.
   8.2. If Unable to Reach:
      8.2.1. The Alliance care manager will outreach the member three times using phone, mail, or text/email, making sure materials match the member's language and cultural needs.
      8.2.2. The Alliance care manager will log each attempt in the system with details (date, time, method used, result).
      8.2.3. After three unsuccessful attempts, the care manager will send an unable to contact letter to the member, asking them to contact the case management team..
   8.3. Safety Concerns: If a visit is determined to be unsafe (e.g., unsafe home), the concern is escalated to the clinical leaders to arrange alternatives, like a virtual video call.
9. Clinical Functions and Assessments that may be completed during the F2F Encounter:
   9.1. Completion of annual wellness visits or physical examinations (conducted by a licensed provider to evaluate the members' overall health status, inform the care plan, and coordinate any necessary preventative care).
   9.2. Health Risk Assessments completed or updated
   9.3. Review and revision of the care plan
   9.4. Provide health-related education to help members address any gaps identified during the encounter, equipping them with the knowledge necessary to manage their health effectively.
   9.5. Assessing and addressing behavioral health, Social Determinants of Health (SDOH). Gaps in care, and overall health, including functional states: The ICT evaluates and responds to issues that may affect the member's well-being
   9.6. Coordinating referrals to community services and home-based care
   9.7. Engaging the members to oversee their health care

DEFINITIONS

- Face-to-Face (F2F) Encounter: A direct meeting between a member and a qualified provider or care manager, held in-person (e.g., at home, clinic, or community location) or via secure telehealth, to assess health, complete care assessments, update care plans, and coordinate services.

- Health Risk Assessment (HRA): A detailed questionnaire used to evaluate a member's medical, functional, mental health and social needs.
- Individualized Care Plan (ICP): A customized plan created by the ICT to outline a member's health goals and care needs.
- Interdisciplinary Care Team (ICT): A collaborative group including the member, their caregiver, primary care provider, care manager, and other relevant providers working together to manage care.
- Qualifying Encounter: A F2F visit that meets CMS MOC standards, including documented clinical assessments and care coordination activities.

AFFECTED DEPARTMENTS/PARTIES

Which departments will this policy affect

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

TBD

REFERENCES

- CMS Managed Care Manual
- CalAIM D-SNP Policy Guide
- Alameda Alliance Wellness Model of Care
- NCQA Case Management Standards
- DHCS Telehealth Policy (APL 22-015)

MONITORING

Face-to-face process is regularly monitoring through quality improvement initiatives, member satisfaction and outcomes of care coordination activities.
Feedback from members and caregivers are actively sought to improve the face-to-face process and address any barriers to accessing services.

review



POLICY AND PROCEDURE

Policy Number	CM-D-119
Policy Name	Interdisciplinary Care Team (ICT) Overview
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) looks for ways to address Social Determinants of Health (SDOH) and improve health equity while understanding the needs and challenges that most vulnerable populations face.

All members are assigned to an Interdisciplinary Care Team (ICT). The Interdisciplinary Care Team (ICT) consists of multi-disciplinary professionals who address the physical, medical, functional, and psychosocial needs of each member. The practitioner and provider network are equipped with the necessary expertise, training, and credentials to support the clinical and social needs of DSNP members.

PROCEDURE

Preview

1. Membership
   Critical members of the Interdisciplinary Care Team (ICT) may include, but are not limited to:
    a. Member
    b. Member's Authorized Representative
    c. Member's Family/Caregiver
    d. Care Manager
    e. Primary Care Physician
    f. Registered Nurse
    g. Behavioral Health Specialist
    h. Palliative Care Specialist
    i. Dementia Care Specialist
    j. Community Partners
    k. Social Worker
    l. Pharmacist
2. The composition of the Interdisciplinary Care Team (ICT) varies according to the unique needs of the members. Additional members may be included as needed, based on Interdisciplinary Care Team (ICT) recommendations, ongoing claims and data review, changes in member health status, care transitions, or member requests.
3. These additional Interdisciplinary Care Team (ICT) members may include:
    a. Physical Therapist
    b. Occupational Therapist
    c. Dietitian
    d. Specialist Physicians
    e. Other relevant health care professionals
4. Members or their caregivers are encouraged to participate in Interdisciplinary Care Team (ICT) meetings.
    a. Meeting times and arrangements are made with consideration for the members' needs, and language translators are provided according to their preferences.
    b. The Alliance uses TTY devices to communicate with hearing-impaired members.
    c. For members with cognitive impairments, dementia care specialists are included to assist in communication.
5. The member's Health Risk Assessment (HRA) and Individualized Care Plan (ICP) are used to tailor the Interdisciplinary Care Team (ICT) composition according to the member's specific needs.
    a. For members diagnosed with dementia, Alzheimer's disease, or those with cognitive impairment or related care needs (such as wandering, home safety concerns, or difficulties with medication adherence), the Interdisciplinary Care Team (ICT) includes the member's caregiver and a trained dementia care specialist, as aligned with the member's preferences.

Review

b. The HRA also identifies members with behavioral or SUD needs, as well as Social Determinants of Health (SDOH) concerns. In such cases, the Alliance includes a behavioral health specialist or social worker in the Interdisciplinary Care Team (ICT), as appropriate.

6. Palliative Care Interdisciplinary Care Team (ICT)

Members with serious illness who meet Medi-Cal's palliative care criteria, including both general and disease specific criteria, have a palliative care coordinator who serves as their lead care manager.

a. For these members, the Alliance utilizes a specialized palliative care Interdisciplinary Care Team (ICT). Members eligible for palliative care can access both palliative care and curative services until their condition improves, stabilizes or results in death.

Palliative Care Team

1. The palliative care team is composed of individuals who address the physical, medical, psychosocial, emotional and spiritual needs of the member and their family. They are trained to identify and manage sources of pain and discomfort for the member.
2. The palliative care team includes:
    a. Member's Primary Care Provider
    b. Registered Nurse, Licensed Vocational Nurse, or Nurse Practitioner
    c. Social Worker
    d. Access to Chaplain Services (as appropriate)
3. A member of the palliative care team coordinates care, ensures ongoing assessment of the member's needs, and implements the care plan.

ICT Dementia Care

1. Dementia care specialists are specially trained to participate in the ICT for members with cognitive impairments, such as those diagnosed with Alzheimer's disease or related dementias. They receive specialized training in comprehensive dementia assessment.
    a. If impairment is detected, the case management team will work collectively to coordinate with a provider (preferably the PCP) to perform a full diagnostic workup.
2. The goal of the dementia care ICT training is to help caregivers, members and ICT members understand Alzheimer's Disease or related dementias, its symptoms and progression, and to provide strategies for managing behaviors, communication challenges, and caregiver stress.

Documentation

review

1. Interdisciplinary Care Team (ICT) meetings will be documented in the system of record.
    a. Documentation will include, at a minimum:
        i. ICT participants present at the time of the meeting
        ii. Changes/updates/edits to the Individualized Care Plan (ICP) for the member(s) discussed
        iii. Meeting minutes

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-120 – Interdisciplinary Care Team (ICT) Participants

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Alameda Alliance Wellness Model of Care
NCQA Case Management Standards

review

MONITORING

The Interdisciplinary Care Team process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members, caregivers and other Interdisciplinary Care Tea members are actively sought to improve the interdisciplinary care team process and address any barriers to accessing services.

review

POLICY AND PROCEDURE

Policy Number	CM-D-120
Policy Name	Interdisciplinary Care Team (ICT) Participants
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) looks for ways to address Social Determinants of Health (SDOH) and improve health equity while understanding the needs and challenges that most vulnerable populations face.

All members are assigned to an Interdisciplinary Care Team (ICT). The Interdisciplinary Care Team (ICT) consists of multi-disciplinary professionals who address the physical, medical, functional, and psychosocial needs of each member. The practitioner and provider network are equipped with the necessary expertise, training, and credentials to support the clinical and social needs of DSNP members.

The summaries below describe ICT members, their roles and responsibilities, and how each contributes to the development and implementation of an effective interdisciplinary process to support the member's clinical and social needs.

Review

PROCEDURE

1. Member and/or Caregiver and/or Family Member(s)
    a. The role of the member and/or caregiver is to participate in person-centered care and share their self-management goals and objectives, and their personal healthcare preferences including what language they prefer to receive information and cultural needs/preferences in accordance with member choice.
    b. They also share information about their clinical and social needs, participate in the development and ongoing maintenance of the ICP and interface with the ICT during meetings or other communications.
    c. Members share when and how they would like to participate, including in-person or via telehealth or by other means available.
    d. Family members and/or caregivers participate as requested by the member.
    e. If cognitive impairment is present, the family and/or caregiver are included.
    f. Family members and caregivers may participate in the development and maintenance of the member's ICP, assist members with accessing needed services and supports, assist members with self-management strategies, and support the member in engaging in ICT processes.
2. Care Manager
    a. The care manager services as the main point of contact for the member and the ICT.
    b. The care manager coordinates the ICT (unless it is palliative care ICT, in which case the Palliative Care Coordinator would coordinate) with the member and the PCP and other ICT members as needed.
    c. The care managers coordinate all care for D-SNP members and ensures that information is exchanged and shared during the ICT meetings and when creating the ICP.
    d. The care manager documents the ICT minutes and maintains the ICP in the system of record as well as updates the ICP as needed, depending on the health status/needs of the member, and provides copies of the updated ICP to the member, caregiver, PCP and other Interdisciplinary Care Team (ICT) members as indicated.
3. Manager, Care Management
    a. The manager of Care Management provides daily oversight of the care management program and provides supervision and support to the care manager and all members of the Interdisciplinary Care Team (ICT) team. The manager monitors and evaluates outcomes associated with the Interdisciplinary Care Team (ICT) meetings and updates processes when needed.
4. PCP

Review

a. The PCP is a strong advocate for the member and Interdisciplinary Care Team (ICT) processes. The members' PCP actively collaborates with the care manager and Interdisciplinary Care Team (ICT) on the member's Individualized Care Plan (ICP) through sharing information related to the member's health needs. This occurs during ongoing telephonic or electronic communications and through attendance and discussions at virtual Interdisciplinary Care Team (ICT) meetings.
b. The PCP supports care management processes and encourages the member to participate in these processes.
c. The PCP shares ongoing report results and services rendered with the care manager and Interdisciplinary Care Team (ICT) to facilitate the individualized care plan and member goals through participation in the Interdisciplinary Care Team (ICT) meetings through regular communications with care manager.
    i. The PCP has essential clinical and SDOH information to share with the Interdisciplinary Care Team (ICT) to promote the member's Individualized Care Plan (ICP).
d. The PCP works collaboratively with the ICT and the member to ensure effective integration of the member's Individualized Care Plan (ICP) and the PCP's treatment plan.
e. The PCP also has established relationships with other providers involved in the member's care to facilitate the Individualized Care Plan (ICP) and member goals.

5. Social Worker
    a. If there are SDOH concerns identified on the HRA, ICP or during an ICT meeting, a social worker is included to assist the member and their family/caregiver with community and plan resources that may assist them.
        i. The social worker attends the meetings and/or participates as needed.
    b. Th social worker utilizes his/her specialized training and experience to provide insight and support for the member's health needs.
    c. The social worker shares recommendations with the ICT about members related to psychosocial support and community resources such as housing assistance, legal assistance, transportation, and referral to community agencies.
    d. The social worker identifies and partners with community agencies to facilitate the member's ICP and ICT processes and can assist the member with navigating the health care system and resources.
6. Specialty and Behavioral Health Providers
    a. Specialty and behavioral health providers are included on the Interdisciplinary Care Team (ICT) based on the member's health needs and collaborate with the ICT through attendance at the ICT meetings and through ongoing communication with the care manager and other members of the ICT.
    b. Specialty and behavioral health providers work collaboratively with the care manager, PCP and other members of the ICT to support the overall health needs

of each member by communicating with and delivering needed and specialized care and services to the member, sharing information with members of the ICT, making recommendations for the development and ongoing maintenance of the ICP, and working together to coordinate member's care.

c. Specialty and behavioral health care providers can offer important recommendations to the ICT to inform the ICP such as recommending self-management strategies for members to deal with their chronic health conditions.
d. Specialty and behavioral health care providers may provide regular ongoing care and services, particularly for those members with chronic conditions and complex care needs and thus can provide important status updates/reports to the ICT regarding member progress with the treatment plan which helps inform the overall ICP.

7. Dementia Care Specialist
    a. To the extent possible and consistent with the member's preferences, a trained dementia specialist is included on the Interdisciplinary Care Team (ICT) for members living with dementia who also have:
        i. Two or more co-existing conditions, or
        ii. Moderate to severe behavioral issues, or
        iii. High utilization, or
        iv. Live alone, or
        v. Lack adequate caregiver support, or
        vi. Have moderate to sever functional impairment
    b. They participate in ICT and provide information on community resources and education including understanding symptoms and progression, how to manage behaviors and communication problems caused by Alzheimer's Disease and Related Dementias (ADRD) as well as caregiver stress and its management.
    c. Their recommendations are included in the development and ongoing maintenance of the ICP.
8. Palliative Care Specialist
    a. A palliative care specialist serves as the head of a specialized Interdisciplinary Care Team (ICT) for members who receive palliative care.
    b. The palliative ICT works together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the member and their family and can help identify the member's sources of pain and discomfort.
    c. The palliative care team members provide all authorized palliative care. A member of the palliative care team provides coordination of care and supports continuous assessment of the member's needs and implements the plan of care.
9. Pharmacist

review

a. Network pharmacists serve as specialized consultants to clinical teams and the Interdisciplinary Care Team (ICT) by providing support on pharmaceutical related needs for members.
b. The pharmacist may offer recommendations to the care manager and ICT on medication alternatives, drug-drug interactions, provide guidance on generic medications, and conduct follow-up on potential gaps in care with members and/or providers related to medication adherence and other pharmaceutical related issues.
c. Pharmacists share updates/information on specialized services provided (e.g., medication education) with the member, care manager, PCP, ICT, and other treating providers to facilitate the member's ICP.
    i. This information is considered by the PCT and incorporated into the member's ICP as applicable.

10. Physical/Occupational and Speech Therapist
    a. Therapists are included in the Interdisciplinary Care Team (ICT) if needed to improve the functional status of the member. They collaborate with the ICT through attendance at the ICT meetings and/or through ongoing communications with the care manager and other members of the ICT.
    b. These therapists can offer important recommendations to the ICT to inform the ICP such as recommending self-management strategies for members to deal with their functional impairments or concerns related to their physical mobility, ability to participate in their ADLs/IADLs, and speech and language or cognitive concerns.
11. Dietitian
    a. Members may have difficulty accessing nutritional food sources, and the dietician can work with the social workers on resources to address food insecurity issues. Members may also have dentition issues (such as tooth decay or loss, or gum disease) that interfere with their ability to eat.
    b. A dietitian can be added to the ICT to help with dietary guidance for members and caregivers/family to improve their nutritional intake and disease condition through nutrition, if appropriate.
12. Other
    a. Other organizations, providers or entities who support the member's health needs may also be a part of the Interdisciplinary Care Team (ICT), including but not limited to:
        i. Community-based organizations
        ii. LTSS providers
        iii. Hospital discharge planners
        iv. Nursing facility staff
    b. Involvement in the ICT will be as the needs arises.

review

The Interdisciplinary Care Team (ICT) uses the information contributed by the various ICT participants to continuously evaluate, recommend, and modify the services provided to the member as needed to manage the member's changing health care needs, to inform needed updates to the Individualized Care Plan (ICP), and to facilitate improvements in the member's health outcomes.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-119 Interdisciplinary Care Team (ICT) Overview

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026
CMS Managed Care Manual
Alameda Alliance Wellness Model of Care
NCQA Case Management Standards

review

MONITORING

The Interdisciplinary Care Team process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members, caregivers and other Interdisciplinary Care Team members are actively sought to improve the interdisciplinary care team process and address any barriers to accessing services.

review

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POLICY AND PROCEDURE

Policy Number	CM-D-121
Policy Name	DSNP Most Vulnerable Population (MVP)
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) looks for ways to address Social Determinants of Health (SDOH) and improve health equity while understanding the needs and challenges that most vulnerable populations face.

Older adults are among some of the most vulnerable populations. Older adults are considered vulnerable because they are more susceptible to age-related conditions such as Alzheimer's disease, diabetes, and heart disease. This population often faces mobility issues and social determinants of health factors that prevent access to care. A majority of older adults 65 and older in the United States have at least one chronic health condition.

PROCEDURE

Review

1. Definition
    a. The Alliance defines the D-SNP most vulnerable population as those whose needs exceed those of the general D-SNP population and in which comprehensive, intensive and person-centered care coordination and case management activities will have the most impact driving high-quality and effective care for the member's complex health and social needs. The following identifiers are included:
        i. California Integrated Care Management (CICM):
            1. Adults experiencing homelessness
            2. Adults at risk for avoidable hospital or ED utilization
            3. Adults with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs
            4. Adults transitioning from incarceration
            5. Adults living in the community and at risk for Long-Term Care (LTC) institutionalization
            6. Adult nursing facility residents transitioning to the community
            7. Adults who are pregnant or postpartum and subject to Racial and Ethnic disparities
            8. Adults with documented dementia care needs
        ii. Members with a serious illness and eligible for community-based palliative care referral using the Medi-Cal palliative care general and disease-specific eligibility criteria:
            1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures
            2. The member has an advanced illness, as defined in disease specific eligibility criteria, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
                a. Congestive Heart Failure (CHF)
                b. Chronic Obstructive Pulmonary Disease (COPD)
                c. Advanced cancer
                d. Living disease
            3. The member's death within a year would not be unexpected based on clinical status
            4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.

review

5. The member and, if applicable, the family/member-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate,
        i. In-home,
        ii. Residential-based, or
        iii. Outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participating in advance care planning

b. The complexity of the members' conditions and other health characteristics contributes to their designation as the most vulnerable members, and this sets them apart from the general D-SNP population.

c. The most vulnerable populations are considered high risk and will have multiple chronic conditions. These members experience more frequent visits to the hospital and emergency department and have a higher number of behavioral health encounters, increased pharmacy utilization such as polypharmacy, and higher social support service needs.

2. Identification and stratification of Most Vulnerable Members
    a. At Enrollment: Information gained during intake and eligibility process (Medicaid waiver status, dual-eligible designation).
    b. Health Risk Assessment (HRA): Completed within 90 days of enrollment and updated at least annually. Assesses physical health, behavioral health, cognitive status, functional limitations, and social determinants of health (SDOH).
    c. Prior health care utilization data, including but not limited to:
        i. Outpatient, inpatient, emergency department and ancillary services data,
        ii. Long-term care utilization or skilled nursing facility institutionalization
        iii. Claims and encounter data (medical and pharmacy)
        iv. Assessment data
        v. Chronic disease conditions
        vi. Palliative care eligibility
        vii. Dementia care needs
        viii. Social determinants of health (SDOH) needs
    d. Care Management Referrals: From members, members, providers, social workers, behavioral health clinicians, or other Interdisciplinary Care Team (ICT) members.
3. Programs and services tailored to the most vulnerable population
    a. The Alliance is committed to providing personalized, comprehensive support for our most vulnerable members, ensuring they receive essential healthcare and the additional services that address their unique needs to enhance their quality of life. Recognizing the complex health and social challenges our members face, we

continue to develop a suite of services specifically tailored to promote their well-being and independence.

b. One of the core and specialty offerings to the vulnerable population is Complex Case Management (CCM). This program is designed to address the comprehensive needs of individuals with complex medical, behavioral and social challenges. CCM goes beyond standard case management (emerging risk) by incorporating multiple layers of support and coordination to improve health outcomes, quality of life and care continuity for high-risk members. CCM is a specialty case management program provided only to the most vulnerable population. Any member who stratifies as high-risk are considered within the most vulnerable population and will be included in complex case management key components, which may include:
    i. Member engagement and monitoring: maintaining more frequent and regular contact with our most vulnerable members via phone calls, home visits, or virtual check-ins to monitor progress, adjust care plans and offer support.
    ii. Interdisciplinary Care Team (ICT) meetings and engagement: collaborating with the ICT more often to ensure a unified care delivery approach.
    iii. Intensive care coordination: facilitating a multi-disciplinary approach among multiple providers to coordinate care services including transitions across care settings such as from hospital to home or from one specialist to another.
    iv. Medication management: reviewing and optimizing medication regimens, especially for members with multiple prescriptions, to minimize adverse interactions and improve adherence. The Alliance also provides education on medication use and side effects, helping members understand and follow their prescribed treatments.
    v. Behavioral health integration: screening for and addressing mental health and substance use issues, which are prevalent in the target high risk population.
    vi. Patient education and self-management support: educating members on their health conditions, treatment options, and self-management strategies to empower them to take an active role in their care. The Alliance also provides coaching to build skills in managing symptoms, diet, and exercise.
    vii. Family and/or caregiver support: involving family members and caregivers in the care process to provide a support network for the member. Coordinating respite care and other support services to alleviate caregiver burden and reduce burnout.

c. Members who are identified as eligible for palliative care, dementia care and California Integrated Care Management (CICM) services are also considered most vulnerable, making these programs specific to the population.
d. Long Term Services and Supports (LTSS)
    i. Long Term Services and Supports (LTSS) encompasses a range of services designated to help members with complex health needs, disabilities, or limitations, manage daily activities and maintain independence.
    ii. LTSS is available to all D-SNP members and is critical to the most vulnerable, as it addresses both health and non-health needs that support independent living and quality of life.
e. The Alliance offers and/or coordinates the following services:
    i. Adult day health
    ii. Adult foster care
    iii. Community-based home care services
    iv. Institutional long-term care services
    v. Non-emergency transportation
    vi. Vision, dental and hearing services
    vii. Housing transition navigation services
    viii. Housing deposits
    ix. Housing tenancy and sustaining services
    x. Medically tailored meals
    xi. Recuperative care (medical respite)
    xii. Asthma remediation
    xiii. Caregiver respite services
    xiv. Personal care and homemaker services
    xv. Home modifications
    xvi. Nursing facility transition/diversion to assisted living

4. Support for members
    a. Understanding the population and critical needs of the most vulnerable members is vital in aligning care and support services including both medical and social needs to ensure that all members have equitable access to quality care to reduce health disparities and support overall well-being.
    b. The Alliance's case management program offers each member individualized care planning, care coordination services, and targeted programs for intensive support, helping mitigate the risks associated with managing multiple chronic conditions.
    c. The Alliance recognizes that members identified as part of the most vulnerable populations often face significant challenges in managing their health for various

review

reasons. The benefit is designed to focus on reducing obstacles related to care coordination, access, and financial constraints.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management DHCS
Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

MONITORING

The care transition process is regularly reviewed through quality improvement initiatives, which track timeliness, member satisfaction, and outcomes of care coordination activities.

Feedback from members and caregivers is actively sought to improve the care transition process and address any barriers to accessing services.

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POLICY AND PROCEDURE

Policy Number	CM-D-122
Policy Name	Disease Management
Department Name	Case and Disease Management Department
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Disease Management (DM) services at Alameda Alliance Wellness (the Alliance) are provided to all Alliance members with a diagnosis of diabetes, asthma, hypertension or perinatal depression that meet certain criteria. The Alliance will:

- Provide disease management as an "opt-out" service meaning that all eligible members identified are enrolled unless they choose to decline participation or "opt-in" meaning that eligible members are not enrolled until they chose to receive Alliance disease management services.
- Ensure that all Alliance members are identified and stratified into appropriate levels for disease management services depending on risk.
- Provide DM services based on evidence-based guidelines and an individual assessment of gaps in care.
- Maintain documentation of program enrollment and provision of services using a Clinical Information System
- Promote DM to members and practitioners via written information about the program.

The Alliance disease management program ensures compliance with the Department of Healthcare

Review

Services Population Health Management Policy Guide, most recent edition. This includes ensuring disease management programs incorporate health education interventions, identify members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions, and improving equity and reducing health disparities.

PROCEDURE

Scope

This Policy and Procedure addresses the DM process at the Alliance. DM consists of the following related processes: Identification and Screening; Risk Stratification; Enrollment; Assessment; Care Plan Development and Management; and DM Evaluation and Closure. Referrals to DM are also addressed as part of the Identification process. Definitions of terms used for the DM program are also included within this Policy and Procedure.

This policy does not address in detail the DM Assessment process or the DM Care Plan Development and Management process as the procedures outlined in CM –D- 101 Policy and Procedure, *DSNP Care Coordination Expectations* and CM – D-102 Policy and Procedure, *DSNP Case Management Care Coordination Activities, CM-D-103 DSNP Individualized Care Plan Components, CM-D-104 DSNP Individualized Care Plan Process and CM-D-105 DSNP Individualized Care Plan Documentation, Maintenance, Updates and Notifications* apply. Any changes from these referenced policies are addressed within this DM policy.

DM Identification and Screening

Members are eligible for DM if they have a diagnosis of diabetes, asthma, hypertension or are at risk for perinatal depression.

The Alliance informs practitioners about the DM programs through multiple methods, including but not limited to: Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe who is eligible for DM programs and how to refer members to DM services.

Training and/or targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital discharge planners will occur at least annually.

1. Members are identified for program eligibility through one of the following:
    a. Monthly report from the Analytics department utilizing claims, encounter, and pharmacy data.
    b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score, as outlined in the *CM-D-108 DSNP SPD HRA Survey and Interventions* policy, calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the CM/DM Department for further processing.

Review

Additional sources or reports from a source include, but are not limited to: self- referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities and internal department referrals such as Utilization Management, (UM), Case and Disease Management, Health Education, and Member Services. All referrals to DM should be directed to the CM/DM Department. A referral form is not required, and all information can be taken by phone or any other means.

Information needed for a DM referral includes:

i. Referral or data source (name, affiliation, and contact information).
ii. Date referral received. If secondary referral, document initial contact information and date.
iii. Member information
iv. Reason for referral
v. Diagnosis (asthma, diabetes, hypertension, or perinatal depression)
vi. Level of urgency
vii. Additional information as necessary.

2. Laboratory results, claims, and encounter data are used to identify members eligible for the DM program.

3. At risk eligible members (or parents/guardians of minors) are sent letters about the availability of the DM program services. The letter will also inform them how to use the program, eligibility criteria and opt-in and opt-out program aspects. The letter also includes health education related to their identified condition.

4. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as termination of coverage.

DM Risk Stratification

1. All members who are directly referred to the Alliance DM services are stratified into the appropriate DM program.

2. Data reports provided to the Case & Disease Management Department monthly are already stratified into levels according to the following risk criteria:

a. High Risk Diabetes: Eligible age members with a diagnosis of diabetes, and meet at least one of the criteria below:
   - Has poor control A1c over 9.0; or
   - Has at least three inpatient visits, four or more emergency department visits, or
   - Two or more emergency department readmissions over the past 12 months; or
   - Is non-adherent for statin therapy.

b. Moderate Risk Diabetes: Eligible age members with a diagnosis of diabetes who are not high-risk, and have identified gaps in diabetes care such as no record of A1c, annual foot care

appointment, eye exam, etc., or whose documented A1c is 8.0 to 9.0.

c. Low risk Diabetes: Eligible age members with a diagnosis of diabetes, and who do not fall into the high or moderate risk category. These members may be new to the plan, have a new diagnosis of diabetes or have no identified gaps in care.

d. High Risk Asthma: Eligible age members with a diagnosis of asthma that meet at least one of the criteria below:

- have at least one or more emergency department visit in the past 12 months with asthma as the primary diagnosis;
- or one more hospitalization in the past 12 months with asthma as the primary diagnosis;
- or two or more urgent care or clinic visits with asthma as the primary diagnosis in the past 12 months;

e. Low Risk Asthma: Eligible age members with a diagnosis of asthma who do not fall into the high-risk category.

f. High Risk Hypertension: Eligible age members with a diagnosis of hypertension and meet at least one of the below criteria:

- members whose blood pressure is not controlled and have at least one anti- hypertensive prescription medication in the last year;
- or has at least three inpatient visits, four or more emergency department visits, or two or more emergency department readmissions over the past 12 months;

g. Low Risk Hypertension: Eligible age members with a diagnosis of hypertension who are not high-risk, and who meet one of the criteria below:
- Have uncontrolled blood pressure;
- or have at least one anti-hypertension prescription medication.

h. At Risk Perinatal Depression: Eligible age members identified as being pregnant or were pregnant within the past 12 months.

3. Existing Complex Case Management (CCM) or California Intensive Care Management (CICM) cases will take precedence over the DM program for members that are eligible for multiple programs. The CM will determine the appropriateness of referring the member to the DM program or simply expand the existing CCM or CICM Care Plan.

4. The CM/DM designee will process referrals within the following time frames:

a. Urgent – referral opened within 1 business day.

b. Routine – referral opened within 5 business days.

5. DM referrals will be completed within the month of receipt of the request of the DM Identification and Stratification. If at any time, the CM or the referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

6. The Alliance analyses DM program eligible members for disparities and develops targeted interventions to address identified disparities.

Enrollment

1. The Alliance will inform members of enrollment in the Alliance DM programs through the following methods:
    a. Asthma, Diabetes, Hypertension or Perinatal Depression members will receive a letter informing them of their enrollment.
    b. Members at-risk for perinatal depression will receive a letter informing them of DM services offered and how they may enroll.
2. Enrollment communications will explain to the member:
    a. How they became eligible for the program
    b. How to use the program services
    c. How to opt in or opt out of the program
3. Program engagement:
    a. Members will be considered enrolled and engaged when they do one of the following:
        i. Receive a letter and either call the DM program asking to learn more and agree to engage or return the Health Education Wellness form requesting program and education information.

Risk Assessment

1. Members who choose to engage in the DM programs will be assessed using an appropriate assessment within the Clinical Information System. Procedures for conducting assessments are addressed in *CM-D-101, Policy and Procedure, Case Management (CM)Care Coordination Activities.*

2. Supports will be assigned depending on their risk stratification, needs and interest.
    - Health Navigation
    - Health Education/Coaching
    - Social Work
    - Medication reconciliation/education – Pharmacy
    - Nurse Case Management
    - Behavioral health care management

3. All cases assessed are already assigned to a case manager, who will then refer and enroll the member in the DM program per previous steps outlined above. However, if during the assessment process, the member chooses to opt-out of the program, the Alliance team member shall close the case appropriately in the Clinical Information System.

4. If unable to contact the member, the member should also be closed within the Program Enrollment Summary and the reason listed as unable to establish or maintain contact with member.

DM Plan Development and Management

1. The procedures described in *CM-D-103, Individualized Care Plan Components and CM-D-104, Individualized Care Plan Process,* apply to the development of a care plan. As

described in that policy, the steps in developing the care plan involve:

a. Development of case management goals, including prioritized goals
b. Identification of barriers to meet the goals and complying with the plans
c. Provision of health education interventions
d. Development of schedules for follow-up and communication with members
e. Development and communication of member self-management plans, including addressing gaps in care
f. Assessment of progress against care plans and goals, and modifications as needed

2. Condition monitoring (self-monitoring and medical testing) and adherence to the applicable chronic disease treatment plan will be an important component of the plan of care and goals should be set accordingly.

3. The care plan for the DM program(s) will contain goals. Goals will be set as short-term goals defined as achievable within 30 days. Goals can be extended by another 30 days.

4. Members enrolled in Asthma Management DM Programs will be referred to the Asthma Preventive Services and Community Support providers as eligible for asthma case management and asthma remediation supports.

5. Referrals for additional services and resources will be made as documented in the plan of care. Referrals will be made as necessary and in a timely manner (within 7 business days of identifying the need) and follow up on these referrals will occur within 30 calendar days after the referral ismade.

DM Case Evaluation and Closure

1. The DM program is structured where the DM program(s) are closed either by meeting prescribed length in program criteria or by defined closure criteria.

2. High Risk Program enrollees will be evaluated for closure to DM services using *CM-D-105, Policy and Procedure, Individualized Care Plan Documentation, Maintenance, Updates and Notifications.* CMs should aim to close the program within 6 months of enrollment, allowing for 30 days of conducting the assessment. DM Program enrollees will also be evaluated for closure to DM services using CM-D-105 *Policy and Procedure,) Individualized Care Plan Documentation, Maintenance, Updates and Notifications*. However, the length of time in the program should not exceed 6 months of participation in the program. If the member is no longer identified as needing disease management support, they will no longer be in the program.

3. For D-SNP if the DM program enrollment is closed, the member will continue to have a CM case and will be managed within the CM program.

4. All closure actions will be documented in the care plan as applicable and in the Program Enrollment section of Clinical Information System.

5. At the time of case closure, a satisfaction survey and a case closure

letter, if appropriate, will be sent.

DEFINITIONS

DM Identification: DM Identification is the initial process of identifying members who qualify for the DM program. DM identification is where members are identified from data sources and referrals are taken for members meeting defined criteria (age and diagnosis criteria).

DM Screening: DM Screening is the process where an initial non-clinical decision is made to determine whether a member remains administratively eligible to proceed to Risk Stratification. This process entails screening against eligibility status and whether the member is being managed in other programs.

DM Risk Stratification: Classification and placement of eligible members according to severity of condition based on data (claims, Rx, lab). The purpose is to place patients in categories of prioritization for a specific DM program or level of service. Stratification is a dynamic process and the member's DM program assignment may change with a change in their status.

DM Assessment Process: Assessment is a process of compiling data including claims and medication history, HRA data and member questions to provide the basis to analyze services needed and to assist in identifying care gaps or creating a care plan.

Care Gaps: Discrete services or tests that the member has not received that are recommended for the member based on approved clinical guidelines.

Care Plan: A comprehensive plan that includes a statement of problems/needs determined upon assessment, interventions to address the problems/needs, and measurable goals to demonstrate the resolution of problem/need, the time frame, the resources available and the desires/motivation of the member.

DM Intervention: An intervention is an action that increases the probability that a desired outcome will occur.

Active Member Participation Rate: Number of members who have received at least one interactive contact in an intervention, divided by the number of members who are identified as eligible for the program.

Interactive contact: Two-way interaction in which the member receives self-management support or health education by interactive mail-based communication, phone, or online contact.

Opt in: A process in which eligible patients choose to receive disease management services and participate in a DM program. Also referred to as *active participation* or *voluntary participation.*

Opt out: A disease management program where eligible members elect not to receive services in order to decline participation in the DM program.

Disease Management: A multidisciplinary continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the

prevention of exacerbation and complications using cost- effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health (NCQA definition).

Outcomes: Measurable results of case management interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle.

Referrals: The arrangement for services by another care provider, agency, or entity.

AFFECTED DEPARTMENTS/PARTIES

All Alliance
Departments Alliance
Members Alliance
Delegated Groups
Alliance directly contracted physicians

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CM-D-101 Policy and Procedure, Case Management Care Coordination Expectations
CM-D-102, Policy and Procedure, Case Management Care Coordination Activities
CM-D-103, Policy and Procedure, Individualized Care Plan Components
CM-D-104, Policy and Procedure, Individualized Care Plan Process
CM-D-105, Policy and Procedure, Individualized Care Plan Documentation, Maintenance, Updates and Notifications
Department of Health Care Services Population Health Management Policy Guide (most recent version)
DM Program Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11 Case Management and Care Coordination, Section 4 Disease Management Program.
2. CMS Managed Care Manual
3. Alameda Alliance Wellness D-SNP Model of Care

REVIEW

MONITORING

The DM program is monitored through:

a. Identification and participation rates including active participation rates. At a minimum an annual evaluation is conducted of this measure and adjustments made to program participation rules as needed.
b. Audits and evaluation of cases using NCQA audit tools and other Alliance tools
c. Case rounds
d. Performance against DM timeliness standards
e. Member grievances specific to DM. Member grievances are reviewed as they are received for program interventions as well as annually in the aggregate for programmatic changes.
f. Satisfaction survey specific to the DM program. At a minimum, surveys are analyzed annually for improvements to the program design.
g. Clinical effectiveness measures as defined in the DM Program Description

review

POLICY AND PROCEDURE

Policy Number	CS-002
Policy Name	Community Supports – Housing Transition Navigation Services
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Long-Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2022
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Housing Transition Navigation Services Community Support.

Housing Transition Navigation Services assist individuals who are homeless or at risk of homelessness with finding, applying for, and obtaining housing. These services do not constitute room and board or rental payments.

Housing Transition Navigation Services may include:

- Conducting a housing assessment that identifies the member's preferences and barriers related to successful tenancy, and identifies the member's preferences, strengths and barriers.
- Developing a housing support plan.
- Assistance searching for housing.
- Assistance with completing housing applications and securing documentation.
- Benefits advocacy, including support with the SSI application process.
- Identifying and securing available resources to assist with attaining housing, such as Housing Deposits, Transitional Rent, HUD Housing Choice Voucher, and other state and local assistance programs.
- Fair Housing/anti-discrimination education and reasonable accommodation request assistance.

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- Landlord education, advocacy, and engagement.
- Ensuring the living environment is safe and ready for move-in.
- Assistance in, arranging for, and supporting the details of the move.
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- Assistance with transportation to housing options prior to transition and on move in day.
- Assistance with securing environmental modifications to install necessary accommodations for accessibility.

Housing Transition Navigation Services will be based on individualized assessments documented in the member's housing support plan. Individuals may only access the services necessary to meet their specific needs.

Housing Transition Navigation Services apply best practices for clients experiencing homelessness and/or complex health conditions, including Housing First, Harm Reduction, Motivational Interviewing, Progressive Engagement, and Trauma-Informed Care.

Housing Transition Navigation Services will not cover:
- Ongoing rental payments.
- Room and board.

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PROCEDURE

I. Eligibility

- Individuals who meet the **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2.
- Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Transition Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan.

II. Referrals

a) Referrals to the Housing Transition Navigation Services Community Support can be received from:
   - Alameda County Health or contracted provider
b) The MCP refers member who are eligible for HTNS to contracted CS providers by way of 211 and in partnership with Alameda County Health, who acts as the referral hub to match eligible

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members with the most appropriate housing navigation providers. The plan will ensure timely access to services via an audit and monitoring process that evaluates timeliness at each point of the member journey, including:

- From referral intake with 211 to authorization submission to the MCP
- From MCP authorization decision to member receipt of services

The MCP conducts regular meetings with contracted ECM providers to collaborate on care for members enrolled in ECM. When ECM-enrolled members are identified to be eligible for and referred to HTNS, the plan facilitates collaboration between ECM and CS providers to ensure coordinated care delivery and non-duplication of services. ECM and CS providers work together to define and divide roles and responsibilities, establishing coordinated channels of communication with members.

- ~~b)~~c) For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.

d) Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

~~c)~~

III. Review

a) When the Alliance receives a request for Housing Transition Navigation Services, they will review the documentation submitted by the provider. This will include the following:
- Request for Housing Transition Navigation Services by the contracted provider
- Attestation for coordinated entry enrollment or social and clinical risk factor requirement.
- Meet DHCS eligibility criteria
- Individualized housing support plan

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.

c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Close Loop Referral

a) All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

V. Data Sharing

a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member ~~agreement~~ consent and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

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b) AAH and CS Provider accesses available data exchange platform(s) when possible.
c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.
d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions and Limitations

a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts,
b) Housing Transition Navigation Services must be identified as reasonable and necessary in the housing support plan.
c) Individuals must have a housing support plan.
d) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
e) A member cannot receive both Housing Tenancy Sustaining Services and Housing Transition Navigation Services at the same time.

VII. Discontinuing of Services

a) Discontinuing of CS services will be based on:
- Housing goals met/member secured housing
- Unable to maintain contact with member
- Termination of coverage
- No longer meets criteria
- Member declines services
- Death of member

VIII. Licensing / Allowable Providers

a) AAH CS Providers must have experience and expertise with providing these unique services.
b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.
c) AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in

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Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS: Community Supports
AC Health: Alameda County Health
AAH: Alameda Alliance for Health

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Cultural and Linguistic Services

RELATED POLICIES AND PROCEDURES

CLS-009 CLS Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Housing Transition Navigation Services Community Supports Standard Operating Procedures

REVISION APPROVAL HISTORY

06/22/2022, 01/11/2023, 3/19/2024, 9/18/2024, 9/17/2025

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CS-001 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CS-003
Policy Name	Community Supports – Housing Deposits
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Long-Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2022
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Housing Deposits Community Support.

Housing Deposits assist individuals who are homeless or at risk of homelessness with identifying, coordinating, securing, or funding one-time services and modifications necessary to establish a basic household. Housing Deposit services do not constitute room and board or ongoing rental payments.

Housing Deposits may include:

- Security deposits required for rental housing.
- Set-up fees/deposits for utilities and arrears.
- First month of utility payments, including gas, electric, water, and phone services.
- Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality standards, or other habitability standards, as applicable, where those costs are not the responsibility of the landlord under applicable law.
- Application fees to cover the cost of the lease application.
- Medically necessary goods like air conditioners, hospital beds, Hoyer lifts, or adaptive aids, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal.

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Housing Deposit services will be based on individualized assessments documented in the member's housing support plan. Individuals may only access the services necessary to meet their specific needs.

Housing Deposit services apply best practices for clients experiencing homelessness and/or complex health conditions, including Housing First, Harm Reduction, Motivational Interviewing, Progressive Engagement, and Trauma-Informed Care.

Housing Deposit services **will not** cover:

- Ongoing rent payments.
- Room and board.
- First month's and last month's rent.
- Security deposit that exceeds an amount of one month's rent (or two month's rent for small landlords renting to non-service members).

PROCEDURE

I. Eligibility

- Individuals who meet **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2
- Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Deposits.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan.

II. Referrals

a) Referrals to the Housing Deposits Community Support can be received from:
   - Alameda County Health or contracted provider

b) For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.

c) Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

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a) When the Alliance receives a request for Housing Deposits, they will review the documentation submitted by the provider. This will include the following:
   - Request for Housing Deposits by the contracted provider
   - Attestation for coordinated entry enrollment or social and clinical risk factor requirement.
   - Meet DHCS eligibility criteria
   - Individualized housing support plan

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.

c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Close Loop Referral

a) All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

V. Data Sharing

a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member ~~agreement~~ consent and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

b) AAH and CS Provider accesses available data exchange platform(s) when possible.

c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions and Limitations

a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts,

b) **Once per demonstration period:** Housing Deposits are available once per demonstration period with a $5,000 cap, with a potential second occurrence if documentation justifies why providing Housing Deposits would be more successful on the second attempt.

c) Housing Deposit services must be identified as reasonable and necessary in the housing support plan and are only available when the individual is unable to meet such expense.

d) Individuals must have a housing support plan.

e) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

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VII. Discontinuing Services

a) Discontinuing of CS services will be based on:
- The member meets the demonstration financial maximum of $5,000
- Termination of coverage
- No longer meets criteria
- Member declines services
- Death of member

VIII. Licensing / Allowable Providers

a) AAH CS Providers must have experience and expertise with providing these unique services.

b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

c) AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports
AC Health	Alameda County Health
AAH	Alameda Alliance for Health

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Cultural and Linguistic Services

RELATED POLICIES AND PROCEDURES

CLS-009 CLS Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024, 9/18/2024, 9/17/2025

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CS-001 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CS-004
Policy Name	Community Supports – Housing Tenancy and Sustaining Services
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Long-Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2022
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Housing Tenancy and Sustaining Services Community Support.

Housing Tenancy and Sustaining Services assist individuals who are homeless or at risk of homelessness with maintaining safe and stable tenancy once housing is secured. These services do not constitute room and board or rental payments.

Housing Tenancy and Sustaining Services may include:

- Early identification and intervention for behaviors jeopardizing housing.
- Tenant and landlord rights/responsibilities education.
- Fair Housing/anti-discrimination education and reasonable accommodation request assistance.
- Coaching on landlord/property manager and/or neighbor relationships with a goal of fostering successful tenancy.
- Coordination with landlords and case managers (including ECM Provider or non-Medi-Cal housing supportive services providers) to address issues that can impact housing stability.
- Assistance with dispute resolution and eviction prevention.
- Advocacy and linkage with community resources to prevent eviction.

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- Benefits advocacy, including support with the SSI application process and housing recertification support.
- Lease compliance assistance and support with household management activities.
- Health and safety visits.
- Early intervention services identified in crisis plan when housing is jeopardized.
- Independent living and life skills training.

Housing Tenancy and Sustaining Services will be based on individualized assessments documented in the member's housing support plan. Individuals may only access the services necessary to meet their specific needs.

Housing Tenancy and Sustaining Services apply best practices for clients experiencing homelessness and/or complex health conditions, including Housing First, Harm Reduction, Motivational Interviewing, Progressive Engagement, and Trauma-Informed Care.

Housing Tenancy and Sustaining Services **will not** cover:

- Ongoing rental payments.
- Room and board.

PROCEDURE

I. Eligibility

- Individuals who meet the **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2.
- Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Tenancy and Sustaining Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan.

II. Referrals

a) Referrals to the Housing Tenancy and Sustaining Services Community Support can be received from:
   - Alameda County Health or contracted provider

b) For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.

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c) Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

a) When the Alliance receives a request for Housing Tenancy and Sustaining Services, they will review the documentation submitted by the provider. This will include the following:
   - Request for Housing Tenancy and Sustaining Services by the contracted provider
   - Attestation for coordinated entry enrollment or social and clinical risk factor requirement.
   - Meet DHCS eligibility criteria
   - Individualized housing support plan

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.

c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Close Loop Referral

a) All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

V. Data Sharing

a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member ~~agreement~~ consent and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

b) AAH and CS Provider accesses available data exchange platform(s) when possible.

c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions and Limitations

a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts,

b) Housing Tenancy and Sustaining Services must be identified as reasonable and necessary in the housing support plan.

c) Individuals must have a housing support plan.

d) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal

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funding.

e) A member cannot receive both Housing Tenancy Sustaining services and Housing Transition Navigation Services at the same time.

VII. Discontinuing Services

a) Discontinuing of CS services will be based on:
- Housing goals met
- Unable to maintain contact with member
- Termination of coverage
- No longer meets criteria
- Member declines services
- Death of member

VIII. Licensing / Allowable Providers

a) AAH CS Providers must have experience and expertise with providing these unique services.

b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

c) AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports
AC Health	Alameda County Health
AAH	Alameda Alliance for Health

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Cultural and Linguistic Services

RELATED POLICIES AND PROCEDURES

CLS-009 CLS Program – Contracted Providers

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CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Housing Tenancy and Sustaining Services Community Supports Standard Operating Procedures

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024, 9/18/2024, 9/17/2025

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CS-001 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CS-007
Policy Name	Community Supports – Medically Tailored Meals/Medically Supportive Food
Department Name	Community Supports
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2022
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

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POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Medically Tailored Meals/Medically Supportive Food Community Support. Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition sensitive, leading to improved health outcomes and reduced unnecessary costs.

MTMs and Medically Tailored Groceries (MTGs), Medically Supportive Food (MSF) are covered by this service, defined as follows:

a. **MTMs**: Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

b. **MTG**: Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

c. **MSF**: Preselected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition sensitive health conditions of the recipients to whom they are prescribed.

Nutrition Education: Health coaching, counseling, classes, behavioral supports, and tools, including equipment and materials, that are based on a Member's health conditions and

needs. Nutrition education is part of this service alongside the MTM/MSF services offered. Nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support.

PROCEDURE

I. Eligibility

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

II. Referrals

a. Referrals to the Medically Tailored Meals/Medically Supportive Food Community support can be received from:

i. The member themselves

ii. A member's representative

iii. A Member's Provider

iv. Other internal departments at the Alliance

v. Through Analytic data ran by the Alliance

b. The MCP identifies and refers members who are eligible for MTM to contracted CS providers after receiving all necessary information to support the appropriateness of the MTM.

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c. Contracted CS providers also receive direct referrals from community partners and clinics; in these instances, contracted CS providers evaluate the referral for eligibility and submit authorization requests to the MCP, along with any necessary supporting information. After the MCP confirms eligibility for MTM, the CS providers are notified of their approval to deliver services.

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~~b.~~d. For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.

~~c.~~e. Members may call AAH Member Services at:

Medi-Cal

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Monday – Friday, 8 am – 5 pm

Toll-Free: **1.877.932.2738**

People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

D-SNP

Monday - Sunday, 8am - 8pm

Toll-Free: **1.888.882.3767 (888-88ADSNP)**

People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

III. Review

a) When the Alliance receives a request for Medically Tailored Meals/Medically Supportive Food, they will review the documentation submitted by the provider. This will include the following:

1. Request from the Medically Tailored Meals/Medically Supportive Food provider
2. Clinical that supports the diagnosis and the need, dated within 30 days of the request
3. Lab values to support the diagnosis and the need, dated within 6 months of the request
4. Documentation of other food resources that the member has been referred to

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy. Medically Tailored Meals when offered post-acute care are inherently time-sensitive and subject to expedited authorization timeframes.

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c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) A CM or ECM referral may be made if the member is not already enrolled, and additional needs are identified.

e) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

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IV. Closed Loop Referral

a. All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

V. Data Sharing

a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member ~~agreement~~ consent and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

b) AAH and CS Provider accesses available data exchange platform(s) when possible.

c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services (DHCS) guidelines.

d) AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions / Limitations

a) Community Supports are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:

1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service,

2) beneficiaries are not required to use the Community Supports and

3) the Community Supports are authorized and identified in the Medi-Cal managed care plan contracts.

b) Service covers up to two (2) meals and/or meal packages per day using a combination of MTMs and MSF interventions.

c) MTM/MSF can be authorized for up to 12 weeks and may be reauthorized thereafter if medically necessary.

d) Meals that are eligible for or reimbursed by alternate programs are not eligible.

e) Meals are not covered to respond solely to food insecurities.

VII. Discontinuing Services

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a) Discontinuing of CS services will be based on:

- Goals met/completion of meal program with no extension needed
- Termination of coverage
- Unable to establish or maintain contact with member
- No longer meets criteria
- Member/caregiver declines services
- Death of member

VIII. Licensing / Allowable Providers

a) CS Medically Tailored Meals/Medically Supportive Foods Providers must have experience and expertise with providing these unique services.

b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

c) AAH plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH managed care plans will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification

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UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION APPROVAL HISTORY

06/22/2022, 01/11/2023, 3/19/2024, 9/18/2024, 9/17/2025

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CS-001 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CS-013
Policy Name	Community Supports – Transitional Rent
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Long-Term Services and Supports
Line(s) of Business	D-SNP, MCAL
Effective Date	01/01/2026
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Transitional Rent Community Support.

Transitional Rent assists individuals who are homeless or at risk of homelessness with 6 months of rental assistance in interim and permanent settings.

Transition Rent may include:

- Up to six months of rental assistance in allowable settings
    - Permanent Settings (renewable lease agreement): Single-family and multi-family homes, apartments, housing in mobile home communities, accessory dwelling units, shared housing, project-based or scattered site permanent supportive housing, single room occupancy, tiny homes, recovery housing, license-exempt room and board.
    - Interim Settings (no lease agreement, or the lease term is not renewable): Single room occupancy units, tiny homes, hotels/motels, interim settings, transitional and recovery housing.
- Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment

Transitional Rent may provide for a member's housing in a permanent or interim setting, or both. When permanent housing is not immediately available, temporary placement in an

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interim setting may be appropriate, but the goal must be to transition to appropriate permanent housing as quickly as possible.

Transitional Rent settings must be compliant with applicable quality standards as defined by HUD, state law, and/or any other minimum quality standards of their respective setting. A member should be housed in a setting that provides the smallest number of bedrooms necessary to house the member's family without overcrowding in accordance with HUD occupancy standards.

Transitional Rent must be administered in accordance with Housing First requirements, meaning that AAH may not condition authorization for or continued receipt of Transitional Rent on sobriety, engagement in or completion of certain services (apart from the completion of a housing support plan), or housing readiness.

Transitional Rent will not cover:

- Rental payments beyond the six-month global cap on Room and Board services within a rolling 12-month period, including both interim and permanent settings.
- Rental arrears or prospective rental assistance for individuals who are housed but at risk of homelessness.

PROCEDURE

I. Eligibility

- Individuals who meet the **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2; **AND**
- Individuals who meet the Transitioning Population Requirement; or
- Individuals who are experiencing unsheltered homelessness; or
- Individuals who are eligible for full-service partnership.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan. Individuals must also meet the population of focus as determined by AAH.

II. Referrals

a) Referrals to the Transitional Rent Community Support can be received from:
   - Alameda County Health or contracted provider
     - Alameda Alliance is participating in the Alameda County Flexible Housing Subsidy Pool as a funder through Transitional Rent. The contracted Transitional Rent provider and flex pool Lead Entity, Alameda County Health, will aggregate and braid multiple funding streams and source referrals for Transitional Rent. The flex pool Operator, will act as the fiscal intermediary for rental subsidies, identify a portfolio of housing units, and connect eligible members to housing.

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b) For members authorized for Transitional Rent, if not already linked with ECM, a referral will be made, and ECM will authorize and provide outreach within 14 days.
c) If the contracted provider elects to adopt Streamlined Provisional Authorizations, the Alliance will ensure that it adheres to the requirements outlined in the Community Supports Policy Guide Volume 2.
d) For members authorized for Transitional Rent, they will be authorized for Housing Trio Services (Housing Navigation, Housing Tenancy, and Housing Deposits), as appropriate. Transitional Rent requests should also include a request to authorize members for Housing Trio services if not already authorized. Through the Alliance's participation in the Alameda County Flexible Housing Subsidy Pool, the Lead Entity will be responsible for connecting the member to a Housing Trio service provider before or at the time of the Transitional Rent request. The Alliance will first ensure that the member is not already connected to Housing Trio Services before processing an authorization.
e) Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

a) When the Alliance receives a request for Transitional Rent, they will review the documentation submitted by the provider. This will include the following:
   - Request for Transitional Rent by the contracted provider
   - Attestation for social and clinical risk factor requirements **and** transitioning population requirements, or experiencing unsheltered homelessness, or eligible for full-service partnership
   - Attestation that member meets the population of focus as determined by AAH
   - Meet DHCS eligibility criteria
   - Individualized housing support plan is developed by either the housing navigator or flex pool case worker in collaboration with the member. The Alliance will utilize a standardized housing support plan for providers that captures all DHCS required elements.
b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Closed Loop Referral

a) All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

V. Data Sharing

a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing

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authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

b) AAH and CS Provider accesses available data exchange platform(s) when possible.
c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.
d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions and Limitations

a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.
b) **Once per demonstration period:** Transitional Rent is available once per demonstration period per household.
c) Individuals must have a housing support plan.
d) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
e) A member cannot exceed the six-month global cap on Room and Board services within a rolling 12-month period. Prior to authorizing a member for Transitional Rent, the Alliance will review all other authorizations on file to ensure the member does not exceed the global cap on coverage of Room and Board services, including prior Transitional Rent, Short-Term Post-Hospitalization Housing, and Recuperative Care authorizations.
f) Rental assistance payments may not exceed amounts set by DHCS in a schedule of reimbursable ceilings.
g) Rental assistance payments must cover the full cost of rent or housing.

VII. Discontinuing of Services

a) Discontinuing of CS services will be based on:
    - Members discontinue receipt of Transitional Rent after a period of less than six months (e.g., returning to unsheltered homelessness, moving into HUD-assisted housing, reunited with family, etc.)
    - Unable to maintain contact with members
    - Termination of coverage
    - No longer meets criteria (for six months from the date of authorization, the Member may use the Transitional Rent benefit without a redetermination of eligibility for the Transitioning Population requirement)
    - Member declines services
    - Death of member

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VIII. Licensing / Allowable Providers

a) AAH CS Providers must have experience and expertise with providing these unique services.

b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

c) AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports
AC Health	Alameda County Health
AAH	Alameda Alliance for Health

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Cultural and Linguistic Services

RELATED POLICIES AND PROCEDURES

CLS-009 CLS Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Housing Transitional Rent Community Supports Standard Operating Procedures

REVISION HISTORY

xx/xx/xxxx

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

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POLICY AND PROCEDURE

Policy Number	CS-014
Policy Name	Non-Housing Community Supports Criteria
Department Name	Community Supports
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	D-SNP, MCAL~~, D-SNP~~
Effective Date	12/01/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~TBD

POLICY STATEMENT

This policy outlines the criteria that Alameda Alliance has established for Community Supports along with the DHCS Medi-Cal Community Supports (CS) or In Lieu of Services (ILOS), Policy Guide (~~July 2023~~April 2025).

PROCEDURE

The following will outline the criteria in relation to each Non-Housing Community support the Alliance offers:

Asthma Remediation
Medically Tailored Meals/Medically Supportive Food
Recuperative Care (Medical Respite)
Community/Home Transition Services~~/Nursing Facility Transition to a Home~~
Personal Care & Homemaker Services
~~Nursing Facility Transition/Diversion to Assisted Living Facility~~Assisted Living Facility Transition Services
Respite Services
Environmental Accessibility Adaptations

I. Asthma Remediation:

- **Criteria:**
  - ~~o~~ Current licensed treating health care provider's order specifying the requested remediations/Enrollment in the Asthma Preventative Services (APS) program
  - o Member has completed in-home environmental trigger assessment within last 12 months that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the member
  - ~~o A brief written evaluation specific to the members triggers and proposed remediation for the members health and welfare~~
  - o ~~Documentation of the members in person home visit/evaluation~~
  - ~~o Supporting documentation for the planned modifications~~
  - o Member has not already used the $7500.00/lifetime max
- **Documentation Requested:**
  - o CS Request Form
  - ~~o~~ Documentation of completed in-home environmental trigger assessment within past 12 months that identifies medically appropriate Asthma Remediations and specifies how the interventions meet the needs of the member ~~Current licensed treating health care provider's order specifying the requested remediations~~
  - ~~o Supporting Clinical~~

II. Medically Tailored Meals (MTM)

- **Criteria:**
  - o Individuals with ~~diet~~ nutrition sensitive ~~and evidence-based, poorly controlled chronic~~ conditions~~,~~ ~~, needing acute stabilization,~~ as part of a clinical care plan such as, but not limited to:
    1. Cancer
    2. Cardiovascular disorders such as:
    3. Hypertension: Adults: ≥130/80; Pediatric: >95th percentile or >130/80)
    4. Adult Hyperlipidemia: Total Cholesterol ≥200, LDL≥130, HDL < 40, non-HDL ≥130, OR TG ≥150;
    5. Pediatric Hyperlipidemia: Total Cholesterol ≥200, LDL≥130, HDL <40, non-HDL ≥145, TG ≥100 for <10yrs or TG ≥130 for children >10yrs
    6. Chronic/End-Stage Kidney Disease (defined as GFR < 60)
    7. COPD
    8. Asthma and enrolled in APS
    9. Congestive heart failure
    10. Diabetes (Hgb A1c ≥ 6.5)
    11. Elevated Lead Levels: ≥ 3.5µg/dL
    12. Human immunodeficiency virus (HIV)/AIDS
    13. Liver Disease (elevated liver enzymes)
    14. Fatty Liver-confirmed by biopsy or imaging
    15. Malnutrition: Adults: BMI < 18.5 kgm2 for adults BMI <5th% for peds

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16. Adult Obesity (defined as BMI >30.0kg/m2)
17. Pediatric (<18) Obesity (BMI >30 OR BMI ≥ 95%ile
18. Stroke
19. GI conditions that are nutritionally sensitive (ie: IBS)
20. Gestational diabetes as confirmed by labs
21. High risk perinatal nutrition sensitive conditions
22. Disabling mental/behavioral health disorders (Serious Mental Disorder as defined by California Welfare & Institutions Code (WIC) 5600.3).

~~1. Diabetes (Hgb A1c > or = 7),~~
~~2. Hypertension (1 medication, > 140/90),~~
~~3. Hyperlipidemia (lipid panel with a low-density lipoprotein (LDL) - >/= 190 mg/dl AND triglycerides (TG) - >500mg/dl),~~
~~4. Congestive heart failure,~~
~~5. Human immunodeficiency virus (HIV)/AIDS with significant weight loss (10% or more weight loss),~~
~~6. Cancer with significant weight loss (more than 5% of one's body weight within 6 months),~~
~~7. Malnutrition (defined as BMI < 18.5 kgm2 and/or unintentional weight loss of over 10%~~
~~8. Adult Obesity (defined as BMI >40.0kg/m2 and two of the three qualifying comorbidities DM, CHF and HLD or BMI >50.0kg/m2Exception: BMI >30.0kg/m2 on a documented MD supervised weight loss plan or prescribed weight loss medication AND a scheduled follow up in 6 months or less),~~
~~9. Peds (<18) Obesity (BMI >30 OR BMI at or above 95%ile AND scheduled follow up in 6 months or less)~~
~~10. Gestational diabetes, or other high risk perinatal conditions,~~
~~11. Disabling mental/behavioral health disorders (Serious Mental Disorder as defined by California Welfare & Institutions Code (WIC) 5600.3).~~
~~12. Chronic Kidney Disease (defined as CKD stage IV or V (GFR <30) or on dialysis)~~
~~13. Conditions not enumerated here will be approved if there is evidence-based published scientific literature demonstrating the condition is a diet-sensitive chronic disease. This must be supported by clinical documentation, OR~~

- ~~Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement. This must be supported by clinical documentation, OR~~
- ~~Individuals with extensive care coordination needs defined as being eligible for enhanced care management or AAH complex case management. This must be supported by appropriate documentation (proof enrollment in program.).~~

- **Documentation Requested:**
  - CS Request Form
  - Diagnosis that meets criteria

- Clinical care plan that supports diagnosis for the service ~~or medical need for the food~~ (dated with in 30D of request date and labs within 6 months of request date)
- Documentation submitted should be from member's primary care provider or specialist referring to Medically Tailored Meals/Medically Supportive Food provider.
- ~~Medical necessity documentation can be provided by a patient's primary care provider or specialist.~~
- Extensions must show adherence to provider visits, medications, laboratory testing, and/or other parts of the ~~treatment~~ clinical care plan.
- Extensions must provide service dates of previous authorization and requested dates for extension, so there is no overlap in dates.
- ~~If approved longer than 4 months, the individual's CalFresh must be leveraged as part of supporting the ongoing benefit as to meet DHCS's stated position that this program is not intended to solve food insecurity or supplant the CalFresh program.~~

III. Recuperative Care (Medical Respite):

- **Criteria:**
  - Homeless or at risk of homelessness (HUD's definitions **with three modifications** as detailed in Policy Guide volume 2, Appendix C, page 113)
  - Individuals needing recovery to heal from an injury or illness
  - ~~Homeless or risk to becoming homeless (HUD def); or~~
  - ~~Individuals who have housing that would jeopardize their health and safety without modification~~
  - ~~Documentation of need to heal from an acute exacerbation of a chronic condition, short-term injury or illness~~
  - ~~Documentation of medical/behavioral health needs~~
  - ~~Plan for discharge after 90D term~~
- **Documentation Requested:**
  - CS Request Form
  - Documentation of Homelessness (HUD def)
  - Documentation of where the member is currently at (i.e.: acute hospital, SNF, home, etc.)
  - Clinical Documentation from the provider (at the Network Provider level) referring to Medical Respite indicating the need to recover and/or heal from an injury or illness, and the medical needs are significant enough to result in ED visits, hospital admissions, or other institutional care.~~to support need~~
  - Retroactive requests and extension requests should include the most updated Medical Respite individualized Care plan including updates on progress towards initial goals, updated clinical documentation, documentation of ECM referral, and transition/discharge plan.

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IV. Community/Home Transition Services~~/Nursing Facility Transition to a Home~~

- **Criteria:**

- Member is currently receiving medically necessary nursing facility Level of Care (LOC) services per Section 51124 of Title 22 of the California Code of Regulations and
- ~~Resided~~ Have lived 60+ days in a nursing home and/or Recuperative Care setting ~~in a nursing facility for 60+ days~~
- ~~Willing~~ Member is interested in moving back to the community, and ~~and able to reside in an assisting living facility~~
- Member can reside safely in the community with appropriate and cost-effective supports and services, and
- Member is not currently receiving other waiver services (HCBA, CCT, MSSP)
- ~~Documentation of waiver application~~
- ~~Documentation of the members current need to determine they can safely live in the community~~
- ~~Documentation of efforts if an extension is needed.~~

- **Documentation Needed:**
  - CS Request Form~~Documentation~~
  - Documentation of the needs that meet a nursing facility admission (functional assessment)
  - Documentation of HCBA waiver, CCT program, and/or MSSP application if eligible
  - Documentation that the member wants to remain in the community
  - Documentation of the members' current needs and plan for addressing needs to determine if they can safely live in the community
  - Documentation of efforts to get the modification completed in the timeframe, if an extension is needed.
  - ~~of where the member is currently at (i.e.: acute hospital, SNF, home, etc.)~~
  - ~~Clinical information to support need to be in current setting~~
  - ~~Documentation that waiver was submitted~~

V. Personal Care & Homemaker Services

- **Criteria:**
  - Members at risk for hospitalization or institutionalization in a nursing facility OR
  - Members with functional deficits and no other adequate support system OR
  - Members approved for IHSS or for Members that are classified as ineligible https://www.cdss.ca.gov/in-home-supportive-services
  - Verification members are not enrolled in Waiver Personal Care Services through HCBA waiver
  - ~~IHSS status~~
  - ~~Current IHSS hours (if reassessment)~~
  - ~~Change in condition (if reassessment)~~
  - ~~Member is >18 yrs or emancipated minor~~
  - ~~Members not eligible for IHSS, but to prevent a short term skilled SNF stay (60D)~~
  - ~~Hours being requested plus IHSS do not exceed 24H/day~~

- ~~Hours being requested~~
- ~~Documentation on why these additional hours are needed~~

- **Documentation Needed:**
  - CS Request Form
  - Clinical documentation of member's functional and/or cognitive assessment and social support system
    For example:
    - PT/OT notes
    - Completed SOC873 and 50/257
    - Completion of standardized cognitive assessment (mini-cog, MOCA, MMSE)
  - IHSS Status including application date for initial authorization or IHSS reassessment date for changes in condition or documentation of ineligibility
  - Current IHSS Hours being provided and delineation of number of hours for:
    - Personal Care
    - Homemaker
  - ~~~~
  - ~~Completed Assessment~~

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VI. ~~Nursing Facility Transition/Diversion to~~ Assisted Living Facility Transition

- **Criteria:**
  - Member resided in a nursing facility for 60+ days OR currently living in the community, AND
  - Member is willing and able to reside safely in an assisted living facility, and
  - If member is currently living in the community, must meet minimum criteria for NF services per Section 51124 of Title 22 of the California Code of Regulations
  - For Wrap Around Services, must be residing in an ALF and need assistance with services listed in CS Policy Guide, Volume 1, April 2025, page 14
  - ~~Documentation that member wishes to remain in the community~~
  - ~~Documentation of the needs that meet a nursing facility admission~~
  - ~~Documentation of waiver application~~
  - ~~Documentation of the members current need to determine they can safely live in the community~~
  - ~~Documentation of efforts if an extension is needed.~~
- **Documentation Needed:**
  - CS Request Form
  - Documentation of where the member is currently at (ie: acute hospital, SNF, home, assisted living/RCFE, etc)
  - Clinical documentation of member's current functional status
  - Documentation indicating member is willing, able, and safe to reside in assisted living
  - Documentation that ALW and other applicable waiver programs (ie: CCT) was submitted
  - Extension requests must include progress report of efforts towards goals.

- Requests for Wrap Around Services must include the above documentation and:
  - Enrollment and engagement in ECM
  - Statement from the ALF attesting they have 24-hour staff onsite to meet unpredictable needs of members, the ADL and IADL services provided by the ALF, and on-site therapeutic and social programming
- ~~Documentation of the needs that meet a nursing facility admission~~
- ~~Documentation of waiver application~~
- ~~Documentation that the member wants to remain in the community~~
- ~~Documentation of the members current need to determine they can safely live in the community~~
- ~~Documentation of efforts if an extension is needed.~~

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VII. Respite Services

- **Criteria:**
  - Member is residing in the community, and
  - Member requires intermittent temporary supervision, and
  - Member is dependent on others for ADLs, and
  - The relief is needed to avoid institutional placement
  - The relief is needed on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them (primary caregiver)
  - Request is non-medical in nature
  - Request is for a limited timeframe
  - Service hours, in combination with any other direct care services, not to exceed 24 hours per day or 336 hours in total per calendar year
  - ~~Clinical to support the individual is dependent on others for ADLs due to a medical condition (ADLs assistance that is age appropriate)~~
  - ~~Documentation that the relief is needed to avoid institutional placement~~
  - ~~Request is for a limited timeframe~~
  - ~~Name of the Caregiver that can provide the needed care~~
  - ~~Based on hours requested, not to exceed 6 months or 336 hours~~
- **Documentation Needed:**
  - CS Request Form
  - Clinical Information to support needs, and need for service to avoid institutional placement
  - Member or member's representative must indicate name of the Caregiver (not the primary caregiver) who will provide the needed care

VIII. Environmental Accessibility Adaptations

- **Criteria:**
  - Member as risk for nursing facility admission per Section 51124 of Title 22 of the California Code of Regulations
  - This equipment is needed directly for the member to keep the member in their home ~~to keep the member in their home~~

- This or similar equipment is not covered under DME
- Not to exceed $7500.00 (unless member moves or condition drastically changes)

- **Documentation Needed:**
  - CS Request Form
  - Home modifications needed
  - ~~Written~~ For a home not owned by the Member, written consent from the home/property owner for physical adaptations or equipment installed in the home ~~consent from the member/ homeowner for~~
  - ~~Provider~~ Documentation from the provider of the equipment or service, with brief written evaluation describing how and why the equipment/service meets the medical needs of the member, including supporting documentation describing efficacy of equipment where appropriate ~~documentation for the reason for the modification and how it will assist the member~~
  - ~~Provider~~ Order from Member's current PCP or other health professional specifying the requested equipment/service ~~order for the equipment/ service~~
  - PT or OT eval supporting the need, how it will benefit the member, that this will prevent installation, similar equipment that have failed
  - ~~Itemized i~~Minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties. If 2 bids cannot be obtained, explain why. ~~nvoice of the needed modifications (from 2 providers if possible)~~
  - ~~o~~ Documentation of a home visit conducted to determine the suitability of any requested equipment or service~~to establish the home can support the equipment~~
  - Proof that the member/homeowner has been informed that the modifications are permanent

DEFINITIONS / ACRONYMS

- Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.
- Community Supports (CS) are substitute services or settings to those required under the California State Plan that <CPs may select and offer to their Members pursuant to 42 CFR section 438.3 (e) (2) when pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan.
- Durable Medical Equipment (DME) is equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Skilled Nursing Facility (SNF)

AFFECTED DEPARTMENTS/PARTIES

- Community Supports

RELATED POLICIES AND PROCEDURES

- CS-001 Community Supports-Oversight, Monitoring & Controls
- CS-002 Community Supports-Housing Transition Navigation Services
- CS-003 Community Supports-Housing Deposits
- CS-004 Community Supports-Housing Tenancy and Sustaining Services
- CS-005 Community Supports-Asthma Remediation
- CS-006 Community Supports-Recuperative Care (Medical Respite)
- CS-007 Community Supports-Medically Supportive Food/Meals/Medically Tailored Meals
- CS-008 Community Supports-Respite Services
- CS-009 Community Supports-Personal Care and Homemaker Services
- CS-010 Community Supports-Environmental Accessibility Adaptations (Home Modifications)
- CS-011 Community Supports-Nursing Facility Diversion
- CS-012 Community Supports-Transition Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- None

REVISION HISTORY

New Policy 4/16/2025

REFERENCES

DHCS Medi-Cal Community Supports or In Lieu of Services (ILOS), Policy Guide (~~July 2023~~April 2025 Volumes 1 and 2)

HUD definition of homelessness Title 24 Section 91.5 of the Code of Federal Regulations

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.

POLICY AND PROCEDURE

Policy Number	UM-000-NEW
Policy Name	Case Rounds/Team Review Policy
Department Name	~~Health Care Servies~~ Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	~~Senior~~ Director, Utilization Management ~~Health Care Services~~
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	TBD
Subcommittee Name	~~UMC~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight ~~, =]u5j'[pn~~ Committee Approval Date	

POLICY STATEMENT

Alameda Alliance for Health ~~-~~and Alameda Alliance Wellness (the Alliance) shall conduct Utilization Management Care Rounds to ensure appropriate, cost-effective, and medically necessary care for D-SNP ~~enrollees~~Members. This policy governs interdisciplinary team reviews focused on utilization management, including prior authorization denials, hospital length of stay (LOS), high-dollar cases, and compliance with medical necessity criteria. The policy aligns with the California Advancing and Innovating Medi-Cal (CalAIM) initiative, Centers for Medicare & Medicaid Services (CMS) D-SNP requirements, Department of Health Care Services (DHCS) mandates, and Applicable Integrated Plan (AIP) unified appeals and grievance processes.

This policy applies to all Alliance ~~D-SNP~~ staff, contracted providers, and Independent Practice Associations (IPAs) involved in utilization management for D-SNP members. It governs UM Case Rounds for reviewing prior authorization denials, extended hospital or skilled nursing facility length of stay, high-dollar cases (e.g., high-cost procedures or medications), and other utilization-related issues to ensure compliance with Medicare and Medi-Cal coverage criteria. The policy ensures integration with Medi-Cal services, alignment with CalAIM, DHCS, and CMS requirements.

PROCEDURE

1. Case Identification and Prioritization

Commented [HC1]: If this policy is for both D-SNP and MCAL IHSS, do we need to say Alameda Alliance for Health, or Alameda Alliance Wellness, what is our standard approach/language for these policies that cover both?

Commented [MT2R1]: Edited.

1.1. Criteria: Cases for review may be~~are~~ identified based on:

1.1.1. Prior authorization denials requiring clinical review.

1.1.2. Extended hospital or skilled nursing facility length of stay (LOS) exceeding expected benchmarks (e.g., MCG)

~~1.1.3. High-dollar cases, including procedures or medications exceeding $50,000 per episode or annually.~~

~~1.1.4.~~1.1.3. High-utilization patterns flagged via claims data (e.g., frequent ED visits, readmissions).

~~1.1.5.~~1.1.4. Referrals from providers, care managers, care coordinators, or the plan for utilization management~~UM~~, discharge planning, or other care coordination concerns

1.2. Process:

1.2.1. UM staff analyze utilization and claims data daily to identify cases.

1.2.2. CM staff may review available assessments, including Health Risk Assessments (HRA) ~~are reviewed within 30 days of enrollment~~ completed within the last 6 months, ~~will be reviewed~~ to identify potential ~~high cost~~ needs.

2. Team Composition

2.1. Interdisciplinary UM Team:

2.1.1. UM nurse~~/case manager~~

2.1.2. UM Leadership (Director, Manager, Supervisor as assigned)

2.1.3. CM nurse

2.1.4. CM Leadership (Director, Manager, Supervisor as assigned)

2.1.5. Long-Term Services and Supports Manager

~~2.1.1.~~2.1.6. Behavioral Health Manager

~~2.1.2.~~2.1.7. Medical Director or Physician Reviewer (for clinical oversight).

~~2.1.3.~~2.1.8. Primary Care Provider or specialist (as needed).

~~2.1.4.~~2.1.9. Pharmacist (for high-cost medication reviews).

~~2.1.5.~~2.1.10. Training: Annual training on CalAIM UM requirements, D-SNP coverage policies, and AIP appeals processes.

3. Frequency and Format

3.1. Frequency:

3.1.1. High priority cases (e.g., ~~denials under appeals~~, LOS >7 days, cases >$100,000)

3.1.1.1. Weekly interdisciplinary team reviews for comprehensive oversight.

3.1.1.2. Daily or every 2-3 day check-ins by UM nurse for expedited appeals or LOS >7 days, with escalation to full team if changes occur.

3.1.1.3. Twice-weekly reviews for high-dollar cases >$100,000 with dynamic cost increases (e.g., ICU stays, ongoing biologics)

3.1.2 Moderate-priority cases (e.g., LOS 4-7 days, cases $50,000-$100,000)

3.1.2.1 Weekly interdisciplinary team reviews for LOS (4-7 days), with UM nurse check-ins every 5 days to monitor progress.

3.1.2.2 Biweekly reviews for high dollar cases ($50,000-$100,000), with ad-hoc reviews every 5-7 days for cases with escalating cost

3.1.3 Routine UM reviews: Monthly interdisciplinary team reviews, with ad-hoc reviews within 5-7 days for cases flagged for significant changes.

3.2 Format:

3.2.2 Virtual or in-person meetings, ensuring accessibility.

3.2.3 Documented in the ~~Electronic Health Record~~Clinical Information System ~~3.2.3~~

Commented [HC3]: Current practice: Internal interdisciplinary case rounds are conducted on ELOS >10 day LOS Acute/LTACH include representatives from IP UM, CM, Pharmacy, BH etc. External rounds are held with several contracted acute hospitals and LTACHs to discuss all members (no limitation on LOS)

Commented [MW4]: Should discuss the threshold here based on current claims data or what is already considered high-dollar

Commented [HC5R4]: From a UM perspective per current process above we identify cases based on LOS (rather than $ amounts)

Commented [AL6]: This is also CM function, so I've added @Hunter, Lily here for line of sight.

@HealyLondon, Carla - please confirm: is the intent to have UM staff review the HRA responses to prep for rounds, or to have CM staff come to rounds prepared to contribute based on members' HRA?

Commented [HL7R6]: Is this a requirement? that it needs to be reviewed by UM within 30 days of enrollment? What happens if there is no HRA on file?

Commented [HC8R6]: @Lam, Allison @Hunter, Lily both UM and CM staff will need to be present in these rounds so I would expect CM to speak to HRAs while UM speaks to UM and both speak to care coordination needs

Commented [HL9R6]: We need to have a realistic approach to this. Not everyone will have a completed HRA, and the current requirement is to complete the HRA within 90 days of enrollment. There is a very big chance that nothing will be present to be reviewed in 30 days of enrollment. Can this be changed to state: If Health Risk Assessments (HRA) are completed in the past 6 months, the HRA will be reviewed to identify potential high cost needs.

Commented [WM10R6]: @Hunter, Lily yes, oversight on the 30 days. It is 90 days. We can update this. edit complete

Commented [HC11R6]: As written in the MOC (p.145), the Inpatient Review Nurse (IP UM RN) and the Care Manager (CM Nurse)participate in the development of the Individualized Care Plan and Transfer and Transition Process. To the degree or extent that ICT are discussed in these rounds, @Hunter, Lily confirming that CM will have representation in these rounds. (recognizing there will be separate IDT rounds)

Commented [AL12R6]: Good discussion team; language in P&P has been edited. Resolving comment.

Commented [AL13]: Do we need to include CM, LTSS, or BH representation?

Commented [WM14R13]: I think we should add them to ensure care coordination. Added bullets to cover these parties participation as well @Lam, Allison

Commented [MT15]: QIO process

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~~3.2.4 Members or representatives may participate for denial appeals upon request.~~

4. ~~UM~~ Case Review Process
   4.1. Preparation: UM/CM Nurse ~~complies~~compiles case data, including HRA, claims, and clinical records~~., or denial rationales.~~
   4.2. Review Focus may include:
      4.2.1. Denials: Evaluate prior authorization denials against medical necessity criteria, assess appeal eligibility under AIP processes.
      4.2.2. Length of Stay: Review hospital/skilled nursing facility LOS for appropriateness; develop discharge or transition plans if extended.
      4.2.3. High~~-~~Dollar Cases: Assess clinical appropriateness ~~cost-effectiveness or~~of procedures/medications (e.g., biologics, gene therapies); explore ~~lower cost~~cost-effective alternatives where appropriate.
      4.2.4. Utilization Patterns: Identify overutilization (e.g., readmissions, ED visits) and recommend interventions (e.g., care coordination, telehealth).
      4.2.5. Engage~~sure~~ case management ~~is engaged~~ with high/moderate priority cases for help with discharge planning and post-discharge follow-ups.
   4.3. Decision-Making:
      4.3.1. Update clinical information system, including ~~UM~~ care plan, with actionable steps (e.g., approve/deny service, adjust LOS, refer to case ~~-~~management or other resources ~~if not already established~~)
      4.3.2. Assign follow-up tasks to team members.
   ~~4.4. Appeals/Grievances: Document denial appeals per AIP unified processes; notify members of outcomes.~~
   ~~4.5.~~4.4. Documentation: Record decisions, rationales, and follow-ups in ~~EHR~~the clinical information system; send communications to~~te with~~ members in preferred language, where applicable.

5. Follow-Up
   5.1. UM Nurse Responsibilities:
      5.1.1. Monitor implementation of UM decisions (e.g., service approvals, discharge plans).
      ~~5.1.1.~~5.1.2. Provider outreach, where appropriate
      5.1.3. Track high-dollar case costs and LOS trends.
   5.2. CM Responsibilities
      5.2.1. Member and provider outreach, where appropriate, to implement recommendations from case rounds
      ~~5.1.2.~~5.2.2. Updates to ICP, where appropriate, and notify member and ICT of updates to care plan
   ~~5.2.~~5.3. Quality Metrics may include, but are not limited to:~~s:~~
      ~~5.2.1.~~5.3.1. Denial overturn rate on appeal ~~(<10% target).~~
      ~~5.2.2.~~5.3.2. Average hospital LOS ~~is aligned with benchmarks.~~
      ~~5.2.3. High-dollar case cost reduction (e.g., 5% savings via alternatives)~~
      ~~5.2.4.~~5.3.3. Reduction in preventable readmissions/ED visits.

DEFINITIONS

- UM: Utilization Management, processes to ensure appropriate and cost-effective healthcare services.

Commented [HC16]: UM Nurse is responsible for preparing case for MD review. UM MD is responsible for denial rationale based on their independent review. (It is not within nurse scope to deny-this is UM MD scope and responsbility)

Commented [MT17R16]: edited

- HRA: Health Risk Assessment, a tool to identify medical, behavioral, and social needs.
- AIP: Applicable Integrated Plan, a D-SNP with unified Medicare and Medicaid appeals/grievance processes.
- LOS: Length of Stay, duration of hospital or skilled nursing facility admission.

AFFECTED DEPARTMENTS/PARTIES

- D-SNP Leadership: Oversees policy implementation, resource allocation, and UM compliance.
- Utilization Management Team: Conducts case reviews and monitors outcomes.
- Medical Directors/Physicians: Provide clinical oversight for denials and high-dollar cases.
- Contracted Providers/IPAs: Participate in reviews and implement UM decisions.
- Member Services: Communicates outcomes and supports appeals/grievances.
- Quality Improvement Team: Tracks metrics and ensures compliance.
- Members: Engage in appeals or UM discussions as needed.

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

TBD

REFERENCES

- CMS D-SNP Integration Requirements (CY 2025).
- DHCS CalAIM Policy Guide, UM and ECM Integration.
- California DHCS Strategic Plan 2023–2027.
- Provider Operations Manual, Alameda Alliance for Health.
- CMS State Medicaid Agency Contracts (SMAC) for CY 2026.
- Medicare Milliman Care Guidelines (MCG) for LOS Benchmarks.

MONITORING

- Oversight: UM leadership conducts quarterly audits to verify policy adherence.
- Reporting: Submit quarterly UM reports to DHCS and CMS on denial rates, LOS trends, high-dollar case cost, and compliance.
- Provider Compliance: IPAs and providers submit UM documentation per Provider Operations Manual.
- Member Feedback: Collect appeal satisfaction scores and resolve grievances via AIP processes.
- Corrective Actions: Address non-compliance through retraining, process revisions, or escalation to D-SNP leadership.

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POLICY AND PROCEDURE

Policy Number	UM-NEW
Policy Name	Integrated Organization Determinations
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	01/01/2026
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

Alameda Alliance Wellness is committed to delivering integrated organization determinations for D-SNP members through a standardized, timely, and equitable process that ensures a single, coordinated authorization decision and unified member notification for all Medicare and Medi-Cal benefits. This policy complies with CMS and DHCS integrated care requirements.

This policy applies to all D-SNP members, their authorized representatives, and providers acting on their behalf. It covers integrated organizational determinations for all covered services, including Medicare Parts A, B, D, and Medi-Cal benefits.

PROCEDURE

1. Intake and Identification
   - 1.1. Requests for integrated organization determinations may be submitted orally or in writing by members, their representative, or provider.
   - 1.2. All prior authorization and service requests are screened to confirm eligibility.
   - 1.3. Requests are routed through the clinical management system to the designated UM Coordinator.
2. Integrated Review Process
   - 2.1. A single review is conducted by a UM nurse and/or medical director trained in both Medicare and Medi-Cal benefits to issue one determination covering all applicable benefits.
   - 2.2. Coverage evaluated as follows:

2.2.1. Medicare Services: Apply Medicare Criteria (e.g., NCD, LCD, MCG)
2.2.2. Medi-Cal Services: Apply Medi-Cal guidelines (e.g., APLs, provider bulletins)

2.3. The rationale for both Medicare and Medi-Cal components is documented in a single determination record in the clinical management system.

3. Timeframe Requirements

3.1. Timeframes align with the most stringent Medicare and Medi-Cal requirements. Refer to UM-051, Timeliness of UM Decision Making and Notification.

4. Unified Notification

4.1. A single integrated ~~Notice of Action (NOA)~~Coverage Decision Letter (CDL) is issued, including:

4.1.1. Decision outcome and rationale for all applicable benefits.
4.1.2. Benefit authority (Medicare, Medi-Cal, or both).
4.1.3. Appeal and grievance rights, including timeframes and procedures.
4.1.4. Compliance with CMS model notices and California language access requirements.

4.2. For expedited request denials, prompt oral notification is provided when feasible, followed by written notification within 3 calendar days.

5. Documentation and Systems

5.1. All decisions, communications, and notices are recorded in the clinical management system and maintained for audit purposes.

5.2. Data is securely shared with care coordinators and delegated partners to ensure seamless service delivery.

6. Oversight and Quality Assurance

6.1. Monthly audits verify compliance, including:

6.1.1. Timeliness of decisions and notifications
6.1.2. Correct application of Medicare and Medi-Cal criteria.
6.1.3. Accuracy and completeness of unified notices.

6.2. Annual training ensures staff are proficient in federal and state requirements.

DEFINITIONS

- Organization Determination: A decision by the plan regarding coverage of requested services or items.
- Integrated Determination: A single review process evaluating both Medicare and Medi-Cal criteria, resulting in one unified authorization decision and notification.

AFFECTED DEPARTMENTS/PARTIES

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

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REVISION HISTORY

REFERENCES

- 42 CFR §§ 422.568, 422.570, 422.572, 422.631 (Integrated Organization Determinations and Timeframes)
- 42 CFR § 422.562 (Unified Grievance and Appeals Process for D-SNPs)
- California DHCS D-SNP Policy Guide
- DHCS-MMCD Policy Letter 22-001 (Unified Processes for D-SNPs)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	XXX
Policy Name	QIO Fast-Track Appeals for Medicare-Covered Services
Department Name	Health Care Services/Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	~~Senior Director of Health Care Services~~Director, Utilization Management
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

Alameda Alliance Wellness shall comply with CMS regulations regarding Fast-Track Appeals through the Quality Improvement Organization (QIO), Livanta, when Medicare-covered services in the applicable settings (skilled nursing facility, home health, hospice, or comprehensive outpatient rehab) are being terminated. The D-SNP plan of Alameda Alliance will ensure timely issuance of the Notice of Medicare Non-Coverage (NOMNC) and coordination with the QIO when a member requests an expedited review.

PROCEDURE

Step 1: Provider Notification of Service Termination

- The rendering provider must notify The Alliance at least 2 calendar days prior to planned termination.
- The Alliance will either confirm medical necessity and authorize or deny continued coverage.

Step 2: Issuing the NOMNC

- The rendering provider will deliver the NOMNC at least 2 calendar days before services are scheduled to end.
- Member or the member's AOR must sign and date the notice.
- A copy of the signed NOMNC is submitted by fax from the rendering provider to the Alliance and ~~a~~ is retained in the utilization management system.

Commented [MW1]: Can receive NOMNC on admission- do we want to add something in here that goes over this process in more detail?

In some cases, permitting flexibility in the timing of notice delivery may result in an early, and possibly premature, enrollee request for a QIO review. In these situations, the QIO must immediately notify the Medicare health plan of the appeal request, but all parties will need to exercise judgment in determining when it makes sense for the Medicare health plan and/or provider to furnish any needed medical records or other documentation to the QIO. Although a Medicare health plan should provide the enrollee (and the QIO) with a detailed notice as soon as it learns of the appeal request, it may be appropriate to delay providing the enrollee's medical records until shortly before the planned coverage termination, when the record is presumably complete enough to permit an informed QIO determination. Nevertheless, the overall deadline for record provision remains close of business of the day before the planned termination.

Commented [AL2R1]: I believe it's better to deliver the NOMNC to the member no sooner than 2 calendar days before services are scheduled to end (as opposed to on admission). @HealyLondon, Carla @Findlater, Michelle - your thoughts?

Commented [HC3R1]: @Lam, Allison I concur-better to deliver letter no sooner than 2 calendar days before services scheduled to end.

Commented [HC4R1]: @Findlater, Michelle do you agree?

Step 3: Member Requests QIO Review

- If the member disagrees with the termination and wishes to obtain an independent appeal, they must contact the QIO by noon the day before the service ends for a fast-track appeal.
- The QIO contact information is listed on the NOMNC.

Step 4: Responding to QIO Review Request

- If the QIO receives an appeal the QIO will notify the Alliance of the request and the Alliance will:
    - Directly or by delegation, deliver a detailed notice to the member as soon as possible, but no later than noon of the day after the QIO's notification. The detailed notice will include the following information:
        - A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered.
        - A description of any applicable Medicare coverage rule, instruction, or other Medicare policy including information about how the enrollee may obtain a copy of the Medicare policy from the MA organization.
        - Any applicable MA organization policy, contract provision, or rationale upon which the discharge determination was based.
        - Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.

Step 5: Coverage During QIO Review

- The Alliance will continue coverage of services until:
    - Noon of the calendar day after the QIO notifies the member of its decision (if the decision is unfavorable), or
    - The QIO decides in favor of continued care.

Step 6: QIO Decision and Next Steps

- If the QIO overturns the termination:
    - The Alliance will authorize continued services immediately.
- If the QIO upholds the termination:
    - The Alliance may end coverage at noon the day after the QIO decision.

DEFINITIONS

- **QIO:** Quality Improvement Organization designated by CMS to review appeals of service terminations.
- **NOMNC:** Notice of Medicare Non-Coverage — notifies the member that a Medicare-covered service is ending.
- **DENC:** Detailed Explanation of Non-Coverage — explains why coverage is ending, issued when a member appeals.
- **Fast-Track Appeal:** An expedited Medicare appeal filed by a member to the QIO to continue services.
- **Applicable Settings:** Skilled nursing facility (SNF), home health agency, hospice, comprehensive outpatient rehab facility (CORF).

AFFECTED DEPARTMENTS/PARTIES

Role	Responsibility
Appeals & Grievances Team	Tracks and responds to QIO decisions
~~Care~~ Utilization Management	Coordinates with facility to ensure ~~Issues~~ NOMNC and DENC has been delivered to the member and coordinates termination
Provider	Notifies plan of intent to discharge or end services
QIO Liaison	Coordinates communication with Livanta

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

TBD

REFERENCES

- CMS Medicare Managed Care Manual, Chapter 13
- CMS 42 CFR §422.620 – Fast-Track Appeals
- Livanta BFCC-QIO guidance: https://www.livantaqio.com

MONITORING

- Appeals and Care Management staff will receive annual training on QIO fast-track appeals.
- Cases will be audited monthly for compliance with CMS timeframes and documentation standards.

Commented [MW5]: Just need to clarify who is responsible for the NOMNC- the CMS guide notes that the provider is responsible but there are changes for delegation to the plan. Do we want to leave it as the provider is responsible with notification? Step 2 notes care manager or provider delivers the NOMNC- I don't love the either or aspect

"The provider is responsible for delivering the NOMNC on behalf of a Medicare health plan no later than 2 days before an enrollee's covered services end; "

Commented [AL6R5]: @Thomsen, Michelle – just confirming we decided to put this responsibility on the hospitals, and include in their contract?

Commented [TM7R5]: Yes NOMNC and DENC - updated policy @Vallejo, Yam can we follow up with PN that this has been added

Commented [HC8R5]: Also, Confirming that this responsibility to issue the NOMNC and DENC will be included in the contract? (to reiterate Allison's question)

Commented [TM9R5]: @HealyLondon, Carla @Lam, Allison Provider network did not want to edit the contracts, so they added it in the provider policy guide

Commented [TM10R5]: @Lam, Allison @HealyLondon, Carla please confirm that you are okay with this approach

Commented [HC11R5]: @Lam, Allison @Thomsen, Michelle My preference would be the provider is responsible for delivering the letter and if we can hold them to this by including in Provider Policy Guide I am ok with this approach.

Commented [HC12R5]: @Findlater, Michelle @Lam, Allison We do need to ensure that our providers are responsible for hand delivering the NOMNC and DENC.

Commented [AL13R5]: Yes, works for me. However, the table says "Case Management" responsibility – should that say Utilization Management" responsibility? @HealyLondon, Carla @Findlater, Michelle

Commented [HC14R5]: @Lam, Allison correct

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POLICY AND PROCEDURE

Policy Number	LTC-001
Policy Name	Long Term Care Program
Department Name	Long Term Care (LTC)
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	D-SNP, MCAL
Effective Date	01/01/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

This policy outlines the process for providing Long Term Care (LTC) services in the following settings:

- LTC Nursing Facilities (NF)-Freestanding and Hospital Based
- Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD)
- Subacute (SA) care facilities
- Pediatric Subacute (PSA) care facilities.

The Alliance shall authorize utilization of LTC facilities and associated services for their members when they are deemed medically necessary.

PROCEDURE

I. Review

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1. When a request is received for Long Term Care, Alliance will review all requests for medical necessity as outlined in the DHCS contract, DHCS Manual of Criteria, Chapter 7, DHCS All Plan Letters (APLs) and the DHCS PHM Policy Guide.
2. The facility shall submit all needed documents to the Alliance LTC Department, which are not limited to:
    - Completed LTC Authorization Request Form (ARF)
    - Copy of denial letter from primary payor (if applicable)
    - MD Order for Level of Care
    - If requesting Continuity of Care (COC)
        - Proof of a previous authorization or
        - Documentation that member was there before they became effective with the Alliance
    - For Nursing facilities:
        - Electronic Preadmission Screening Resident Review (PASRR) Level I Screening documentation of a positive or negative result
            - If the member is positive, a Level 2 screening is needed
        - Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay.
    - For Subacute facilities:
        - 6200 Form
    - For ICF/DD Facilities:
        - HS 231
        - DHCS 6013A
        - IPP/ISP-if available

3. Alliance members will only be placed at LTC facilities that are licensed and certified by the California Department of Public Health, (CDPH.)
    a. Providers are contractually required to meet the Credentialing requirements of AAH, be subject to the Credentialing process and NCQA requirements set forth in the Provider Manual prior to providing any health care services to Members. Only credentialed Providers may provide health care services to Members.
    b. AAH will ensure that if a Member needs adult or pediatric subacute care services, they are placed in a health care facility that is under contract for subacute care with DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

4. The Alliance shall maintain standards for determining levels of care and authorizing services for Medi-Cal services that are consistent with policies established by the Centers for Medicare and Medicaid (CMS) and with the criteria for authorizing Medi-Cal services specified in Title 22, CCR, Section 51003.
    a. Members receiving Hospice services in Long Term Care will not be disenrolled.
    ~~4.~~b. Hospice services provided in a Long Term Care Setting will not require authorizations.

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5. AAH will adhere to the timeliness of authorization requirements applicable to each category of LTSS facilities.

    a. **Urgent** Preservice requests for members transitioning from an acute hospital: 72 hours from request receipt date
    b. **Routine** Preservice requests/Extension Requests prior to expiration of previous authorization: 5 business days, may extend to 14 calendar days in order to obtain needed information for review.
    c. **Retrospective** Requests (after member has been admitted): 30 calendar days

6. The AAH is responsible for ensuring timely access to:
    a. Routine and unusual specialty referral and access
    b. Ancillary services in the LTC setting. The Alliance approves Authorization Requests for covered therapy services when necessary for a LTC Facility resident to attain or maintain the highest practicable physical, mental, or psychosocial functioning in accordance with the comprehensive resident assessment and individualized plan of care.
    c. Covered medically necessary dental services. The Alliance ensures Members residing in the LTC setting receive the covered medically necessary dental services including care coordination as described in LTC Program Description.
    d. Covered medically necessary behavioral health care services. The Alliance ensures Members residing in the LTC setting receive, and the facility must provide, the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
    e. Standing referrals. The Alliance maintains a process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and the Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC).

II. Continuity of Care

For Members already residing in a LTC facility after January 1, 2023, that have transitioned to the Alliance, the Alliance ensures eligible members will have continued residency in the LTC facilities:

1. When medical necessity is met:
    - For up to 12 months for members who are currently residing in a SNF
    - For up to 24 months for ICF/DD facilities
    - For up to 6 months for subacute facilities

    This will be granted without having to be requested by the Member, authorized representative, or Provider in accordance with the

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requirements in APL 23-022, or any superseding APL. Members that transition to the Alliance after 01/01/2024, will need to request continuity of care.

Following their initial 12-month continuity of care period, Members or their authorized representatives may request an additional 12 months of continuity of care pursuant to APL 23-022 Continuity of Care.

Additional procedures implemented are outlined in UM 036-Continuity of Care for Terminated and Non-Participating providers, and UM 059-Continuity of Care for Medi-Cal Beneficiaries Transitioning into Managed Medi-Cal.

2. By recognizing any services treatment authorization requests (TAR) made by DHCS for the member enrolled into the Alliance.

3. For Members residing in ICF/DD or Subacute facilities as of January 1, 2024, the Alliance ensures eligible Members will have continued residency in the facilities, conforming to the Continuity of Care requirements of APL 24-011 for ICF/DD. AAH will ensure that a Member's ICF-DD Home/SA/PSA will not change for at least 12 months while AAH works to bring the ICF-DD Home/SA/PSAs into the network. During this continuity of care period, AAH will automatically provide 12 months of continuity of care, with no need for the Member to request it, but may be granted for up to two years.

4. The Alliance provides continuity of care with an out-of-network or terminated provider, including NF, ICF-DD, and Subacute service providers, for up to 12 months when:
    a. The Alliance can determine that the Member has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider). An existing relationship means the Member has resided in an out-of-network NF/ICF-DD/SA/PSA at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance, unless otherwise specified in DHCS guidance.
    b. The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates; and
    c. The provider meets the Alliance's applicable professional standards and has no disqualifying quality-of-care issues (W&I Code Section 14182.17 and APL 23-022).
    d. If a Member was residing in an out-of-network skilled nursing facility (SNF,) ICF/DD or Subacute facility when the Member transitioned into the Alliance, the Alliance shall offer the Member the opportunity to return to the out-of-network SNF/ICF-DD/Subacute facility after a medically necessary absence, such as a hospital admission. This requirement does not apply if the Member

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is discharged from the SNF/ICF-DD/Subacute facility into the community or a lower level of care.

5. ICF/DD services, continuity of care is automatically applied. Medical necessity is determined by documentation reflecting current care needs and recipient's prognosis by the Regional Center. The HS 231, DHCS 6013 A and Treatment Authorization Request (TAR) form (LTC TAR 20- 1) are considered sufficient information to determine medical necessity; however, if documentation is lacking, the AAH will request additional supporting documents to substantiate medical necessity.

6. AAH allows Members to stay in the same ICF-DD Home/SA/PSA under continuity of care if the Member chooses to continue living in the ICF-DD Home/SA/PSA and all of the following apply:
    - The ICF-DD Home/SA/PSA is licensed by CDPH;
    - SA/PSA facility is contracted or actively in the process of being contracted by DHCS' SCU
    - The ICF-DD Home/SA/PSA is enrolled as a Medi-Cal Provider;
    - AAH will pay the ICF-DD Home/SA/PSA payment rates that meet the state statutory requirements.
    - The ICF-DD Home/SA/PSA meets AAH's applicable professional standards and has no disqualifying quality-of-care issues.

III. Long Term Services and Supports (LTSS) Liaison

AAH has an LTSS liaison for the Long-Term Services and Supports (LTSS) Provider community. The LTSS liaison is not required to be credentialed or licensed but has the ability to support the LTC population's service needs. The Liaison is trained by AAH to identify and understand the full spectrum of Medi-Cal long-term institutional care, including payment and coverage rules. The LTSS liaison serves as a single point of contact for service providers in both a Provider representative role and to support care transitions, as needed. The LTSS liaison assists service providers in addressing claims and payment inquiries in a responsive manner and assists with care transitions among the LTSS Provider community to best support a Member's needs.

AAH has an identified LTSS Liaison and disseminated their contact information to their network providers. AAH will notify network providers of changes to LTSS liaison assignment expeditiously to ensure coordination and services offered to Members.

IV. Regional Center/ICF-DD Roles

Regional Center

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AAH adheres to the requirements of the Lanterman Act, working with the Regional Center of the East Bay (RCEB) to ensure that Members obtain all rights to comprehensive services and supports to enable people to live more independent, productive, and fulfilled lives. Per the Lanterman Act, persons with developmental disability receive available services and supports to approximate the pattern of everyday living available to people without disabilities of the same age. Members, and where appropriate, their parents, legal guardian, or conservator, are empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. In providing these services, Members and their families, when appropriate, participate in decisions affecting their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way in which they spend their time, including education, employment and leisure, the pursuit of their own personal future, and program planning and implementation.

AAH will coordinate and work with Regional Centers in the identification of services that will be provided to the Member by AAH. The goal is to reduce any duplication of effort or work between AAH and Regional Centers, and to ensure AAH is fully aware of the Member's needs and the services to be provided by AAH and Regional Centers. It is the Regional Centers' duty to ensure their members residing in ICF/DD Homes receive all services and supports identified in the IPPs. AAH will inform the Regional Centers of which services will be provided by AAH. The Memorandum of Understanding between RCEB and AAH that includes coordination for Members living in ICF/DD Homes supports this effort.

The Regional Center is the primary Case Manager and Care Coordinator for any member residing in an ICF/DD facility.

1. The Regional Center develops an Individualized Program Plan (IPP) for each individual with intellectual or developmental disabilities, based on the individual's person-centered goals and needs.
    a. The IPP serves as a contract between the Member and identifies all services and supports the Member needs and is entitled to receive and whether the Regional Center will provide, supervise, or pay for the service, or another agency will. The IPP includes all services and supports the Member needs, even if they will be provided by another sources, such as AAH. The IPP process centers on the individual, and if appropriate, the individual's parents, legal guardian or conservator, or authorized representative. The individual may choose whomever they wish to take part in their IPP meeting.
    b. Enrollment with AAH does not change a Member's relationship to the Regional Center; access to Regional Center services and to the current IPP process remains the same.

ICF/DD

1. An Individual Service Plan (ISP) is developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the

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individual, direct care staff, and includes all relevant staff of other agencies involved in serving the individual. The ISP implements the requirements of the Regional Center's IPP and is based on a detailed individual developmental assessment which includes disabilities, developmental strengths, and the individual's needs. It includes active treatment goals. The ISP is completed 30 days following a transition to an ICF/DD Home.

V. Discharge Planning/Case Management

1. The Alliance maintains processes to support NF/ICF-DD/SA/PSA in the event of a change in Member's condition and discharge. A NF/ICF-DD/SA/PSA may modify its care of a Member or discharge the Member if the NF/ICF-DD/SA/PSA determines that the following specified circumstances are present:
    i. The NF/ICF-DD/SA/PSA is no longer capable of meeting the Member's health care needs;
    ii. The Member's health has improved sufficiently so that he or she no longer needs NF/ICF-DD/SA/PSA services; or
    iii. The Member poses a risk to the health or safety of individuals in the NF/ICF-DD/SA/PSA.

2. Facility Transitions:
    When transitioning Members to and from Skilled Nursing Facilities, ICF-DD, SA/PSA Facilities, AAH ensures timely Member transitions that do not delay or interrupt any medically necessary services or care by meeting the following requirements, at a minimum:

    i. Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and Transitional Care Services during all transitions. For members with developmental disability, such coordination will include the Regional Center. (See CM-034 Transitional Care Services for a full description of the TCS program.)

    ii. Assist Members being discharged or Members' parents, legal guardians, or authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with In Home Supportive Services, (IHSS,) Community Supports, Long Term Services and Supports, (LTSS,) and other Home and Community Based Services, (HCBS);

    iii. Maintain contractual requirements for Skilled Nursing Facilities to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data, and incorporate MDS Section Q data into transition assessments;

    iv. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

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v. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

vi. Follow-up with Members, Members' parents, legal guardians, or authorized representatives, Regional Center, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

3. The Alliance Pharmacy Team will work with all LTC facilities to coordinate medication coverage.

4. AAH provides Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation to Members, including those residing in a SNF/ICF/SA, in accordance with the DHCS contract and APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, or any superseding APL. This includes providing NEMT services if the Member is being transferred from an emergency room or acute care hospital to a SNF/ICF/SA, without prior authorization. For covered services requiring recurring appointments, AAH provides authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months. The Member must have an approved Physician Certification Statement form authorizing NEMT by the Provider. Day Program and related transportation (referenced in the ICF/DD State Plan Amendment (SPA) will continue to be provided by ICF/DD Homes and are not the responsibility of AAH. AAH also coordinates medically necessary drugs or medications on behalf of the Member.

5. The Alliance has implemented a Population Health Management (PHM) program that ensures all Medi-Cal managed members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services, (TCS,) care management programs, and Community Supports. Through the implementation of BPHM, which is available to all Members regardless of level of need, The Alliance ensures members have access to needed services and programs, including primary care.

6. As part of the PHM Program, AAH provides TCS, when all Members are admitted discharged, or transferred from facilities, including SNFs, ICF-DD's, and ~~/~~Subacute facilities. AAH also ensures that all TCS are completed for all high-risk Members, (which includes members in LTCs,) and includes assigning a single point of contact, referred to as a care manager, to assist Members throughout their transition and ensure all required services are complete. Coordination of care for members in ICF-DD facilities will include Regional Center case managers. AAH and assigned care managers ensure that Member transitions to and from a SNF/ICF/SA are timely and do not delay or interrupt any medically necessary services or care, and that all required transitional care

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activities are completed. The Alliance provides Transitional Care Services to include:

1. Timely authorizations for all Members
2. Awareness of when all Members are admitted, discharged, and transferred
3. Provide Transitional Care Services for all high-risk Members, including assigning a Care Manager to assist Members throughout their transition. A full description of the TCS program is in CM-034 Transitional Care Services.

Care management beyond transitions consists of two programs: (1) Complex Care Management (CCM) and (2) Enhanced Care Management (ECM). If a member is enrolled in either CCM or ECM, TCS is provided by the Member's assigned care manager. AAH also continues to provide all elements of BPHM to Members enrolled in care management programs. Members receiving long term services and supports (LTSS), including SNF/ICF-DD/Subacute services, are one of the groups considered to be "high risk" regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. Members living in ICF/DD/SA Homes are eligible for basic PHM, TCS, and TCM as applicable. While they are not currently eligible for ECM, if there are other individual care needs or concerns, their needs can be reviewed for consideration. If a member is transitioning out of an ICF-DD Home/SA/PSA, the restriction of duplicative service is removed, and the Member is assessed to determine need/eligibility for ECM services.

VI. Quality Monitoring

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided, to include collecting quality assurance and improvement findings from CDPH, (and for SA/PSA, from SCU), to include, but not limited to, survey deficiency results, site visit findings, and complaint, and potential quality issue findings.

1. The AAH QAPI program incorporates:
    a. Contracted NF/SA/PSA's QAPI programs, including the 5 key CMS elements:
        (1) Design and Scope
        (2) Governance and Leadership
        (3) Feedback, Data Systems and Monitoring
        (4) Performance Improvement Projects
        (5) Systematic Analysis and Systematic Action
    b. Monitoring of LTC measures per the Managed Care Accountability Set (MCAS) of claims data for NF/SA/PSA residents, including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions.

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AAH supplies WQIP data via a template provided by DHCS on a quarterly basis or as requested

c. Mechanisms, such as investigation of Potential Quality Issues, to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan.
d. Efforts supporting Member community integration
e. Compliance with DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents through reporting of incidents to the Compliance Department

2. The Alliance reports on LTC measures per the Managed Care Accountability Set (MCAS) of performance measures and submits QAPI program reports on an annual basis to DHCS through the External Quality Review Organization (EQRO). AAH will adhere to quality and enforcement standards in APL 19-017 and APL 23-012, including APL 24-009 Skilled Nursing Facilities – Long-term care benefit standardization and transition of members to managed care, APL 24-010: Subacute Care Facilities – LTC Benefit Standardization and Transition of Members to Managed Care, and APL 24-011: ICF/DD – LTC Benefit Standardization and Transition of Members to Managed Care respectively, or any superseding APLs.

3. AAH monitors quality and appropriateness of care provided to Members who reside at contracted ICF/DD Homes through review of compliance findings and data from the California Department of Public Health (CDPH) and service delivery findings from the Regional Centers through the AAH and Regional Centers' executed Memoranda of Understanding as part of the quality assurance program.

4. Upon DHCS request, AAH will submit quality assurance reports with outcome and trending data.

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DEFINITIONS / ACRONYMS

1. **Skilled Nursing Facility (SNF)** means any institution, place, building, or agency which is licensed as a skilled nursing facility by the Department or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a skilled nursing facility) and has been certified by the Department for participation as a skilled nursing facility in the Medi-Cal program. This term includes "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility."

2. **Nursing Facilities** are defined by DHCS as:
    a. Freestanding Skilled Nursing Facilities Level-B (FS/NF-B),
    b. Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B),
    c. NF-Bs designated as
        i. Institutions for Mental Diseases (IMD),
        ii. Distinct Part Pediatric Subacute (DP/PSA) and
        iii. Freestanding Pediatric Subacute Facilities Level B (FS/PSA).
3. **Subacute Facilities** provide a level of care needed by a member who does not need hospital acute care but who requires more intensive skilled nursing care than is provided to most patients in a SNF. Criteria for Subacute Services is in section 7.2 of the Medical Provider Manual. Subacute care patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Adult subacute care is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process.
4. **Pediatric Subacute Care** Services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.
5. **Intermediate Care Facilities/Developmental Disability (ICF/DD**) are services provided in hospitals, skilled nursing facilities or intermediate care facilities for individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center requiring skilled care or observation on an ongoing intermittent basis and 24-hour supervision.
    a. Members eligible for Regional Center are members who:
        i. Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
        ii. Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
        iii. Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.
    b. With respect to services furnished to individuals under age 65, Intermediate Care services may include services in a public institution (or distinct part thereof) for members with a developmental disability or persons with related conditions only if:
        i. The primary purpose of such institution (or distinct part thereof) is to provide a program of health or rehabilitative services for individuals with intellectual disabilities and such institutions meet standards as may be prescribed by the United States Department of Health and Human Services.
        ii. The individual with intellectual disabilities with respect to whom a request for payment is made has been determined to need and is receiving active treatment under such a program.
        iii. Payment for intermediate care services to any such institution (or distinct part thereof) will not be used to displace with Federal funds any non-Federal expenditures that are already being made for persons with intellectual disabilities.

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AFFECTED DEPARTMENTS/PARTIES

1. Long Term Care
2. Member Services
3. Utilization Management
4. Claims Department
5. Provider Relations
6. Quality Management
7. Grievance and Appeals
8. Case Management

RELATED POLICIES AND PROCEDURES

LTC-002 – Authorization Criteria
LTC-003 – LTC Case Management Identification and Enrollment
LTC-004 – LTC Bed Hold and Leave of Absence
UM-057 – Authorization Request
CM-034 – Transitional Care Services
CM-001-CCM Identification Screening, Enrollment, and Identification
CM-010-ECM Enrollment
CM-011-Enhanced Care Management
CS-001- Community Supports-Oversight, Monitoring and Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

02/21/2023, 3/19/2024, 01/01/2025, **4/16/2025, 07/24/25, 10/24/25**

Blue = material updates

REFERENCES

Title 22, CCR, Section 51003
Welfare and Institutions Code (W&I) Section 14186.3(c)(5)
Health &Safety Code Sections 1371– 1371.39
W&I Code Section 14186.1(c)(4)
Title 22, CCR, Sections 51535 and 51535.1.
Department of Health Care Services (DHCS) and Alameda Alliance for Health Contract
Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services
Alliance Policy EE.1135: Long Term Care Facility Contracting
AAH Policy – Grievance and Appeals
Claims Policy – Provider Disputes Resolution
The Alliance Provider Manual
The Alliance Utilization Management Program

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Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
DHCS APL 23-022: Continuity of Care
Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
Title 22, California Code of Regulations (CCR), §§ 51120, 51120.5, 51121, 51123,51124, 51124.5, 51124.6, 51215, 51118 and 51212, 51334,51335, 51535.1, 51335.5, 51335.6,
The Medi-Cal Provider Manual, Part 2 Long Term Care, Subacute Care Programs: Level of Care for Adults and Children
Lanterman Developmental Disabilities Services Act
Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR 51003(e)
DHCS Contract Exhibit A Attachment III, section 5.3.7 Services for all members.
DHCS All Plan Letter (APL) 24-009 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
DHCS All Plan Letter (APL) 24-010 Subacute Care Facilities-Long Term Care Benefit Standardization and Transition of Members to Managed Care
DHCS APL 24-011 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the QIHEC Committee annually.

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POLICY AND PROCEDURE

Policy Number	LTC-004
Policy Name	LTC Bed Hold and Leave of Absence
Department Name	Long Term Care
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports~~Manager, LTC~~
Line(s) of Business	D-SNP, MCAL
Effective Date	1/1/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~4/19/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for approving Bed Holds and Leave of Absence (LOA) for members residing in Long Term Care facilities.

A Bed Hold occurs when a Member residing in a nursing facility is admitted to an acute care hospital and the Member is expected to return to the nursing facility upon discharge from the acute hospital. AAH will provide continuity of care for Members that are transferred from a SNF to a general acute care hospital, and then require a return to a SNF level of care due to medical necessity.

A Leave of Absence (LOA) occurs when a beneficiary leaves the facility to visit relatives or friends.

A Developmentally Delayed (DD) LOA occurs when a beneficiary leaves the facility to visit relatives or friends or to participate in an organized summer camp for developmentally disabled Members.

The AAH Bed Hold and LOA policy will be compliant and consistent with State and Federal regulations including but not limited to CA Code of Regulations Title 22 Section 51535.1

PROCEDURE

A. Training for **SNFs**

All facilities are trained on Bed Hold and LOA Regulatory requirements at the time of a new contract and at least annually. Training documents and The Facility Resource guide is updated annually and are available to all SNFs upon request by visiting the AAH website or Provider Portal.

B. SNF Required Communication with Member or Member's Authorized Representative

1. SNFs are required to Notify all Members or the Members Representative in writing of their right to exercise the bed hold provision.
2. In the case that the SNF refuses to readmit the Member after an admission the SNF must notify the member of their right to request a Refusal to Readmit (RTR) hearing.
    a. The request is submitted to the Office of Administrative Appeals (OAHA) while the resident is still hospitalized.
    b. OAHA will conduct the RTR hearing only for those residents who wish to return to their nursing facility
    c. Only a resident or the residents authorized representative may request RTR hearing.

C. Bed Hold Procedure

1. When a beneficiary residing in a nursing facility is admitted to an acute care hospital the SN facility must notify AAH UM within 24 hours (1 business day) of the admission.
    a. Upon notification to the acute hospital LTC-UM will update the existing LTC authorization to show the bed hold revenue code.
        a. Facilities should utilize the LTC authorization request form and/or discharge disposition form to notify AAH.
    b. The IP UM team will process inpatient authorization for acute hospital admission.
2. Facilities must bill for all bed hold (BH) days.
3. Reimbursement for bed hold days is subject to the following
    a. The BH is limited to a maximum of seven days per hospitalization.
    b. The attending physician must order the acute hospitalization (must have physicians order as part of documentation)
    c. The facility must hold a bed vacant when requested by the attending physician, unless the attending physician notifies the Skilled Nursing Facility (SNF) that the Member requires more than seven days of hospital care at which time the Skilled Nursing Facility (SNF) will notify AAH.
        i. LTC UM will close SNF authorization once BH is exhausted.
        ii. IP UM will continue to process all concurrent reviews until which time the Member is discharged to a SNF or Home
            1. Member may be referred to Transitional Care Services to ensure smooth transitions between settings or to the community/home. This may be the LTC CM, the AAH CM, or other identified Care Manager.
        iii. LTC UM will submit a referral for internal SW/DCP
            1. LTC SW/DCP will work with the inpatient facility to address placement in another facility and may function

as the assigned TCS Care Manager.

2. LTC SW/DCP will coordinate all community support services if member is discharged to home

D. LOA Procedure

1. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
    a) Eighteen days per calendar year for non-developmentally disabled recipients. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:
        i. The request for additional days of leave shall be in accordance with the individual recipient care plan and appropriate to the physical and mental well-being of the patient.
        ii. At least five days of LTC inpatient care must be provided between each approved LOA.
    b) Seventy-three days per calendar year for developmentally disabled recipients.
    c) Thirty days for patients in a certified special treatment program for mentally ill recipients or recipients in a mental health therapy and rehabilitation program approved and certified by a local mental health director.

*These limits are in addition to bed hold (BH) days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the recipient's bed (bed hold).

2. LOA Requirements
    a) Provisions for LOAs are part of the patient care plan for NF-A or NF-B.
    b) Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H or ICF/DD-N facility.
    c) Readmission Treatment Authorization Requests (TARs) are not necessary for recipients returning from a leave of absence if there is a valid TAR covering the return date.
    d) Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
    e) A recipient's record maintained in an NF-A, NF-B, ICF/DD, ICF/DD-H or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
    f) For all NF-A and NF-B recipients, including the mentally disabled, the provider is paid the appropriate NF-A and NF-B rate(s), minus the raw food cost established by the Department of Health Care Services (DHCS) LOA/BH days. The supplemental payment for special treatment programs for the mentally disordered is included in the LOA/BH reimbursement.

g) For all ICF/DD, ICF/DD-H or ICF/DD-N recipients, the provider is paid the appropriate ICF/DD, ICF/DD-H or ICF/DD-N rate(s) minus the raw food cost established by DHCS for LOA or bed hold days.
h) Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
i) At the time of admission, if a recipient has not been an inpatient in any LTC facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations

3. AAH LTC-UM Process for LOA
    a) When a beneficiary residing in a nursing facility is on LOA the Nursing facility must notify AAH UM within 24 hours (1 business day).
    b) Upon notification LTC-UM will update open LTC authorization with the LOA revenue code
    c) Upon return form LOA the Nursing facility will notify AAH LTC-UM and LTC-UM will update open LTC authorization with the appropriate revenue code (SN or CC)

*If a recipient has used the total number of leave days for the calendar year, the facility may grant the recipient a leave of absence. However, the facility will not receive reimbursement for those unauthorized leave days from AAH.

E. Developmentally Disabled (DD) LOA Procedure

1. Developmentally disabled (DD) recipients can receive a leave of absence (LOA) for relatives/friend visits or summer camp for up to 73 days per calendar year.
2. If an overnight LOA is for summer camp participation by a DD recipient, a physician signature is required.
3. Skilled nursing and intermediary care facilities will receive reimbursement for DD recipients attending relatives/friend visits or summer camp for up to 73 days per calendar year if the following qualifications are met.
    a) Recipient's attendance at camp is prescribed by a licensed physician and approved by an appropriate regional center for the developmentally disabled.
    b) Recipient is not discharged from the facility while attending camp.
    c) Facility holds a recipient's bed during the period of absence.
    d) Term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year
4. AAH LTC-UM Process for LOA
    a) When a beneficiary residing in a nursing facility is on LOA the SN

facility must notify AAH UM within 24 hours (1 business day).

b) Upon notification LTC-UM will update open LTC authorization with new skill level and enter LOA revenue code

c) Upon return form LOA the SN facility will notify AAH LTC-UM and LTC-UM will update open LTC authorization with new skill level and enter appropriate revenue code (SN or CC)

F. Leave of Absence Termination

1. The LOA will terminate, and the discharge status will take effect under the following circumstances:
   a) If the recipient expires while at camp, the LOA terminates on the day of death (discharge date is the day of the death).
   b) If a recipient is admitted to an acute care hospital from camp, the LOA terminates on the day of departure from camp.
   c) If a recipient leaves camp and does not return to the nursing facility, the LOA terminates on the day of departure.

G. General Requirements for Bed Hold and LOA

1. The day of departure is counted as one day or LOA/BH, and the day of return is counted as one day of inpatient care.
2. A facility will hold the bed vacant during LOA/BH.
3. A LOA or BH is ordered by a licensed physician.
4. A recipient's return from LOA/BH must not be followed by discharge within 24 hours.
5. A LOA/BH must terminate on a recipient's date of death.
6. A facility claim must identify the inclusive dates of leave.

DEFINITIONS / ACRONYMS

A. Acute Care Hospital means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

B. Authorization Status evaluation of whether care is medically necessary and otherwise covered

C. Bed Hold is a temporary reimbursable status that allows one to return to a nursing facility after an acute care hospitalization

D. Community Support Services includes support that may be organized through extended family members, friends, neighbors, religious organizations, community programs, cultural and ethnic organizations, or other support groups

or organizations

E. **Concurrent Review** is a review of medical necessity decisions made while the patient is currently in an acute or post-acute setting

F. **Discharge Planner** is one who identifies and prepares for a patient's anticipated health care needs after they leave the hospital

G. **LTC** refers to Long Term Care

H. **Member** means any eligible beneficiary who has enrolled in AAH and who has been assigned to or selected a Plan.

I. **OAHA is the Office of Administrative Hearings and Appeals** is an administrative hearing forum created by the Department of Health Care Services to provide a fair and impartial appeal process for providers and individuals.

J. **RTR Appeals is Refusal to Readmit:** under federal and state law, when a resident is transferred to the hospital or approved for therapeutic leave, they have a right to return to the nursing facility after they are hospitalized or when the period of therapeutic leave has concluded. When the resident is hospitalized and the nursing facility refuses to readmit the resident, the resident may request a hearing.

K. **Skilled Nursing Facility (SNF) is** a health facility that provides skilled nursing and supportive care to persons who need this type of care on an extended basis.

L. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Long Term Care
Case Management
Claims
Billing

RELATED POLICIES AND PROCEDURES

LTC-001 – Long Term Care Program
LTC-002 - Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)

LTC-003 – LTC Case Management Identification and Enrollment
CM-034 -Transitional Care Services
UM-001 – Utilization Management
UM-057 – Authorization Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

New

REVISION HISTORY

New Policy: 2/23/2023
Updates: 3/19/2024, 6/12/2024, 07/24/2025

REFERENCES

CA Code of Regulations Title 22, Sections 51335, 51535.1, 51335.5, 51335.6, 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, and 51334

DHCS APL ~~23-004~~24-009 "Skilled Nursing Facilities-Long Term Care Benefit Standardization, and Transition of Members to Managed Care"

DHCS APL ~~23-023~~24-011 "Intermediate Care Facilities for Individuals with Developmental Disabilities -Long Term Care Benefit Standardization, and Transition of Members to Managed Care"

DHCS APL ~~23-027~~24-010 "Intermediate Care Facilities-Long Term Care Benefit Standardization, and Transition of Members to Managed Care"

DHCS Policy on Leave of Absence, Bed Hold, and Room and Board, dated August 2020

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to QIHEC (Quality Improvement Health Equity Committee) ~~the Health Care Quality Committee~~ annually.

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POLICY AND PROCEDURE

Policy Number	LTC-006
Policy Name	One to One Observation (Personal Attendants/Sitter) in Nursing Facilities
Department Name	Long Term Care
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	D-SNP, MCAL
Effective Date	08/01/2025
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

This policy is to outline the requirements for Alameda Alliance to consider coverage of One to One Observation (Personal Attendants/Sitter) at a nursing facility.

PROCEDURE

I. Request

a) A Pre-Service authorization is required when requesting for One to One Observation (Personal Attendants/Sitters) in a nursing facility.

b) The facility must send an authorization request to the Alliance for the One to One Observation (Personal Attendants/Sitter). A complete authorization request includes all the following items:

1. **Authorization Request Form**

2. **Physicians Order:** A physician's order is needed indicating the behaviors and conditions necessitating One to One Observation (Personal Attendants/Sitter).

3. **Nursing notes:** documentation showing use of One to One Observation (Personal Attendants/Sitter) during shift including hours and assignments and interventions directed towards member behaviors

4. **Medical History and Diagnosis:** A review of the member's medical history, current diagnosis, and care needs which may include
    a. Cognitive testing: OT KELS, MMSE, MOCA, neuropsychological testing, capacity evaluation
    b. Psychiatric evaluation

5. **Risk Assessment:** Evaluation of risks, including observed behaviors, associated with the member's condition and behavior. Documentation may include
    a. Functional assessment: PT/OT evaluation, nursing notes

6. **Interventions tried and results of previous interventions** which may include, but are not limited to:
    a. Environmental adaptations such as, but not limited to: providing members with their sensory aids (hearing aids, glasses), practices to promote sleep hygiene and cognitive reorientation, providing distractions, de-escalating/eliminating physical restraints and triggers such as IV lines, physical restraints, indwelling catheters, timed toileting
    b. Pharmacological adjustments: reviewing and adjusting medications that may be causing behaviors (such as, but not limited to, psychoactive medications, anticholinergic medications), evaluating and treating for behaviors and delirium (such as, but not limited to, constipation, pain management), treatment of underlying mental and behavioral health conditions such as withdrawal symptoms, substance use cravings, and underlying psychiatric conditions

7. **Care Plan Review:** re-evaluation of member's care and safety justification for One to One Observation (Personal Attendants/Sitters) at regular intervals with ongoing plans to address underlying causes leading to One to One Observation (Personal Attendants/Sitters) assignment.
    a. Must document review and justification in initial and quarterly care plans.
    b. Must include evaluation of achievement/improvement of One to One Observation (Personal Attendants/Sitters) in addressing member behaviors.

II. Review

a) Upon receipt of all necessary information, the Alliance clinical team(s) will review the request for appropriateness based on the following parameters:

1. Fall Risk

- **Frequent or High Risk of Falls:** The member has a history of frequent falls or is at a high risk of falling due to factors such as impaired mobility, balance issues, or a recent change in their health status.
- **Inability to Call for Help:** The member is unable to call for assistance in the event of a fall or other emergency due to cognitive impairment or physical limitations.

2. **Cognitive Impairment**
   - **Cognitive Impairment impairing judgement:** The member exhibits significant cognitive impairment, such as dementia or other neurocognitive disease, leading to an increased risk of wandering, self-harm, or neglect of personal needs.
   - **Behavioral Issues:** The member displays behaviors that are potentially harmful, such as aggression or self-injurious actions, and requires continuous supervision to ensure safety to self or others.

3. **Safety Concerns**
   - **Risk of Elopement:** The member is at risk of eloping (leaving the facility without authorization) due to cognitive impairment or behavioral issues, posing a safety risk.

4. **Psychiatric Conditions**
   - **Severe Psychiatric Disorders:** The member has severe psychiatric conditions that lead to dangerous behaviors or self-harm, necessitating constant supervision to ensure their safety.
   - **Medication Side Effects:** The member experiences severe side effects from medications that could affect their safety and require constant observation.

5. **Reauthorization requests**
   - Documentation submitted must include updated evaluation of achievement/improvement of One to One Observation (Personal Attendants/Sitters) in addressing member behaviors within the last two months.
   - Documents submitted with prior authorization requests will not be accepted.

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.

c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) If a request is denied, the Member will have all rights associated with

any UM decision as set forth in the UM 057 policy. A denial of One to One Observation (Personal Attendants/Sitters) services does not affect any other services the member is receiving.

DEFINITIONS / ACRONYMS

A. One to One Observation (Personal Attendants/Sitter) is defined in the literature as:
   a. Staff who are immediately at hand and can help prevent a fall or redirect a patient from engaging in a harmful act

B. Nursing Facilities are defined by DHCS as:
   a. Freestanding Skilled Nursing Facilities Level-B (FS/NF-B),
   b. Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B),
   c. NF-Bs designated as
      i. Institutions for Mental Diseases (IMD),
      ii. Distinct Part Pediatric Subacute (DP/PSA) and
      iii. Freestanding Pediatric Subacute Facilities Level B (FS/PSA).

C. Skilled nursing facility means any institution, place, building, or agency which is licensed as a skilled nursing facility by the Department or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a skilled nursing facility) and has been certified by the Department for participation as a skilled nursing facility in the Medi-Cal program. This term includes "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility."

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Long Term Care
Claims
Billing

RELATED POLICIES AND PROCEDURES

LTC-001 – Long Term Care Program
LTC-002 - Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
LTC-003 – LTC Case Management Identification and Enrollment
CM-034 -Transitional Care Services
UM-001 – Utilization Management
UM-057 – Authorization Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- None

REVISION HISTORY

- Created 05/06/2025

REFERENCES

1. American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults. American Geriatrics Society abstracted clinical practice guideline for postoperative delirium in older adults. J Am Geriatr Soc. 2015 Jan;63(1):142-50. doi: 10.1111/jgs.13281. Epub 2014 Dec 12. PMID: 25495432; PMCID: PMC5901697.
2. Adela M. Greeley, Elizabeth P. Tanner, Selene Mak, et al. Personal attendant/sitters as a Patient Safety Strategy to Reduce Hospital Falls: A Systematic Review. Ann Intern Med.2020;172:317-324. [Epub 4 February 2020]. doi:10.7326/M19-2628
3. Shekelle PG, Greeley AM, Tanner EP, et al. One-to-One Observation: A Systematic Review [Internet]. Washington (DC): Department of Veterans Affairs (US); 2019 Aug. Executive Summary. Available from: https://www.ncbi.nlm.nih.gov/books/NBK553691/
4. By the 2023 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatr Soc*. 2023; 71(7): 2052-2081. doi:10.1111/jgs.18372

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the QIHEC committee annually.

POLICY AND PROCEDURE

Policy Number	UM-008
Policy Name	Coordination of Care – California Children's Services (CCS)
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	TBD~~7/17/2024~~

POLICY STATEMENT

A. PCPs and specialists are responsible for:
   1. Early identification and referral of children with potentially eligible conditions to the California Children's Services (CCS) program.
   2. Notifying Alameda Alliance's Utilization Management Unit of Members referred to CCS.
   3. Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into the CCS program. e.g., Medi-Cal for Kids & Teens, (formerly known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services for Medi-Cal Members.)

~~3.~~

B. Alameda Alliance's Utilization Management Unit is responsible for:
   ~~1.~~ Entering into a Memorandum of Understanding (MOU) with the Alameda County CCS Program.

   1.
   2. Consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.
   3. Facilitating referrals and tracking outcomes.
   4. Ensuring that plan providers:
      a. Are informed of the identity of CCS paneled providers and facilities.

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b. Perform appropriate baseline assessments and diagnostic evaluations that provide sufficient clinical detail to establish or raise a reasonable suspicion that a member has a CCS eligible condition.

c. Refer potentially eligible children to the CCS program.

5. Ensuring that there is continuity of care between plan and CCS providers.
6. Submitting to the State required annual CCS reports on referrals accepted, denied, and pending with local CCS program by October 31st of each year.
7. Delivery of:
   a. All covered medically necessary health care and case management services for a member referred to CCS until CCS Program eligibility is established.
   b. Otherwise covered services not covered by the CCS program once eligibility is established.
   c. All other medically necessary covered services other than those provided through the Pediatric Palliative Care Program (PPC) for the CCS eligible condition once CCS eligibility is established.
8. In collaboration with CCS, assure coordination of services among the plan, the plan's primary care providers (PCP), the CCS specialty providers, and the CCS Program.
~~8~~9. Maintenance of a CCS Liaison position in alignment with DHCS APL 23-014 who has received training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with the counties, care management and authorization processes.
10. Authorization of and payment of healthcare providers, including CCS paneled providers and approved facilities, for the delivery of medically necessary covered services that are unrelated to the member's CCS eligible condition

~~9~~.

C. The CCS program is responsible for:
1. Diagnostic and treatment services for CCS eligible conditions.
2. Authorization of CCS paneled providers, Special Care Centers (SCCs) and approved facilities for the delivery of medically necessary covered services to treat the member's CCS eligible condition.
3. Covering Medi-Cal for Kids and Teens (EPSDT) Supplemental Services related to the CCS condition for Medi-Cal Members.
4. In collaboration with the plan, assure coordination of services among the plan's primary care providers (PCP), the CCS specialty providers, and the CCS Program.
5. Direct delivery of Physical Therapy (PT) and Occupational Therapy (OT) services for children eligible for the Medical Therapy Program (MTP)

PROCEDURE

Section I. Coordination of Care Process

A. PCPs and specialists are responsible for early identification of Members that may have eligible CCS conditions.
1. CCS Medical Eligibility criteria are outlined in Title 22, California Code of Regulation, Sections 41800-41872.
2. The CCS website also contains CCS Medical Eligibility criteria.

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Alameda County CCS
CCS 1100 San Leandro Blvd., San Leandro CA 94577 Phone: (510) 208-5970 Fax: (510) 267-3254 http://dhs.ca.gov/pcfh/cms/ccs/

B. The identification can occur at any medical encounter including Well Child Visits, acute or chronic illness visits, and the Initial Health Assessment performed at a visit within 120-days of enrollment.
   1. CCS referrals are documented in the Medical Record. Documentation must include:
      a. Appropriate and timely referrals for actual and potential cases (within 24 hours of identification of CCS case).
      b. Periodic management of medically necessary health care throughout the course of CCS eligibility.
      ~~b.~~

C. Members with potential CCS conditions may also be identified in the following ways:
   1. Alliance Utilization Management (UM) - identification can occur through review of specialty or diagnostic referrals that suggest a CCS condition.
   2. Alliance Case Management (CM) - may directly identify potential CCS cases during discharge planning or other CM activities.
   3. Monthly reporting from CCS of members attributed to the MCP with the CCS benefit and CCS eligible diagnoses, but may or may not have an open Service Authorization Request (SAR)
   ~~3.~~

D. CCS provides diagnostic services, medical treatment, Case Management, and transition services to children with conditions eligible for treatment under the CCS program. PCPs, the Alliance's UM/CM program or referral specialists identify children with potential CCS eligible conditions. CCS offers three program components:
   1. Diagnosis and Treatment Program - Provides medically necessary care and Case Management to infants, children and adolescents meeting program eligibility requirements, complications of a CS eligible condition, or other conditions which complicate or interfere with the management of the CCS eligible condition. CCS may authorize diagnostic services necessary to confirm a suspected CCS eligible condition if the referring physician's medical records support a high probability of presence of the suspected CCS condition.
   2. CCS Medical Therapy Program (MTP) - Provides medically necessary physical therapy, occupational therapy, equipment consultation, and durable medical equipment (DME) to children who are medically eligible for CCS. Please refer to the CCS MTP eligibility regulations at https://www.dhcs.ca.gov/servcies/ccs/Pages/medicaleligibility.aspx
   3. High Risk Infant Follow-up Program (HRIF) - If eligible, provides follow-up for infants discharged from a Neonatal Intensive Care Unit (NICU) for up to age 3 who are at risk for developing a CCS eligible condition. These services include developmental testing, neurological, ophthalmologic, and audiological evaluations.
   4. Transition Services – a transition specialist (social worker) leads the local CCS team in coordinating transition of care. Services are coordinated with Special Care Centers (SCC), pediatric and adult PCPs, families, DME vendors and family

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members. Multidisciplinary case conferences are held as needed to support transition planning.

E. CCS accepts referral forms from individuals or entities. Therefore, PCPs, specialists or the Alliance are responsible for the completion of referral forms. Applicable medical records and a request for CCS services should be submitted to CCS.

F. CCS sends a CCS program application and agreement to the Member, parent, or legal guardian. The PCP may assist with the completion of the forms. The Member, parent or legal guardian must sign the form in order to be eligible for benefits not covered by Medi-Cal.
~~F.~~

G. CCS determines medical eligibility by evaluating medical records in order to determine whether the child has, or is likely to have, a CCS medically eligible condition. CCS reviews medical necessity and appropriateness of the requested service. All services require prior authorization by CCS.
~~G.~~

H. Once CCS program eligibility is established and the request for service is approved, CCS issues an authorization for treatment and payment to a CCS approved practitioner, Special Care Center, or hospital.
~~H.~~

I. The PCP continues to provide medically necessary care for the child in comprehensive fashion, including delivery of appropriate services, within their scope of practice, that are related to the CCS eligible condition and are provided in coordination with the CCS-authorized specialist or Special Care Center. CCS is responsible for Case Management of CCS eligible conditions and will collaborate with the PCP as needed to accomplish this.
   1. A link to the CCS Paneled Provider Directory is available for Alliance PCPs and Specialists on the Alliance Provider portal.
   2. An article on the CCS Program is published annually in the Alliance Provider Bulletin.
   3. The Alliance Provider Manual includes contact information for the county CCS offices.
   ~~3.~~

J. Members not accepted into the CCS Program receive all medically necessary covered services through the Alliance and its contracted specialists.
~~J.~~

K. The Alliance must assist the PCP in coordinating available services and providing follow-up for Members requiring referral to CCS through the following methods:
   1. Maintenance of continuity of care through coordination with case managers from the CCS programs.
   2. Coordination with the PCP to ensure that medically necessary health care services are provided for conditions not eligible for the CCS program.
   ~~2.~~

L. The Alliance and the local CCS program exchange enrollment data on a monthly basis in order to facilitate coordination of care. The local CCS program provides the Alliance with a list of its members who have been accepted into the program
   1. Members aging out of the CCS program will be identified by the AAH UM Team 12 months prior to their 21st birthday. UM team member will assist the member in coordinating the transition back into the Alliance Network quarterly. Quarterly check ins will include:
      a. Identifying the Member's CCS-Eligible Condition

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b. Planning for the needs of the Member Transition from the CCS Program
c. A communication plan with the Member in advance of the transition
d. Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS Eligible Condition(s) and
    - e. Continued assessment of the member through the first 12 months of the transition. If member is found to have extensive care coordination needs, a referral will be placed for the Complex Case Management team to assist member.

Section II. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 Delegation Oversight.

DEFINITIONS

California Children's Services (CCS) - A state-county partnership with blended federal/state/county funding which covers medically necessary care and case management services related to certain diagnoses for children birth to age 21 years of age. CCS services are delivered by paneled providers and approved tertiary care medical centers in local communities.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-002 – Coordination of Care
CM-043 Child Welfare Liaison
CMP-019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Medical Service Workflow – CCS Referrals

REVISION HISTORY

1/1/2008 10/28/2009, 8/18/2011, 3/4/2014, 01/10/2016, 12/15/2016, 04/16/2019,5/20/2020, 3/22/2022, 6/20/2023, 7/17/2024, 10/24/2025

REFERENCES

1. DHCS APL 24-013 Managed Care Plan Child Welfare Liaison
~~1. Title 22, CCR, Section 41518.~~
2. DHCS Contract Exhibit A, Attachment 11. §9.
3. MRMIB Contract § A.IV.B.
4. Title 22, CCR, Section 41518.
~~3.~~

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MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC) Committee annually.

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POLICY AND PROCEDURE

Policy Number	UM-011
Policy Name	Coordination of Care - Hospice Services and Terminal Illness
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

Hospice

A. Hospice services will be provided in a timely manner, preferably within 24 hours of request, to any member who receives a physician's certification that the member has a terminal illness and who then elects hospice services.

B. Members who qualify for, and elect hospice remain enrolled in the Alliance while receiving these services.

C. Hospice Care is not Long-Term Care (LTC) regardless of the Member's expected or actual length of stay in a nursing facility.

~~C.~~1. Members in Long-Term Care who elect the hospice benefit will not be disenrolled from the Alliance.

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D. The "election period" for hospice services consists of the following: (1) an initial 90 day period; (2) a subsequent 90 day period; or (3) an unlimited number of 60 day periods.

E. These services include, but are not limited to:

1. Nursing services.
2. Physical, occupational, or speech language pathology.
3. Medical social services under the direction of a physician.
4. Home health aide and homemaker services.
5. Medical supplies and appliances.
6. Drugs and biological.
7. Physician services

Review

8. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.
9. Continuous nursing services may be provided on a 24-hour basis only during periods of crisis as necessary to maintain the terminally ill member at home.
10. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.
11. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
12. Any other palliative item or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

F. Prior Authorization may not be required for routine home care, continuous home care, respite care, or hospice physician services. The Alliance may require documentation, for reasons of justification, following the provision of general inpatient care.

G. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day.

H. Members are informed of the availability of Hospice Care as a covered service and the methods by which they may elect to receive these services through their Combined Evidence of Coverage and Disclosure Forms (EOCs).

I. The hospice provider will notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medi-Cal hospice benefit. See APL 13-014 for reimbursement guidelines.

J. Services not covered by a hospice provider include:
   1. Private pay room and board or residential care
   2. Acute in-patient hospitalization unrelated to the terminal illness
   3. Level A or B nursing facility (NF) for unrelated issues
   4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
   5. Other necessary services for conditions unrelated to the terminal illness.

K. CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent non-palliative services. See MMCD Policy Letter PL 11- 004.

Terminal Illness

The Alliance will comply with CA Health and Safety Code regulatory guidance when making service request decisions for enrollees who have been diagnosed with a terminal illness.

PROCEDURE

Hospice

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A. Hospice Care shall be limited to Members who have been certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

B. A Member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement shall include:

1. Identification of the hospice;
2. The Member's or representative's acknowledgement that:
   a. There is a full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.
   b. Certain specified Medi-Cal benefits are waived by the election.
3. The effective date of the election;
4. The signature of the Member or representative.

C. A Member's voluntary election may be revoked or modified at any time.

1. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;
2. A Member or representative may:
   a. Execute a new election for any remaining entitled election period at any time after revocation;
   b. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

D. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.

E. If the member is residing in a Long-Term Care Facility

1. Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a nursing facility (NF) or Intermediate Care Facility for the Developmentally Delayed (ICF/DD). Payment will be provided to the hospice agency directly.
2. The hospice will then reimburse the NF for the room and board at the rate negotiated between the hospice and the NF
3. Dual eligible members the hospice shall notify the MCP when a member elects Medicare hospice benefit. The MCP will then pay the room and board payment to the hospice provider.
   a. Eligibility for nursing facility room and board will be determined by the MCP and the nursing facility.
4. Hospices will bill the MCPs using the following revenue codes:
   a. Revenue Code 0658- Facility Type Code 25
   b. Revenue Code 0658- Facility Type Code 26
   c. Revenue Code 0658- Facility Type Code 28
   d. Revenue Code 0658- Facility Type Code 65

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e. Revenue Code 0658- Facility Type Code 81

f. Revenue Code 0658- Facility Type Code 86

~~a.~~g.

Terminal Illness

A. The Alliance shall provide the following information to an enrollee with a terminal illness within five (5) business days of a denial coverage for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider:

1. A statement setting forth the specific medical and scientific reasons for denying coverage.
2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

B. Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a) of CA Health and Safety Code §1368.1 (b), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference:

1. To review the information provided to the enrollee pursuant to paragraphs (1) and (2) of CA Health and Safety Code §1368.1 subdivision (a);
2. Conducted by a plan representative having authority to determine the disposition of the complaint;
3. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate;
4. However, the conference required by CA Health and Safety Code §1368.1 subdivision (a) shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

C. Guidelines to Identify a Terminally Ill Diagnosis or Condition

1. The Alliance uses written utilization review criteria based on sound medical evidence, consistently applied, regularly updated, and annually reviewed and approved by the Quality Improvement Health Equity Committee (QIHEC)
2. MCG (formerly Milliman Care Guidelines) Guidelines are licensed and approved for use as a primary reference in the medical necessity decision making process. Other applicable publicly available guidelines from recognized medical authorities are referenced, when indicated.
3. Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:
   1) Levels of Care

(a) Routine home care

(b) Continuous home care requiring a minimum of eight hours of care per 24-hour period

(c) Respite care provided on an intermittent non-routine, and occasional cases for up to five consecutive days at a time

(d) General Inpatient care for pain and symptom control

i. Documents to be submitted for authorization include:

1. Certification of physician orders for general inpatient care.

2. Justification for this level of care.

4. The Alliance's policies shall conform to the statutory definition of terminal illness: "Terminally ill means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."

D. Communication of Denial Determination

1. Requesting provider and Member written notifications for denied requests related to a terminal illness will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.
2. The denial Notice of Action (NOA) letter includes statements about the specific medical and scientific reasons for denying coverage.
3. The denial NOA letter will include, if appropriate, a description of alternative treatment, service, or supply covered by the Alliance.

DEFINITIONS / ACRONYMS

A. Terminally ill is defined in:

1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

B. Hospice Care is defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

C. Palliative care means that hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Interventions focus primarily on reduction and abatement of pain and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b)

D. Crisis is the period in which the member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Care provided requires a minimum of eight hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The eight hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is needed.

Review

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 10/30/2013, 3/04/2015, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 12/18/2024

REFERENCES

A. CA Health and Safety Code §1368.1(a) (b)
B. DHCS Contract, Exhibit A, Attachment 10, Provision 8.C.
C. CCS NL: 04-0207 Palliative Options for CCS Eligible Children
D. CCS NL: 06-1011 Authorization-Concurrent Treatment for CCS Clients Who Elect Hospice
E. MMCD All Plan Letter 13-014 Hospice Services and MCMC
F. MMCD Policy Letter 11-004 ACA –Concurrent Care for Children
G. Title 22, CCR, Sections 51180 and 51349
H. Social Security Act §1905(o)(1)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.

Review

POLICY AND PROCEDURE

Policy Number	UM-015
Policy Name	Emergency Services and Post-Stabilization Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance and its delegates are responsible for the coverage and payment of Emergency Services and post-stabilization care services regardless of whether or not the Provider that furnished the services is a Network Provider, Subcontractor, Downstream Subcontractor, or Out-of-Network (OON) Provider. The Alliance will cover Emergency Services and Post-Stabilization Care Services in accordance with federal and state requirements.

Emergency Services are defined as services that provide care for an Emergency Medical Condition – as defined in Health and Safety Code section 1371.4 and Welfare and Institutions Code (WIC) section 14454.

Post Stabilization Care is delivered when the member is stabilized, but the health care Provider believes that they require additional Medically Necessary Covered Services -and may not be discharged safely. Under certain circumstances, these services are provided to improve or resolve the enrollee's condition. [42 CFR §438.114(a); 42 CFR §422.113(c)(1)]

With respect to an emergency medical condition, meaning that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during a transfer of enrollee to another facility, including with respect to a pregnant woman in labor. [42 CFR §489.24(b)]

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PROCEDURE

1. The Alliance maintains processes to ensure providers are not required to obtain authorization prior to the provision of emergency services and care needed to stabilize a member's emergency medical/mental health condition.
2. Emergency services and care also includes any additional screening, evaluation, care and treatment necessary to determine the existence of and to relieve or eliminate a psychiatric emergency medical condition.
    a. There is no limit on what constitutes an emergency medical condition based on a list of diagnoses or symptoms.

Collaboration

b. When a member needs emergency department services while out of the service area, the member is directed to visit the nearest Emergency Room.
c. No prior authorization is needed for emergency services.
d. The member is reminded to contact his/her primary care physician at his first opportunity, and to follow up with that PCP.
e. The Alliance shall cover Emergency Services regardless of whether the emergency department provider or hospital notified the primary care provider, medical group, or Plan of the medically necessary screening and treatment within 10 calendar days of presentation of Emergency Services.

~~1.~~3. Emergency rooms are notified that no authorization is required to stabilize the Member's condition; any services required after the Member's condition is stabilized will require authorization including a hospital admission.

4. The Alliance follows the same procedures for post-stabilization care for BH as with medical care. ~~mental health proviVoluntary and involuntary admissions are covered based on the Member's benefit coverage.~~
   a. For MediCal inpatient psychiatric admissions, Alliance will triage, screen, and refer admissions related to ~~SED~~/SMI conditions admissions to Alameda County Behavioral Health Services.
   b. For Group Care, inpatient psychiatric admissions are managed by Alliance BH staff. ~~or 24 hour triage line for assistance~~
   c. ~~.~~The Alliance provides a Post Stabilization Care process for members and providers to obtain timely authorization for ongoing medically necessary care, for circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely. 42 CFR § 422.113(c) (2); 42 CFR § 438.114 (e)

5. The Alliance maintains a process to approve or disapprove requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request.
   a. If The Alliance fails to approve or disapprove a health care Provider's request for authorization to provide medically necessary post- stabilization care services within one half hour of the request, or the Alliance cannot be contacted, the Medically Necessary post-stabilization care services are deemed as authorized in alignment with Title 28 CCR section 1300.71.4 and 42 CFR § 422.113(c)(2); 42 CFR § 438.114(e)

6. Notifications can be made to the Alliance UM Department for post-stabilization services from a contracted facility, an in-area, non-contracted facility, or an out-of-area non-contracted facility 24 hours per day, 7 days per week:

7. UM Clinical Staff who receive notification from the Emergency Department staff, facility or provider about a Member in need of post-stabilization medically necessary services will open Nurse On Call Logs and document the request to include:
   a. Date and Time of Call
   b. Member Demographics (Name, ID Number, DOB)
   c. Requesting Facility Information
   d. Name of the health care provider making the request and Contact information
   e. Request
   f. Name of the Alliance representative responding to the request

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8. The Alliance UM Staff reviews the ~~presented information~~information presented and determines if post-stabilization services are medically appropriate.
    a. If medically appropriate, the UM Staff will document the reason in the UM Authorization and issue authorization service request as defined in UM Policy 057 Authorization Service Request.
    b. If the Alliance UM Staff disagree regarding the need for necessary medical care, the UM Staff will outreach to the Alliance Medical Director to discuss a potential denial of post-stabilization services.

9. If the Alliance Medical Director also disagrees regarding the need for necessary medical care and denies post-stabilization services, following stabilization of the enrollee, the Alliance UM Staff will:
    a. Coordinate the transfer of stabilized Member~~s~~ in an emergency department to an appropriate Network provider, if necessary, as required under Health & Safety Code (H&S) section 1371. This would apply in situations where an alternative general acute care hospital or hospital with mental health care facilities under contract with the plan ~~agree~~agrees to accept the transfer of the ~~patient~~member.
    b. Contact the PCP to assume responsibility for the care of the ~~patient~~member by having medical and/or mental health care personnel contracting with the Plan personally take over the care of the member~~patient~~ within a reasonable amount of time after the disagreement
    c. Assist in coordination of the discharge from the emergency department including ensuring the ER follow up care is in place, authorizations noted, transportation needs addressed and follow up communication is made to the PCP/Provider Group.
    d. The treating Provider may continue with care of the Member until a~~n~~ MCP physician is reached or one of the following criteria is met:
        i. A~~n~~ MCP physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;
        ii. A~~n~~ MCP physician assumes responsibility for the Member's care through transfer;
        iii. The MCP and the treating Provider reach an agreement concerning the Member's care; or
        iv. The Member is discharged.

10. For providers seeking authorizations and assistance with discharge planning and transfers to step down facilities, Alliance clinical staff are available after hours, weekends and holidays to assist with coordination and urgent authorization requests that allow for transfers and discharges to occur with minimal delay.
    a. The Alliance maintains documentation of all requests for authorization and responses to such requests.

11. Emergency Departments contracted with the Alliance will be notified of the procedure to:
    a. Report system and/or protocol failures to the plan and the process for ensuring corrective action by contacting the Alliance Provider Services Department.
    b. Refer Alliance members who present at the emergency department for after-hours care or for non-emergency medical or behavioral health services by instructing the member to follow up with their Alliance PCP/BH Care Practitioner, the~~o~~ Alliance CM or delegate Case Management (CM) for timely follow ups to Primary Care, Behavioral Health Services, and social services.
    c. Care coordination is provided for all post-ER or hospitalization needs through the Alliance Case and Disease Management program, and contact information for the PCPs or other providers is on the Alliance website: https://alamedaalliance.org/providers/case-and-disease-management. Behavioral

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Health care coordination is provided by the Behavioral Health department and contact information is on the Alliance website: https://alamedaalliance.org/providers/non-specialty- behavioral-health-care-services.

d. Referral forms for Prior Authorization requests and Case Management referrals for coordination of care are on the Alliance website for use by PCPs or other providers: https://alamedaalliance.org/providers/provider-forms. https://alamedaalliance.org/providers/non-specialty-behavioral-health- care-services.

12. On an annual basis, The Alliance provides non-contracting hospitals in California to which one of its members can be transferred, the necessary Plan contact information to contact the health Plan.
    a. The Alliance provides UM contact information to the Department of Managed Health Care for updating to the DMHC Website "24 Hour Contact Line". This site serves as the notification process for non-contracting facilities to obtain UM post-stabilization assistance.
    b. On an annual basis, The Alliance sends a letter to all non-contracted hospitals in California with information on how to contact The Alliance for Post Stabilization care.

13. The Alliance ensures that providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee and
    a. The Alliance shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical/mental health condition.
    b. The Alliance maintains processes to ensure that providers are reimbursed for emergency services and care provided to its enrollees in and out of service areas, until the care results in stabilization of the enrollee
    c. The Alliance may deny reimbursement to a provider if the Member is not eligible for services at the time the service was rendered.
    d. The Member was admitted to the same hospital and ER facility charges are included in the Hospital claim.
    e. The Alliance, or its contracting medical providers, reasonably determines that the emergency services and care were never performed
    f. The Member did not require emergency services and care, and the Member reasonably should have known that an emergency did not exist. As noted in DMHC APL 17-017, the standard articulated by the Knox-Keene Act (section 1371.4 and 1371.5) is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors. Whether the enrollee believed they were experiencing a medical emergency may not always be evident from the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

14. Any member responsibility for charges from post-stabilization care services (based on plan benefits) is limited to an amount no greater than the Member's co-payment, co-insurance, or deductible.

15. For non-contracted emergency services, any Member responsibility for charges from post-stabilization care services (based on Plan benefits) is limited to an amount no greater than what the Alliance would charge that member if he or she had obtained the services through

the Alliance.

16. For Emergency Services provided by out-of-network providers, the Plan shall pay at least the Medi-cal/Medicare fee-for-service rate or a rate negotiated with the provider. [42 CFR438.114(b); DHCS All Plan Letter 19-008]
    a. For Post-Stabilization Care Services that required pre-approval but were not pre-approved, the Alliance shall pay the treating provider for services in accordance with rates established until discharge or the Alliance physician has assumed care of the patient in the event of disagreement in plan as described in item 9.d.
    b. For Post-Stabilization Care Services provided by out-of-network providers that were pre-approved by the Alliance, the Alliance shall pay the rates specified in the pre-approval.

17. Delegation Oversite: The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards including a process by which Facilities can notify of a post-stabilization admission 24/7 availability of medical staff to authorize medically necessary post stabilization care and coordinate transfer of stabilized Members to an appropriate network provider, if necessary. Refer to CMP-019 – Delegation Oversight and CMP-020 Corrective Action Plan. For Members assigned to a delegated Provider Group, the UM Clinical Staff will inform the caller to outreach to the designated delegate after hours call number.
    a. When an emergency department contacts the Alliance, and the member is assigned to a delegated network, the one-half hour notification is enforced, and Alliance will contact the delegated network UM Department or PCP with the emergency room contact information.
    b. The Alliance will log the notification to ensure timely payment for services.

18. Covered Ambulance Services associated with Emergency Care Services are:
    a. 911 emergency response system is activated for a condition the member reasonably believed was emergent.
    b. Transportation of Enrollees to the nearest 24-hour emergency facility with Plan Physician coverage.
    c. For Transportation of Members to alternative appropriate facility, the attending physician should identify the type of transportation most appropriate to manage the Member's condition.

19. Member based on the identified needs.
    a. For denied post-stabilization care, the Alliance or its delegates are not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider. The Alliance should take into consideration the care necessary to ~~effect~~affect the enrollee's transfer or discharge so as not to have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

20. The Alliance shall incorporate Emergency Services and Post-Stabilization Care Services into its Quality Assessment and Performance Improvement program [42 CFR§ 438.330] The Alliance will monitor Emergency Services utilization patterns, including:
    a. Appropriate utilization of Emergency Services

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b. Potentially avoidable Emergency Department visits
c. Follow-up care after Emergency Services
d. Coordination between emergency providers and the Plan's network providers.

DEFINITIONS

Authorized Representative – any employee or contractor of Alameda Alliance for Health who directs the members to seek services.

Emergency Medical Condition – as defined in 42CFR §438.210€, 10CCR§2699.6700(9), and Health and Safety Code §1371.5(b) is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay-person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency Services –

1. As defined by Centers for Medicare and Medicaid (CMS), are health care services provided to evaluate and stabilize medical/behavioral health conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson with average knowledge of medicine and health to believe that failure to get immediate medical care could result in:
    a. Serious jeopardy to the health of an individual or, in the case of a pregnant woman, the health of the woman or unborn child;
    b. Serious impairment to bodily functions;
    c. Serious dysfunction of any bodily organ or part, or
    d. Serious disfigurement.
2. Are inpatient or outpatient services furnished by a provider that is qualified to furnish these services~~,~~ and are needed to evaluate or stabilize an emergency medical condition.

Post Stabilization Care – covered, medically necessary, non-emergency services (related to an emergency condition) at an out-of-network general acute care hospital needed to ensure that the patient remains stabilized from the time that the treating hospital requests authorization until:

1. The patient is discharged;
2. A contracted physician arrives and assumes responsibility for the patient's care; or
3. The treating physician and the contracted physician agree to another arrangement.

Prudent Layperson – a person who is without medical training and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

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Alameda Alliance for Health

RELATED POLICIES AND PROCEDURES

BH-001, Behavioral Health Services, Medi-Cal
BH-008, Behavioral Health Services, Group Care
BH-XXX, Behavioral Health Services, D-SNP
~~BH-001 Behavioral Health Services~~
CLM-003 Emergency Services Claims Processing
CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan
CMP-024 Subcontracted Relationships and Delegation
UM- 016 Transportation
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/26/2009, 9/23/2011, 3/16/2012, 5/9/2012, 9/18/2012, 7/14/13, 3/19/2014, 4/8/2014, 9/2/2014, 01/10/2016, 12/15/2016, 5/3/2018, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 10/19/2023, **8/21/2024; 02/21/2025, 05/15/2025**

REFERENCES

1. 42 CFR §438.114(a)
2. 42 CFR §438.114(c)
3. 42 CFR §422.113(c)(1)
4. 42 CFR §489.24(b)
5. 42 CFR §422.113(b)(2)(i)
6. 42 CFR §438.114(c)(1)(ii)
7. 42 CFR § 438.114(d)(1)(i)
8. 42 CFR § 438.114(d)(1)(ii)
9. 42 CFR § 447.54
10. 42 CFR § 447.54 (b)
11. 42 CFR § 422.113(c) (2)
12. 42 CFR § 438.114 (e)
13. 28 CCR §1300.67.2(c)
14. 42CFR §438.114(e)
15. Balanced Budget Act (BBA) §422.100, Federal Register 34986
16. DHCS APL 15-015 Physical Health Care Covered Services Provided for Members Who Are Admitted To Inpatient Psychiatric Facilities.
17. DHCS APL 19-008 Rate Changes for Emergency and Post Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnosis Related Group Payment

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18. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation and Related Travel Expenses
19. DHCS APL 23-009 Authorizations for Post-Stabilization Care Services
20. DHCS Contract, Exhibit A, Attachment 7, Sec. 7, Attachment 9, Sec. 7 4.
21. DHCS Policy Letter 00-01 Medi-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
22. DMHC APL 17-017 Standard for Determining Emergency
23. Title 10, Section. 1300.71.4 and Title 22, Section 53855
24. Health and Safety Code §§ 1300.71.4, 1317.1(a)(2)(A); 1345(b); 1367(i); 1371.4(a) (b)
25. Medicare Manual Chapter 4, Section 10.2
26. Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020.

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

~~POLICY AND PROCEDURE~~

	~~UM 015~~
	~~Emergency Services and Post-Stabilization Services~~
	~~Health Care Services~~

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~~**POLICY STATEMENT**~~

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~~1. Emergency health care services are available and accessible within the service area 24 hours a day, seven (7) days a week.~~

~~2. The Alliance (Alameda Alliance for Health, (The Alliance) maintains contracts with medical/mental health practitioners, programs, and Emergency Services facilities to provide services to enrollees that require urgent or emergent medical/mental health care, including the services of one or more Physicians and one or more nurses on duty at all times.~~

~~a. Services include medical/mental health crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area 24 hours a day, 7 days a week~~

~~3. The Alliance ensures ambulance service is available to transport Enrollees to the nearest 24 hour emergency facility with Plan Physician coverage.~~

~~4. The Alliance provides a process for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.~~

~~a. The Alliance maintains a process to receive notification of emergency room evaluations and subsequent admissions, whether voluntary or involuntary, 24 hours a day, 7 days a week.~~

~~b. UM Staff is available 24 hours, 7 days a week for providers seeking authorizations for post ER stabilization care. Calls after hours are triaged by Alliance clinical staff. Staff is also available on the weekends and holidays during the daytime for assistance with discharge planning and transfers to step down facilities.~~

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5. The Alliance ensures providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee.

a. A Physician is available 24 hours a day to authorize Medically Necessary post- stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

b. The Alliance maintains a process to approve or disapprove requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request.

i. If The Alliance fails to approve or disapprove a health care Provider's request for authorization to provide medically necessary post- stabilization care services within one half hour of the request, the Medically Necessary post-stabilization care services are deemed as authorized.

c. The Alliance maintains documentation of all requests for authorization and responses to such requests for post-stabilization medically necessary care.

6. The Alliance maintains a 24/7 telephone line for behavioral health services. See policy BH-002 Behavioral Health Services.

7. If The Alliance and the provider disagree regarding the need for necessary medical care, following stabilization of the enrollee, The Alliance shall assume responsibility for the care of the patient either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the Plan agree to accept the transfer of the patient.

a. The Alliance shall assume responsibility for the care of the patient by either of the following:

i. Having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement -- Or --

ii. Having another general acute care hospital or hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient.

8. The Alliance ensures that providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee and

a. The Alliance shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical/mental health condition.

b. The Alliance maintains processes to ensure that providers are reimbursed for emergency services and care

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provided to its enrollees in and out of service areas, until the care results in stabilization of the enrollee

c. The Alliance reimburses providers for emergency services and care provided to its enrollees until the care results in stabilization of the enrollee and does not require a prior authorization for that reimbursement.

d. The Alliance may deny reimbursement to a provider if:

i. The Member is not eligible for services at the time the service was rendered.

ii. The Member was admitted to the same hospital and ER facility charges are included in the Hospital claim.

iii. The Alliance, or its contracting medical providers, reasonably determines that the emergency services and care were never performed

iv. The Member did not require emergency services and care, and the Member reasonably should have known that an emergency did not exist. As noted in DMHC APL 17-017, the standard articulated by the Knox-Keene Act (section 1371.4 and 1371.5) is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors. Whether the enrollee believed they were experiencing a medical emergency may not always be evident from the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

9. The Alliance maintains processes to ensure providers are not required to obtain authorization prior to the provision of emergency services and care needed to stabilize a member's emergency medical/mental health condition.

10. Emergency services and care also includes any additional screening, evaluation, care and treatment necessary to determine the existence of and to relieve or eliminate a psychiatric emergency medical condition. There is no limit on what constitutes an emergency medical condition based on a list of diagnoses or symptoms.

11. Any member responsibility for charges from post-stabilization care services (based on plan benefits) is limited to an amount no greater than the Member's co-payment, co-insurance, or deductible.

a. For non-contracted emergency services, any Member responsibility for charges from post-stabilization care services (based on Plan benefits) is limited to an amount no greater than what the Alliance would charge that member if he or she had obtained the services through the Alliance.

12. Emergency Departments contracted with the Alliance

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will be notified of the problem to:

a. Report system and/or protocol failures to the plan and the process for ensuring corrective action by contacting the Alliance Provider Services Department.

b. Refer Alliance members who present at the emergency department for after-hours care or for non-emergency medical or behavioral health services by instructing the member to follow up with their Alliance PCP/BH Care Practitioner, to Alliance CM or delegate Case Management (CM) for timely follow ups to Primary Care, Behavioral Health Services, and social services.

i. Care coordination is provided for all post-ER or hospitalization needs through the Alliance Case and Disease Management program, and contact information for the PCPs or other providers is on the Alliance website: https://alamedaalliance.org/providers/case-and-disease-management. Behavioral Health care coordination is provided by the Behavioral Health department and contact information is on the Alliance website: https://alamedaalliance.org/providers/non-specialty-behavioral-health-care-services

ii. Referral forms for Prior Authorization requests and Case Management referrals for coordination of care are on the Alliance website for use by PCPs or other providers: https://alamedaalliance.org/providers/provider-forms. https://alamedaalliance.org/providers/non-specialty-behavioral-health-care-services.

13. On an annual basis, The Alliance provides non-contracting hospitals in California to which one of its members can be transferred, the necessary Plan contact information to contact the health Plan.

a. The Alliance provides UM contact information to the Department of Managed Health Care for updating to the DMHC Website "24 Hour Contact Line". This site serves as the notification process for non-contracting facilities to obtain UM post-stabilization assistance.

b. On an annual basis Alliance sends a letter to all non-contracted hospitals in California with information on how to contact Alliance for Post Stabilization care.

14. Delegation Oversight: The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 – Delegation Oversight and CMP-020 Corrective Action Plan.

PROCEDURE

1. Alliance contracts stipulate that a PCP will be available 24 hours a day, seven (7) days a week for

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urgent/emergent requests from assigned members or from Emergency Department personnel about the PCP's members to/for:

a. Coordinate the transfer of care of a member whose emergency condition is stabilized.

b. Authorize medically necessary post-stabilization services.

c. General communication with emergency room personnel.

d. Provide medical advice and supervision (triage services) to assigned members either directly or through coverage arrangements with another credentialed provider.

e. When Alliance and the treating provider cannot reach an agreement concerning the Member's care and an Alliance physician is not available for consultation, Alliance will give the treating provider the opportunity to consult with an Alliance physician and the treating Provider may continue with care of the member until an Alliance Physician is reached or one of the following criteria is met:

- An Alliance physician with privileges at the treating provider's hospital resumes member's care
- An Alliance physician assumes care via transfer
- Alliance and treating physician reach an agreement regarding care
- Member is discharged.

f. If Alliance cannot be contacted within one half hour (30 minutes) of the request the authorization will be deemed approved.

2. If the Provider Group or PCP receives notice from an emergency department or is contacted by a Member who received services in an emergency department, the Provider Group or PCP shall provide the follow-up care and refer to CM, behavioral health providers or social services.

3. When an emergency department contacts Alliance, and the member is assigned to a delegated network, the one-half hour notification is enforced and Alliance will contact the delegated network UM Department or PCP with the emergency room contact information.

a. Alliance will log the notification to ensure timely payment for services.

4. When Alliance is responsible for post-stabilization services, and a member needs emergency department services while out of the service area, he/she is directed to visit the nearest Emergency Room.

a. No prior authorization is needed for emergency services.

b. The member is reminded to contact his/her primary care physician at his first opportunity, and to follow up with that PCP.

c. Emergency rooms are notified that no authorization is required to stabilize the Member's condition; any services required after the Member's condition is stabilized will

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require authorization including a hospital admission.
d. Psychiatric admissions are managed by the Behavioral Health department. When notifications are made to the Alliance UM Department, UM staff will coordinate with the applicable mental health provider. Voluntary and involuntary admissions are covered based on the Member's benefit coverage.
- For MediCal inpatient psychiatric admissions, Alliance will triage, screen, and refer admissions related to SED/SMI conditions admissions to Alameda County Behavioral Health Services.
- For Group Care, inpatient psychiatric admissions are managed by Alliance BH staff or 24 hour triage line for assistance.

5. Notifications made to the Alliance UM Department for post-stabilization services from a contracted facility, an in-area, non-contracted facility, or an out-of-area non-contracted facility:

a. When UM Clinical Staff receives a notice from the Emergency Department staff or provider of a Member in need of post-stabilization medically necessary services, UM Staff will open ER Post-stabilization Log, and document the request to include:
i. Date and Time of Call
ii. Member Demographics (Name, ID Number, DOB)
iii. Requesting Facility Information
iv. Caller Name and Contact Information
v. Name of the health care provider making the request and Contact information
vi. Request
vii. Name of the Alliance representative responding to the request
b. For Members assigned to a delegated Provider Group, the UM Clinical Staff will inform the following information should be gathered:
i. Working Diagnosis
ii. Vital Signs
iii. Chief Complaints and symptoms such as bleeding, chest pain, impaired neurological status
iv. How the member was brought into the ED such as ambulance, paramedics, police transport, or employer, parent, spouse, friend, or self-transport.
v. Duration of the condition such as sudden onset or length of days or weeks.
vi. Treatment or services already provided such as suturing, injections, medications, IV fluids, oxygen.
vii. Procedures or tests already conducted such as chest tube insertion, x-rays, MRI, laboratory work.
viii. Actual or suggested type of discharge from the Emergency Department such as hospital admission, transfer

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to another facility, discharge home with instructions and follow-up by PCP/BH Provider.

6. If The Alliance UM Staff reviews the presented information and determines if post-stabilization services are medically appropriate.

a. If medically appropriate, the UM Staff will document the reason in the UM Authorization and issue authorization service request as defined in UM Policy 057 Authorization Service Request.

b. If the Alliance and the provider disagree regarding the need for necessary medical care and denies post-stabilization services, following stabilization of the enrollee, the Alliance UM Staff will transfer the Member as soon as possible. UM Staff will contact the PCP to assume responsibility for the care of the patient either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the Plan agree to accept the transfer of the patient.

i. The Alliance or the PCP/Provider Group shall assume responsibility for the care of the patient by either of the following:

a) Having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement Or

b) Having another general acute care hospital or hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient.

ii. When agreement is made to accept the admission, The Alliance UM/BH Staff or the delegated Provider Group will issue the authorization for the admission.

iii. When post-stabilization services are denied and the agreement is made to discharge the Member from the emergency department, the UM Staff are responsible for ensuring the ER follow-up care is in place, authorizations noted, transportation needs addressed and follow-up communication is made to the PCP/Provider Group.

iv. When post-stabilization services are denied and the agreement is met and transfer to an in-network hospital is made, the Alliance UM Staff is responsible for the coordination of all necessary services to safely transfer the Member based on the identified needs.

v. For denied post-stabilization care, the Alliance or its delegates are not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider. The Alliance should take into consideration the care necessary to effect the enrollee's transfer or discharge so as not to have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

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7. Ambulance services are to be covered when:
a. 911 emergency response system is activated for a condition the member reasonably believed was emergent.
b. Ambulance Services to transfer to appropriate facility, the attending physician should identify the type of transportation most appropriate to manage the Member's condition.
8. Delegate Networks are required to adhere to all Emergency Service requirements including 24/7 availability of medical staff to authorized medically necessary post stabilization care and coordinate transfer of stabilized Members to an appropriate network provider, if necessary.

DEFINITIONS

Authorized Representative – any employee or contractor of Alameda Alliance for Health who directs the members to seek services.

Emergency Medical Condition – as defined in 42CFR §438.210€, 10CCR§2699.6700(9), and Health and Safety Code §1371.5(b) is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency Services –
4. As defined by Centers for Medicare and Medicaid (CMS), are health care services provided to evaluate and stabilize medical/behavioral health conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson with average knowledge of medicine and health to believe that failure to get immediate medical care could result in:
a. serious jeopardy to the health of an individual or, in the case of a pregnant woman, the health of the woman or unborn child;
b. serious impairment to bodily functions;
c. serious dysfunction of any bodily organ or part, or
d. serious disfigurement.

5. Are inpatient or outpatient services furnished by a provider that is qualified to furnish

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these services, and are needed to evaluate or stabilize an emergency medical condition.

Post Stabilization Care – covered, medically necessary, non-emergency services (related to an emergency condition) at an out-of-network general acute care hospital needed to ensure that the patient remains stabilized from the time that the treating hospital requests authorization until:

1. The patient is discharged;
2. A contracted physician arrives and assumes responsibility for the patient's care; or
3. The treating physician and the contracted physician agree to another arrangement.

Prudent Layperson – a person who is without medical training and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

1. CLM-003 Emergency Services Claims Processing
2. UM-057 Authorization Service Request
3. UM-016 Transportation
4. CMP-019 Delegation Oversight
5. CMP-020 Corrective Action Plan
6. CMP-024 Subcontracted Relationships and Delegation
7. BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/26/2009, 9/23/2011, 3/16/2012, 5/9/2012, 9/18/2012, 7/14/13, 3/19/2014, 4/8/2014, 9/2/2014, 01/10/2016, 12/15/2016, 5/3/2018, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 10/19/2023, **8/21/2024**

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~~REFERENCES~~

~~1. Title 10, Section. 1300.71.4 and Title 22, Section 53855~~

~~2. DHCS Contract, Exhibit A, Attachment 7, Sec. 7, Attachment 9, Sec.7 4. 28 CCR §1300.67.2(c)~~

~~5. Medicare Manual Chapter 4, Section 10.2~~

~~6. Balanced Budget Act (BBA) §422.100, Federal Register 34986~~

~~7. Health and Safety Code §§ 1300.71.4, 1317.1(a)(2)(A); 1345(b); 1367(i); 1371.4(a) (b)~~

~~8. 42CFR §438.114(c)~~

~~9. DHCS APL 19-008 Rate Changes for Emergency and Post Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnosis Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020.~~

~~10. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation and Related Travel Expenses~~

~~11. DHCS APL 15-015 Physical Health Care Covered Services Provided for Members Who Are Admitted To Inpatient Psychiatric Facilities.~~

~~12. DHCS Policy Letter 00-01 Medi-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program.~~

~~13. DHCS APL 23-009 Authorizations for Post-Stabilization Care Services~~

~~14. DMHC APL 17-017 Standard for Determining Emergency~~

~~MONITORING~~

~~The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.~~

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POLICY AND PROCEDURE

Policy Number	UM-024
Policy Name	~~Care Coordination –~~Dental Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Senior Director, Health Care Services
Line of Business	MCAL, DSNP
Effective Date	1012712005
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024, TBD
Compliance Committee Approval Date	3/19/2024, TBD

Policy Number	UM-024
Policy Name	Care Coordination= Dental Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	~~Senior Director, Health Care Services~~Director, Social Determinants of Health
Line of Business	MCAL, D-SNP
Effective Date	10/27/2005
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

~~Purpose:~~
~~**This policy establishes guidelines for dental screening, referral and associated services with medical services for healthcare providers.**~~

~~Scope:~~
~~**The policy encompasses Primary Care providers (PCP), dental providers and healthcare clinical staff.**~~

POLICY STATEMENT

Purpose:

This policy establishes guidelines for dental screening, referral and associated services with medical services for healthcare providers.

Scope:

Primary Care Providers (PCPs) are required to conduct dental screenings during initial health assessments and periodic evaluations, with annual referrals starting at age one for members under 21, based on Bright Futures guidelines. While dental services are not covered under the Alliance Medi-Cal contract and are provided via Fee-for-Service (FFS) or Dental Managed Care (DMC), the Alliance

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supports care coordination, including assisting with prior authorizations. Medically necessary services tied to dental care, such as anesthesia or inpatient care, are reimbursable based Alliance guidelines. The Alliance collaborates with dental providers and ensures timely access to necessary services, including IV sedation and anesthesia for certain cases. Additionally, the Alliance employs a Dental Liaison and ensures subcontractors adhere to its policies to provide seamless care for its members.

Alameda Alliance for Wellness (D-SNP) follows the same process as above. For Med-Cal dental services that are not covered under the Alliance Medi-Cal contract are provided via Fee-for-Service (FFS) or Dental Managed Care (DMC). The Alliance has partnered with Liberty Dental to manage the Medicare portion of D-SNP dental services. Under this arrangement, Liberty Dental will cover certain dental services for D-SNP members. Dental providers within the Liberty Dental network will process claims in two distinct ways:

1. Medi-Cal FFS Claims: One claim will be submitted to Medi-Cal Fee-for-Service for the services covered under Medi-Cal.
2. Alliance Claims: Another claim will be submitted to the Alliance for dental services covered under Medicare.

Alameda Alliance for Wellness will support care coordination efforts as discussed above.

The policy encompasses Primary Care providers (PCP), dental providers and healthcare clinical staff.

~~1) Primary Care Providers (PCPs) are required to perform dental screening examinations as part of the initial health assessment and as part of specified other physical examinations.~~

~~a) The Alliance must assist providers and beneficiaries with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed.~~

~~2) For Members under 21 years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made beginning at age one or earlier if conditions warrant. Oral health screenings and referrals for members less than 21 years of age are conducted in accordance with the Recommendations for Preventive Pediatric Health Care (Bright Futures / American Academy of Pediatrics).~~

~~3) PCPs are responsible for referring Members to dentists for care on a routine basis or as needed based on results of the dental screening exam.~~

~~4) Dental services are not covered services under the Alliance Medi-Cal contract. Members receive services on a Fee-for-Service (FFS) basis or through a Dental Managed Care (DMC) plan.~~

~~5) Per state law and Medi-Cal program policy, all Medi-Cal members enrolled in Managed Care Plans who are eligible for Medi-Cal dental services are entitled to dental services under intravenous (IV) moderate and deep sedation/general anesthesia when medically necessary in an appropriate setting, using the criteria provided in Attachment A of APL 23-028.~~

~~6) The Alliance covers medically necessary services administered in connection with dental services that are not performed by dental providers. Subject to the Alliance's coverage criteria and prior authorization guidelines, the Alliance will~~

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reimburse for contractually covered prescription drugs, laboratory services, preadmission physical examinations required for dental offices, admission to ambulatory surgical settings, or an inpatient hospital stay for a dental procedure, and facility fees, as applicable.

7) Subject to the Alliance's coverage criteria and prior authorization guidelines, the Alliance will cover services related to dental procedures that requires intravenous (IV)moderate and deep sedation/general anesthesia and are provided by individuals other than a dental provider, including but not limited to, any associated contractually required prescription drugs, laboratory services, physical examinations required for admission to a medical facility, outpatient surgical center services, and inpatient hospitalization services required for a dental procedure, including facility fees for services provided in any hospital or ambulatory surgery center

8) Alliance members may receive treatment for a dental procedure provided under IV moderate sedation and deep sedation/general anesthesia by a physician anesthesiologist in the below settings, if the setting is deemed appropriate and according to the criteria in Attachment A:

a) Hospital;

b) Accredited ambulatory surgical center (stand-alone facility);

c) Dental office; and

d) A community clinic that participates in the provision of Medi-Cal dental services (Dental FFS or DMC plan), is a non-profit organization, and is recognized by DHCS as a licensed community clinic or FQHC or FQHC look-alike, including Tribal Health Program clinics

9) The Alliance will authorize privileges for Medi-Cal Dental providers who need to use anesthesiology at Alliance contracted facilities, or coordinate for out of network access for members if a contracted facility is not available, in accordance with timely access standards for specialty care.

10) The Alliance is contractually responsible forcovering anesthesia services provided in conjunction with dental services offered to enrollees less than 7 years of age, developmentally disabled regardless of age, or for whom general anesthesia is necessary.

11) The Alliance will ensure all subcontractors and delegated entities will also adhere to this policy.

12) The Alliance procedures for prior authorization *UM 001 Utilization Management Program* have been reviewed and approved by DHCS in accordance with Health and Safety Code, CCR, Section 1367.01; and are designed to ensure that all decisions, including those for appeals, are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.

13) The Alliance has a Dental Liaison in the Case Management department who is available to dental providers, including Dental FFS providers, to assist with referring Members to other covered services and to assist with care coordination of medical and dental needs.

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PROCEDURE

A. Primary Care Physician Responsibilities

~~1)~~1. Provider Services Department will educate PCPs of their responsibility to provide and document dental services through the Provider Manual and other periodic communication as needed:

a. Initial Health Evaluation

~~a)~~i. As part of the initial health evaluation for new members, PCPs shall conduct a dental screening including examination of the teeth, gums, and mouth to determine the presence of gum disease, obvious dental caries, masses, lesions, infections, and pain, mal-alignment of teeth or jaw, and severe halitosis, among others.

ii. PCPs shall provide routine preventive dental advice regarding mouth care including daily tooth brushing, flossing, and the use of fluoride toothpaste.

~~b)~~iii. PCPs are responsible for referring Members to dentists for care on a routine basis or as needed based on results of the dental screening exam.

b. Periodic Health Evaluations

i. PCPs shall provide routine preventive dental advice regarding mouth care including daily tooth brushing, flossing, and the use of fluoride toothpaste.

ii. PCPs are responsible for referring Members to dentists for care on a routine basis or as needed based on results of the dental screening exam.

iii. PCPs shall continue to provide all medically necessary health care services to Members even if referred to a dental practitioner for services.

2. The Alliance covers medically necessary services administered in connection with dental services that are not performed by dental providers. Subject to the Alliance's coverage criteria and prior authorization guidelines, the Alliance will reimburse for contractually covered prescription drugs, laboratory services, preadmission physical examinations required for dental offices, admission to ambulatory surgical settings, or an inpatient hospital stay for a dental procedure, and facility fees, as applicable.

3. For Alameda Alliance for Health (Medi-Cal) ~~D~~dental services are not covered services under the Alliance Medi-Cal contract. Members receive services on a Fee-for-Service (FFS) basis or through a Dental Managed Care (DMC) plan.

4. For Alameda Alliance for Wellness (DSNP) dental services are not covered services under the Alliance Medi-Cal contract. Members receive services on a Fee-for-Service (FFS) basis or through a Dental Managed Care (DMC). Under the Medi-Care contract for D-SNP certain dental services are covered through a partnership with Liberty Dental and administered by Liberty Dental network.

5. PCPs shall continue to observe the Member for dental conditions during periodic health examinations for adults ~~and~~

~~a)~~a. ~~according to the Alliance's Pediatric Preventative Services requirements for children with referrals for treatment as appropriate.~~For Members under 21 years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made beginning at age one or earlier if conditions warrant. Oral health screenings and referrals for members less than 21 years of age are conducted in accordance with the Recommendations for Preventive Pediatric Health Care (Bright Futures / American Academy of Pediatrics).

b. Refer Medi-Cal members less than 21 years of age needing dental services to Denti- Cal practitioners by giving the Member the Denti-Cal practitioner referral phone number, (800)

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~~i.~~

6. PCPs shall document the results of the dental screening exam in the medical record.

7. The Alliance must coordinate all necessary non-anesthesia services provided to a member.
   a. The Alliance has a Dental Liaison in the Case Management department who is available to dental providers, including Dental FFS providers, to assist with referring Members to other covered services and to assist with care coordination of medical and dental needs.

~~ii. PCPs shall continue to provide all medically necessary health care services to Members even if referred to a dental practitioner for services.~~ Dental Anesthesia

~~b)~~

1. Subject to the Alliance's coverage criteria and prior authorization guidelines, the Alliance will cover services related to dental procedures that requires intravenous (IV)moderate and deep sedation/general anesthesia and are provided by individuals other than a dental provider, including but not limited to, any associated contractually required prescription drugs, laboratory services, physical examinations required for admission to a medical facility, outpatient surgical center services, and inpatient hospitalization services required for a dental procedure, including facility fees for services provided in any hospital or ambulatory surgery center.

2. Alliance members may receive treatment for a dental procedure provided under (IV) moderate sedation and deep sedation/general anesthesia by a physician anesthesiologist in the below settings, if the setting is deemed appropriate and according to the criteria in APL 23-028 Attachment A:
   a. Hospital;
   b. Accredited ambulatory surgical center (stand-alone facility);
   c. Dental office; and
   d. A community clinic that participates in the provision of Medi-Cal dental services (Dental FFS or DMC plan), is a non-profit organization, and is recognized by DHCS as a licensed community clinic or FQHC or FQHC look-alike, including Tribal Health Program clinics.

3. The Alliance will reimburse facility services and general anesthesia services provided in any dental office, hospital, ambulatory surgery center, or community clinic that meets the APL 23-028 requirements.

B. Prior Authorization for (IV) Moderate Sedation

~~2) The Alliance will cover intravenous (IV) sedation and general anesthesia and associated facility charges for dental procedures rendered in a hospital surgery center community clinic that participates in Dental FFS or DMC plan and is recognized by DHCS as a licensed community clinic or FQHC including Tribal Health Program clinics setting, when the clinical status or underlying medical condition of the Member requires IV sedation or general anesthesia.~~

1. Prior authorization is required for intravenous sedation and general anesthesia associated with dental procedures. Coverage is subject to the Alliance's prior authorization guidelines. The dental provider will work collaboratively with an anesthesia provider to determine whether a member meets the minimum criteria necessary for IV sedation or general anesthesia.

~~c)~~

2. Coverage shall be limited to dental services that are performed by a licensed ~~-~~dentist, ~~-~~that are reasonable and necessary for the prevention, diagnosis and treatment of dental disease, injury, or defect.

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3. The Alliance procedures for prior authorization UM-001 Utilization Management Program have been reviewed and approved by DHCS in accordance with Health and Safety Code, CCR, Section 1367.01; and are designed to ensure that all decisions, including those for appeals, are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.
   a. Criteria for coverage is 2 tiered: (1 element from each tier must be met for coverage)
      i. Tier 1:
         a) Use of local anesthesia to control pain fails or unfeasible based on the medical needs of the member OR
         b) Use of minimal sedation (inhalation or oral) failed or was not feasible based on the
         c) medical needs of the member.
      ii. Tier 2: If the above is met, then 1 of the following must also be present:
         a) Inability to immobilize a member or is not feasible based on the medical needs of the member
         b) Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation
         c) The member has acute situational anxiety due to immature cognitive functioning
         d) The member is uncooperative due to physical or mental compromising conditions

4. Members with certain medical conditions such as, but not limited to moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrythmias, significant bleeding disorders, uncontrolled seizures, sleep disorder breathing should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

5. Authorization for general anesthesia provided by a physician anesthesiologist to a member during an inpatient stay must be part of the authorization for the inpatient admission. This does not preclude any subsequent inpatient stay necessary due to an outpatient procedure. In addition, an inpatient stay is not required for the provision of outpatient surgical center services.
6. A prior authorization is not required for intravenous sedation in a state certified skilled nursing facility (SNF) or any category of Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

~~d)~~

~~a)~~7. ~~Members may receive treatment for a dental procedure provided under general anesthesia by an Alliance anesthesiologist in a dental office, hospital, accredited ambulatory surgery center, or community clinic that meets the APL 23-028 requirement.~~The Alliance is contractually responsible for covering anesthesia services provided in conjunction with dental services offered to enrollees less than 7 years of age, developmentally disabled regardless of age, or for whom general anesthesia is necessary.

~~The Alliance will reimburse facility services and general anesthesia services provided in any dental office, hospital, ambulatory surgery center, or community clinic that meets the APL 23-028 requirements.~~

C. Out-Of-Network Care Coordination

1. The Alliance will authorize privileges for Medi-Cal Dental providers who need to use anesthesiology at Alliance-contracted facilities, or coordinate for out-of-network access for members if a contracted facility is not available, in accordance with timely access standards for specialty care.

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~~e)~~

~~f) The Alliance must coordinate all necessary non-anesthesia services provided to a member.~~

~~g) Authorization for general anesthesia provided by a physician anesthesiologist to a member during an inpatient stay must be part of the authorization for the inpatient admission. This does not preclude any subsequent inpatient stay necessary due to an outpatient procedure. In addition, an inpatient stay is not required for the provision of outpatient surgical center services.~~

~~h) A prior authorization is not required for intravenous sedation in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled.~~

~~3) Criteria for coverage is 2 tiered: (1 element from each tier must be met for coverage)~~

~~i) Use of local anesthesia to control pain fails or unfeasible based on the medical needs of the member OR~~

~~j) Use of minimal sedation (inhalation or oral) failed or was not feasible based on the medical needs of the member.~~

~~k) If the above is met, then 1 of the following must also be present:~~

~~1. Inability to immobilize a member or is not feasible based on the medical needs of the member~~

~~11. Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation~~

~~111. The member has acute situational anxiety due to immature cognitive functioning~~

~~1v. The member is uncooperative due to physical or mental compromising conditions~~

~~4) Members with certain medical conditions such as, but not limited to moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrythmias, significant bleeding disorders, uncontrolled seizures, sleep disorder breathing should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.~~

~~14)~~2. CMS covers the integration of dental and medical services when dental services are inextricably linked to the clinical success of other CMS covered procedures or services This requires the coordination between medical and dental professionals.

a. Treatment services to eliminate infection prior to chemotherapy and transplant or cardiac procedures.
b. Dental reconstruction because of surgery to remove a tumor
c. Stabilize or immobilize teeth related to a fracture
d. Splints related to dislocated jaw joints
e. Workup as part of dialysis services for ESRD
f. IV sedation for surgery, diagnostic services, complex medical conditions

~~5) The Alliance has a Dental Liaison in the Case Management department who is available to dental providers, including Dental FFS providers, to assist with referring Members to other covered services and to assist with care coordination of medical and dental needs.~~

~~6)~~D. Delegation Oversight

~~I)~~ The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also comply with the same standards. Refer to ~~ADM~~ CMP-0~~19042~~ for monitoring of delegation oversight.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-019
Provider Manual
UM-033 Topical Fluoride Varnish
UM-001 Utilization Management Program
~~Provider Manual~~

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 10/14/2011, 9/7/2012, 12/10/2013, 1/14/2014, 10/08/2015, 01/10/2016,
12/15 /2016, 5/3/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 12/27/2023,
3/19/2024, 4/30/25

REFERENCES

1. CA Health and Safety Code, Section 1367.71
2. CA Health and Safety Code, CCR, Section 1367.01
3. CMS Medicare Dental Coverage
4. DHCS APL 21-005 CalAIM Implementation Requirements
5. DHCS APL 23-028 Dental Services- Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia Coverage

~~A.~~6. DHCS Contract Exhibit A, Attach 11, Provision 15
~~B. CA Health and Safety Code, Section 1367.71~~
~~C.~~7. DHCSMMCD Policy Letter 13-002 Dental Services- General Anesthesia Coverage
~~D.~~8. DHCS MMCD All Plan Letter07-008 Topical Fluoride Varnish
~~E.~~9. DHCS MMCD All Plan Letter 23-028 Dental Services - Intravenous Moderate Sedation and Deep Sedation/General Anesthesia Coverage
   - a. Attachment A: Policy for Intravenous Moderate Sedation and Deep Sedation/General Anesthesia
   - b. Attachment B: Intravenous Moderate Sedation and Deep Sedation/General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios

~~F. Table 21.4: CHDP/EPSDT Periodicity Schedule for Dental Referral By Age, Revised 2/20/2019~~

~~G.~~10. Table: Bright Futures/American Academy of Pediatrics Recommendations for Preventative Pediatric Health Care, Updated July 2022

~~H. CMS Medicare Dental Coverage~~

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

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POLICY AND PROCEDURE

Policy Number	~~UM-025~~CM-044
Policy Name	Guidelines for Obstetrical Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	~~Utilization Management Director~~Director of Social Determinants of Health
Lines of Business	MCAL, IHSS, DSNP
Effective Date	12/4/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	~~7/17/2024~~TBD

POLICY STATEMENT

General Guidelines

A. The Alliance covers and ensures the provision of all medically necessary services for members who are pregnant and postpartum. All providers of obstetrical (OB) services to Members are required to follow the most current editions and strictest guidance of the following:

1. Standards for Obstetric Services and Guidelines and Oral Health Care during Pregnancy and Through the Lifespan from the American College of Obstetricians and Gynecologists (ACOG).
2. Guidelines for Perinatal Care, The American Academy of Pediatrics
3. Guide to Clinical Preventive Services, Report of the U.S. Preventive Services Task Force.
4. Newborn Screening regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.
5. Comprehensive Perinatal Services Program (CPSP) regulations as set forth in Title 22.
6. Maternity Care Clinical Recommendations & Guidelines, AAFP
~~6.~~7. Assembly Bill No. 1936 – Maternal Mental Health Screenings

Collaboration

B. In addition to medical OB services, all Members receive perinatal support services, including an initial comprehensive risk assessment, reassessments, interventions as determined by risk, and an Individualized Care Plan (ICP).

C. All Members may initiate perinatal services without prior authorization with any Alliance OB practitioner. Perinatal services include basic and low risk nutrition, health education, and psychosocial support services. Referrals for high-risk OB, dental anesthesia, nutrition, health education, and psychosocial services are processed through the regular authorization process.

Obstetrical Care by Certified Nurse Midwives and Certified Nurse Practitioners

A. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) and Certified Nurse Practitioners (CNP).

B. CNMs and CNPs must contract with the Alliance to care for Alliance Members.

C. Prenatal care initiation does not require prior authorization from a PCP.

D. Members have the right to obtain out-of-network CNM/CNP services if a CNM/CNP is not available in the Alliance network within the time and distance requirements.

PCP Role in Care of Pregnant Members

A. PCPs are responsible for assessing Member's health status, including potential pregnancy.

B. PCPs may provide prenatal care to pregnant Members within their scope of practice.

C. PCPs are responsible for referring pregnant Members for prenatal care to an obstetrical (OB) practitioner within the Alliance or referring Members for voluntary termination of the pregnancy if desired by the Member.

D. PCPs are responsible for coordination of care with the OB practitioner, if necessary.

E. Members may also self-refer for prenatal care and voluntary termination within the Alliance. Basic prenatal care or preventive services do not require pre-authorization.

F. Members of childbearing age are informed of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

G. Alliance provider credentialing standards are applied to all prenatal care providers.

Multi-Disciplinary Perinatal Services

A. All Members receive perinatal support services in addition to medical Obstetrical (OB) care. Support services are in the areas of nutrition, health education, dental and psychosocial issues, and are provided by a variety of multi-disciplinary staff as appropriate, including doula services.

B. The Alliance maintains a Memorandum of Understanding (MOU) with the Alameda County Public Health Department for Maternal and Child Health.

Collaboration

PROCEDURE

General Procedures

A. **Accessing Perinatal Services**:

1. Once the PCP, Case Management or any other practitioner has established that the Member is pregnant, the Member may initiate prenatal care from an Alliance OB. Members may receive assistance from the PCP or Alliance Member Services in scheduling an appointment.
2. The initial prenatal visit must be made within one week of the request. Urgent prenatal visits must be scheduled the same day. Prenatal care should be initiated within the first trimester whenever possible. The initial prenatal visit may not be delayed for authorization.
3. Members may access basic support services without prior authorization. Basic services include the initiation of prenatal care visits, initial comprehensive risk assessment, all subsequent risk assessments each trimester, and low risk interventions conducted in the OB practitioner's office. Referrals for high-risk OB conditions, health education, nutrition, dental anesthesia, or psychosocial services are processed through the standard authorization process.

B. Initial Comprehensive Assessment (ICA). The ICA must be completed and documented at the initial prenatal visit, ideally within 4 weeks of entry to prenatal care. Providers must use a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. They must maintain the results of this assessment as part of the member's obstetrical record, which includes the following:

1. Physical examination to evaluate the Member's current condition, including height, weight, blood pressure, breast exam, abdominal and pelvic exams, and external and internal genitalia evaluation, as appropriate.
2. Comprehensive health and obstetrical history with information on past and current pregnancies, Estimated Delivery Date (EDD), menstrual history, family planning methods used, detailed history of past pregnancies and outcomes, medication sensitivities and allergies, family health and social history.
3. Nutritional assessment, to include dietary evaluation and prenatal vitamin/mineral supplementation.
4. Psychosocial assessment, to include past and present social and mental health history, substance use/abuse, support systems/resources.
5. Health Education assessment of language and education needs; and
6. Laboratory tests to include:
    a. Hemoglobin/hematocrit
    b. Urinalysis and microscopic examination or culture
    c. Urine testing to detect asymptomatic bacteriuria
    d. Blood group and Rh type determination
    e. Rubella antibody titer measurement

f. Gonorrhea culture, VDRL/RPR and chlamydia
g. Antibody screen
h. Cervical cytology (Pap Smear)
i. Hepatitis B testing
j. TB screen as indicated by risk status
k. Toxicology screen as indicated by risk status

7. Assessment of diabetic risk factors necessitating glucose screening, and any risk factors that may affect treatment (e.g., other medical conditions, significant past medical history, etc.).
8. HIV testing and counseling.

C. Individualized Care Plan (ICP). The initial prenatal evaluation must also include the development of an ICP, and interventions as appropriate. Each identified risk must be followed up with appropriate interventions consistent with ACOG standards and CPSP standards that are documented in the medical record. The interventions must be designed to ameliorate or remedy the specified risk condition and for Medi-Cal members, must be consistent with the requirements of Title 22, CCR, Sections 51348 and 51348.1. Each Member's ICP must document the Member's risk condition(s) and include the following elements:

~~a.~~1. Identification of proposed interventions
~~b.~~2. Identification of method(s) of intervention (e.g., referral, counseling by a specified staff person)
~~c.~~3. Anticipated outcome of intervention
~~d.~~4. Identification of staff person responsible
~~e.~~5. Members should receive care through a multi-disciplinary team approach, with interventions by various staff types as needed.

D. The risk assessment may be completed virtually through a telehealth visit with the member's consent. Whether the assessment is performed in person, telephonically, or by telehealth, it will be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

Subsequent Comprehensive Prenatal trimester re-assessments: Comprehensive prenatal re-assessments for risk factors must be completed once each trimester after the initial prenatal visit and at the postpartum visit, using a comprehensive risk assessment tool that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348, and include documentation of obstetric/medical, nutrition, psychosocial and health education re-assessments.

E. The OB practitioner assesses risk factors and the need to access appropriate specialists to assist in the provision of care, including perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, Licensed Midwives, Certified Nurse Practitioners, Doulas, and genetic screening. Alliance OB practitioners are responsible for the provision of counseling for nutrition, health education and psychosocial needs, or appropriate referrals to specialists and other services, as required.

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F. If administration of the risk assessment tool is missed at the appropriate timeframes, the provider and the Alliance must ensure case management and care coordination are working directly with the member to accomplish the assessment.

G. Each Member's ICP must be reviewed in the second and third trimesters, and in the postpartum period. The ICP should be reviewed more often as the Member's risk status is required and updated accordingly.

H. All Members must receive a prescription for prenatal vitamins as a standard of care.

I. Ante partum Care

1. Visits for an uncomplicated pregnancy include an exam every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter. Women with active medical or OB problems should be seen more frequently at intervals determined by the nature and severity of the problems.
2. Each ante partum visit must include the following:
    a. Measurement of blood pressure
    b. Weight
    c. Measured fundal height
    d. Fetal heart rate
    e. Urinalysis for albumin and glucose
3. The Alliance offers tests and screens recommended by ACOG at the appropriate times during the pregnancy, or as required.

J. Realizing that the pregnant Member has a variety of needs, Alliance allows perinatal services to be provided to Members by a variety of staff, within their scope of practice, as appropriate. Physicians, non-physician practitioners, nurses, medical assistants, social workers, dieticians, health educators, doulas or others may provide interventions as suitable.

K. Antenatal screening must be done when indicated to identify risks prior to pregnancy. Couples who have increased risks for producing abnormal offspring are offered the opportunity to undergo prenatal diagnostic studies after appropriate counseling.

L. OB practitioners are responsible for all education and specialized diagnostic referrals for their members. OB practitioners are responsible for the care and monitoring of pregnancy for Members, and coordination of all referrals and communication between specialists and PCPs.

1. Genetic Screening:
    a. Each pregnant Member receives screening and assessment for genetic risk factors. Members assessed as at risk for genetic disorders receive counseling and referrals, as appropriate.
    b. The initial prenatal evaluation must include a risk assessment and screening for genetic risk factors. Included in the assessment is a maternal serum alpha- fetoprotein (MSAFP) screen between 16-18 weeks of

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gestation.

c. Factors which place Members at risk include:
   - Advanced maternal age (mother 35 years or older at expected time of delivery)
   - Previous offspring with a chromosomal aberration
   - Chromosomal abnormality in either parent
   - Family history of a sex-linked condition
   - Ancestry indicating risk for Tay-Sachs, sickle cell anemia, or other hemoglobinopathies

d. Newborns must also be screened and referred for genetic disorder evaluation as appropriate.

~~M.~~

~~N.~~M. As the primary practitioner of care during pregnancy, the OB practitioner is responsible for identifying the newborn's Physician on the ante partum record. In addition, the OB practitioner, with the hospital, coordinates referral of the newborn to an Alliance PCP for inpatient newborn care and continuing outpatient care.

~~O.~~N. The OB practitioner is responsible for coordinating the care of the Member back to the PCP after the postpartum evaluation is completed.

~~P.~~O. Dental screening is included as a part of routine prenatal care and is also available through the PCP. The PCP is responsible for screening Members for dental and oral health and making referral for treatment as appropriate. Referral for dental care does not require prior authorization by the Alliance, and Members may self refers to Medi-Cal dental practitioners. Healthy Families and Healthy Kids Members may access dental care through their contracted Dental Plan. See Policy UM-024 "Coordination of Care – Dental Services".

P. Maternal Mental Health Screening – Assembly Bill No. 1936 requires at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgement of the treating provider.

Q. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) and Certified Nurse Practitioner, (CNP). CNMs/CNPs must meet Alliance's credentialing standards and be contracted with the Alliance. Services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period. CNMs/CNPs must have physician back-up with an Alliance obstetrical practitioner who is contracted and credentialed by the Alliance and must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has privileges.

R. High Risk Obstetrical Care:

1. High risk OB Members must be referred for evaluation and care if beyond the scope of practice of the initial prenatal practitioner. High risk indicators (or markers) include:

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a. Evidence or history of asthma, gestational diabetes, pre-eclampsia, or eclampsia
b. Indication of multiple fetuses
c. Prior C-sections
d. History of complicated deliveries such as placenta previa or abruption placenta
e. History of pregnancy difficulties such as incompetent cervix
f. Prior premature labor and/or delivery
g. History of substance use/abuse
h. Homelessness
i. Under 18 or over 35 years of age.

2. The Alliance ensures that appropriate hospitals are available within the network to provide high-risk pregnancy services.

S. Intra-partum Care

1. As a part of their prenatal care and counseling, all Members must be informed of the hospital where they are going to deliver.

T. Postpartum Care must include the following services:

1. A comprehensive postpartum review and examination is required between three and eight weeks after delivery. The postpartum assessment must include the following 4 components:
   a. Obstetric/medical exam: an interval history and physical examination to evaluate the Member's current condition that includes weight, blood pressure, breast exam, abdominal exam, external and internal genitalia evaluation, and laboratory tests, as necessary;
   b. Nutritional assessment: dietary intake of mom and infant feeding status, that includes evaluation of problems/needs of the breastfeeding mother;
   c. Psychosocial assessment: evaluation of Member's emotional status, resources, and available support system; and
   d. Educational needs assessment.
2. The development of an ICP and interventions as appropriate.
3. Family Planning Evaluation: This evaluation includes education on family planning and counseling, referral, and provision of services.
4. Referral to a pediatric practitioner for follow-up, as indicated.
5. Referral to the WIC program for State Program Members or Members that meet WIC's financial eligibility requirements (see Section 12E, "Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)").
6. Immunization information, including rubella, if appropriate.
7. Evaluation for special problems and return-to-work status, as indicated.
8. Referral to a Dentist for preventative care (exam/ cleaning) or therapeutic (extractions, fillings, abscess drainage, root canal), and to promote oral health for infants.

Collaboration

a. Medi-Cal Postpartum Care Extension (PCE) under the Provisions of American Rescue Plan Act (ARPA)"

- i. "Effective 4/1/2022, the Medi-Cal postpartum coverage period was extended from 60 days to 12 months for all Medi-Cal eligible pregnant individuals under the providers of the ARPA. The 12 month postpartum coverage period for Medi-Cal eligible pregnant individuals begins on the last day of pregnancy and will end on the last day of the month in which the 365th day occurs. ARPA PCE is an automatic postpartum extension"
- ii. **"**Minor Consent beneficiaries do not qualify for ARPA PCE, as eligibility is month-to-month and cannot be applied automatically."
- iii. The only allowable reasons that an individual can be discontinued from the ARPA PCE protections during their pregnancy and/or the 365-day postpartum period are as follows:
  - Death
  - Loss of California residency
  - Beneficiaries request for discontinuance
  - Receipt of Supplemental Security Income
  - Aid on another Case

Certified Nurse Midwives/Certified Nurse Practitioners

A. Once pregnancy has been established by the PCP, Members may either request initiation of prenatal care from an Alliance Obstetrician, CNM/NPor other qualified prenatal care practitioner, or receive assistance from the PCP or the Alliance in scheduling an appointment.

B. Members may receive services from any gynecological or obstetrical specialist provider (OB/GYN), certified nurse midwife, certified nurse practitioner, or within the Alliance Network. Alliance providers are listed in the Provider Directory.

C. The law states Medi-Cal Members may get family planning services from any family planning agency, clinic, or provider who is willing to accept Medi-Cal rates.

D. CNMs must have physician back up with an Alliance network obstetrical practitioner credentialed by the Alliance for consultation, high-risk referral, and delivery services, as needed.

1. The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivery facility in which the CNM has delivery privileges.
2. The designated supervising physician or surgeon may not exceed the established ratio of 1:3 (full-time equivalent) CNMs.
3. The designated supervising or back-up physician is available in person or by electronic communication when the CNM is caring for patients.

E. The CNM must operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the CNM, and the administration within the Delegated Provider in which standardized procedures are used.

Collaboration

1. Standardized Procedures for the CNM define the scope of services provided by the CNM, and must identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.
2. Standardized Procedures and Supervisory Guidelines must undergo periodic review, and are revised, updated, and signed by the supervising physician and CNM at each change in scope of services.
3. A current copy of the Standardized Procedures must be available at each facility where services are rendered for members.

Each CNM that prescribes controlled substances must have a valid DEA Registration Number.

PCPs

A. PCPs are responsible for assessing whether a member is pregnant, including providing pregnancy testing as appropriate.

B. Once a member is determined to be pregnant, PCPs are responsible for determining whether the Member plans to carry the pregnancy to delivery or wishes to pursue a voluntary termination.

C. If the Member plans to continue the pregnancy, the PCP is responsible for referring the Member to an OB, or giving the Member a choice of OB practitioners, within the Alliance network.

D. For Members wishing to pursue voluntary termination of the pregnancy, PCPs are responsible for assisting with the referral to an Alliance provider.

E. For pregnant Members in prenatal care, PCPs are responsible for coordinating care with the OB practitioner as necessary, including but not limited to:

1. Informing the OB by phone or in writing of any significant medical conditions that may impact, or be impacted, by the pregnancy.
2. Coordinating referrals with the OB for any necessary specialty care needed for the Member.

F. Providing updates to the OB during the pregnancy of changes in the Member's medical status as needed.

Multi-Disciplinary Perinatal Services

A. Members must have an Individualized Care Plan (ICP) developed that outlines a plan for addressing specific risks. These services are to be offered in the medical, health education, nutrition, and psychosocial areas. Participation in support services is voluntary, and Members have the right to refuse any or all the services offered.

B. Members may access basic perinatal support services from an obstetrical provider within the Alliance Provider Network, without prior authorization from the Alliance. Examples of basic perinatal support services include:

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1. Basic nutritional counseling for women at low nutritional risk due to minor dietary deficiencies.
2. Basic health education interventions include counseling regarding exposure to secondhand smoke, counseling regarding alcohol use during pregnancy, etc.
3. A basic psychosocial intervention for women with low-risk conditions such as counseling women regarding sibling rivalry, and expectations for the pregnancy.

C. Basic perinatal support services are generally provided by one of the multi-disciplinary staff members in the perinatal practitioner's office. Examples of staff that can provide basic services include:
   1. MD or DO
   2. Nurse Practitioner
   3. Certified Nurse Midwife
   4. RN
   5. LVN
   6. Medical Assistant
   7. Social Worker
   8. Health Educator
   9. Health Care Worker

D. The Alliance ensures that pregnant and postpartum members are referred to Doulas as required under W&I Code section 14132.24.

E. Multi-disciplinary staff members in a perinatal practitioner's office only provideservices within their scope of licensure and appropriate training. These may include:
   1. Staff training in maternal health
   2. Emergency readiness
   3. Transfer protocols
   4. Quality improvement programs
   ~~E.~~5. Behavioral health integration

F. Members needing perinatal support services for high-risk conditions identified through the risk assessment tool are referred for appropriate intervention utilizing the Providers referral authorization process. ~~Examples of high-risk conditions are outlined in Policy 12D1, "Guidelines for Obstetric Services."~~

G. ~~.~~Perinatal support services for Members with high-risk conditions are generally provided outside the perinatal practitioner's office by licensed professionals including:
   1. Registered Dietitian
   2. Health Educator with ~~master's~~ Master's level degree
   3. Marriage, Family and Child Counselor (MFCC) or Licensed Clinical Social Worker (LCSW)

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will

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also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

~~None.~~

Maternal mental health: mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-015 Minor Consent to Medical Care
HED-010 Doula Services
UM-024 Coordination of Care – Dental Services
UM-029 Sensitive Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024

REFERENCES

1. 1. American Rescue Plan Act of the 117th Congress 2021-2022 (ARPA) (Pub. Law 117-2)
2. Assembly Bill No. 1936
3. California Business and Professional Code 2725
4. 42 CFR §482.59, 422.107
5. DHCS Contract Exhibit A, Attachment 10. Provision 7 2.
6. DHCS MMCD Policy Letter 12-003, Obstetrical Care- Perinatal Services
7. Title 22, CCR, Sections 51240, 51241, 51348, 51348.1

~~3. California Business and Professional Code 272~~
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~~4.~~8. W&I Code section 14132.24
~~5. Title 17, California Code of Regulations, Section 6500 et seq.~~

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Collaboration

~~6. DHCS MMCD Policy Letter 12-003, Obstetrical Care-Perinatal Services~~
~~American Rescue Plan Act of the 117th Congress 2021-2022 (ARPA) (Pub. Law 117-2)~~
~~7. Assembly Bill No. 1936~~

MONITORING

The Compliance and ~~Utilization~~ Case Management Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity and Administrative Oversight Committees annually.

collaboration

POLICY AND PROCEDURE

Policy Number	~~UM-030~~CM-045
Policy Name	Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, DSNP
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	~~12/18/2024~~TBD

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POLICY STATEMENT

Alliance PCP, Obstetrical (OB), and Pediatric practitioners must inform Members of the availability of WIC services and make appropriate referrals to the local WIC program for their assigned Members who are potentially eligible for WIC services.
The Alliance maintains a Memorandum of Understanding (MOU) with Alameda County that includes referrals into the WIC program as required in DHCS Contract Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) that ensure closed loop referrals. AAH maintains procedures to identify and refer eligible Members for WIC services. As part of the referral process, AAH ensures the provision to the WIC program of the Member's current hemoglobin or hematocrit laboratory value. AAH also ensures the documentation of the laboratory values and of the referral in the Member's Medical Record.
AAH ensures the referral, and documentation of the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

PROCEDURE

A. Identification:

1. The WIC program provides nutrition assessment, education and counseling to participants, coupons for supplemental foods from WIC authorized vendors, and links participants to community resources. WIC works in collaboration with the participant's medical practitioner and encourages ongoing and preventive care.
2. WIC participants must meet the following eligibility criteria:

Confidential Information

a. Pregnant, breastfeeding up to one year, post-partum non-breastfeeding up to 6 months
b. Child from birth to age of fiveMeet income guidelines
c. Live in a local agency's service area
d. Determined to be at nutritional risk by a health professional
e. Receive regular medical assessments

3. Members receive information regarding availability of the WIC Programthrough the following methods:
   a. OB, pediatrician, or other PCP
   b. Alliance Member Services Department
   c. Member Newsletter
4. Providers must identify pregnant, breastfeeding, and postpartum women, as well as children under the age of five, who would benefit from participating in the WIC program as part of the Initial Health Assessment (IHA) of Members, or, as part of the initial evaluation of newly pregnant women.
   a. They must also, no less than annually provide written notice of the availability of WIC, benefits including the location and telephone number of the local WIC agency, or instructions on how to obtain more information.
   b. Providers must provide all members who are blind, deaf or need the documents available in another language with alternative access to the information.

B. Referral:

1. Each county WIC program can provide OBs, pediatricians, and other PCPs with WIC informational brochures, and educational materials for Members.
2. OBs, pediatricians, and other PCPs assist Members in applying for WIC by providing referral numbers to WIC centers and the required documentation, including:
   a. Height and weight
   b. Identified nutritional risk factors
   c. Estimated date of delivery for pregnant women
   d. Growth assessment for infants and children
   e. Results of hemoglobin or hematocrit laboratory tests
   f. Identification of any high-risk condition
   g. Diagnosed clinical conditions as appropriate
   h. Physical/medical, biochemical, and anthropometric data
   i. Medical justification for members requiring special therapeutic formula which is not a WIC contract formula.
3. Such documentation can be provided to the patient for submission to WIC on the WIC referral form, (PM 247 or PM 247A), the physician's prescription pad, or other

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reporting forms commonly used by the PCP.

4. The referring practitioner must document the WIC referral in the member's medical record.
5. If required, the referring practitioner must provide additional laboratory test results or other data to the WIC program.
6. Members must apply for WIC services directly and meet eligibility requirements.
7. Program Sites – A list of WIC program sites in Alameda County can be found on the California State WIC Branch's website.

WIC Program Sites

California State WIC Branch Phone: (888) 942-9675
http://www.cdph.ca.gov/Programs/CFH/DWICS N

Alameda County Healthcare Services Agency - WIC Program Phone: (510) 595-6400
Participant Information/Appointments
Phone: (510) 595-6464 Provider Information Serving all areas of Alameda County
Offices at most community clinics and at the City of Berkeley Public Health Department

C. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP- 019 Monitoring of Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/28/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 12/18/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 11, Provision 17
DHCS Contract Exhibit A, Attachment III, section 2.2.10 and section 4.3.20
Title 42 Chapter IV Subchapter C Part 431 Subpart M 431.635

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee, and Administrative Oversight Committee, for annual review and approval.

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POLICY AND PROCEDURE

Policy Number	UM-035
Policy Name	Care Coordination - Vision Services
Department Name	Health Care Services
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, DSNP
Effective Date	01/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024, TBD
Administrative Oversight Committee Approval Date	12/18/2024, TBD

Purpose:
~~To establish guidelines for the provision of vision services in healthcare settings ensuring compliance with DHCS and CMS regulations~~To outline the process used to ensure access to medically necessary care for the provision of vision services in healthcare settings consistent with DHCS and CMS requirements.

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Scope:
This policy applies to all healthcare professionals involved in the care of vision services for members

POLICY STATEMENT

A. PCPs are required to perform vision screening examinations as part of the initial health assessment and as part of specified other physical examinations such as the Bright Futures/ American Academy of Pediatric Preventive Pediatric Health Care.

B. PCPs are responsible for referring Members to vision specialists for care on a routine basis following evidenced based guidelines, school-based screening, or as needed based on results of the vision screening exams

C. PCPs are required to provide covered medical services related to vision services that are not provided by vision specialists. Covered medical services include prescription drugs on the Alliance formulary; laboratory services; and pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a vision procedure.

D. Per APL 23-005 requirements for Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)), vision services are provided at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and include diagnosis and treatment for defects in vision, including eyeglasses.

E. AAH Providers must use the current AAP/ Bright Futures periodicity schedule and guidelines when delivering the Medi-Cal Kids and Teens (EPSDT) benefit, including but not limited to screening services, and vision services.

F. All Alliance members have an ophthalmology benefit and may be referred to an ophthalmologist by their PCP or specialist if the member experiences a medical eye problem.

G. CMS offers services that are medically necessary to diagnose or treat specific medical condition or injury, such as glaucoma, diabetes, cataracts with and without lens replacement, congenital issues.

~~G.~~ **Vision benefits and services for Alameda Alliance Wellness D-SNP members are managed by VSP Vision.** These services are delegated to VSP Vision, which oversees their administration. Members receive information on how to contact VSP Vision for accessing these services at enrollment, in the Explanation of Coverage, and the Member Handbook.

H. Vision benefits differ based by Line of Business as described in the Explanation of Coverage (EOC) booklet:

1. Medi-Cal EOC Section 4 Benefits and Services: Vision Benefits
2. Alliance Group Care EOC Contact Public Authority

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Commented [AL1]: Add the D-SNP EOC reference

PROCEDURE

A. ~~P~~Provider Services Department will educate PCPs and Specialists of their responsibility to provide and document vision services through the Provider Manual and other periodic communication as needed:

1. As part of the initial health evaluation for new members, PCPs shall conduct a vision~~1s1on~~ screening.
2. ~~PCPs shall~~PCPs provide routine preventive vision ~~advice.~~advice.
3. PCPs shall continue to observe the Member for vision conditions during periodic health examinations for adults and according to the Alliance's Pediatric Preventative Services requirements for children with referrals for treatment as appropriate.
4. PCPs shall refer to the appropriate vision provider based on the member's plan benefit.
5. PCPs shall document the results of the vision screening exam in the medical record.
6. PCPs shall continue to provide all medically necessary health care services to Members even if referred to a vision practitioner for services.

B. Members may call the Alliance Member Service using the number printed in their Explanation of Coverage booklet.

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DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

REVISION IDSTORY

10/28/09, 9/20/1, 9/7/12, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 12/18/2024

REFERENCES

MediCalEOC
Alliance Group Care EOC
All Plan Letter 23-005 Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
DHCS Contract Exhibit A, Attachment 10, Sections 3, 5, 6, and 8.D.
Preventive Care/ Periodicity Schedule (Bright Futures / AAP), Preventive Care/Periodicity Schedule (aap.org)
CMS Medicare Vision Services

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/10/2016
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~11/15/2024~~
Administrative Oversight Committee Approval Date	TBD~~12/18/2024~~

POLICY STATEMENT

Alameda Alliance will meet all applicable state and federal timely decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.

POLICY

A. Alameda Alliance maintains current regulatory required timeliness standards for Utilization Review decision making and subsequent notification timeframes of the decision to both the Member and Provider.

1. Regulations, licensure and contractual requirements, and accreditation standards require Utilization Management (UM) decisions (medical and behavioral health) and notifications to be made within required timeframes. When these required timeframes differ, Alameda Alliance has determined that the strictest standard takes precedence.

2. The attached, "UM Timeliness Standards for Medi-Cal/ Group Care/D-SNP" document shows the timeliness standards specific to Medi-Cal, ~~and~~ Group Care and D-SNP and is based on DHCS, DMHC, 42 CFR, Health and Safety Code §1367.01, & NCQA Standard UM 5.

3. UM timeliness standards shall apply to all UM decisions whether the decisions are made on the basis of benefit coverage or on medical necessity, and to all UM decisions; approvals (favorable), partially favorable, modifications, denials (adverse), and terminations.

B. Measurement of Timeliness

Commented [MF1]: @Lam, Allison how are we going to handle Hospice requests- I do not see them specifically on the grid, but APL 25-008 it mentions "MCP policies and procedures (P&Ps) should clarify and detail how Members may access hospice care services in a timely manner, preferably within 24 hours of the request from in-Network hospice Providers. "

Are we going to follow the 24 hour TAT for Hospice moving forward?

Commented [AL2R1]: The DHCS contract specifies 24hrs, so I think it's safe to go with DHCS timeframe if CMS doesn't specify. @Findlater, Michelle however, can you confirm with the Hospice section of the D-SNP EOC? It mentions that original Medicare is responsible for hospice requests.

1. Counting days for Authorization Requests
   a. Day of receipt of request is counted as day zero.
   b. Day following day of receipt of request is counted as day one, etc.

2. Counting Hospital Days
   a. Day of admission is counted as day one
   b. Discharge day is not counted.

C. Determining Day of Receipt of a Request for Authorization at AAH
   1. The day of receipt of a request for authorization is when the request is made to Alameda Alliance in accordance with its reasonable filing procedures, regardless of whether Alameda Alliance has all the information necessary to make the decision at the time of the request.

D. Receiving Authorizations During Business Hours and After Business Hours

   1. For requests received during normal business hours by UM phone line, fax, or portal the date/time received is logged as the same the telephone call, fax, or portal submission is received.

   2. Alameda Alliance informs providers, via the provider manual and website that Acute Inpatient, Post Stabilization or Urgent Discharge ~~urgent~~ requests submitted after normal business hours should be made by calling UM On-call line 510-326-5271.
      a. For requests received by fax or portal submissions that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.

E. Alameda Alliance has a process for determining urgency (expedited request status)
   1. When a pre-service request is marked as urgent (expedited) on the request form and the UM Clinical Reviewer questions the urgency, the UM Clinical Reviewer will forward the request to a Medical Director reviewer to determine whether the request is urgent (expedited) or routine, based on the presenting referral information.
      a. The Physician Reviewer is the only decision maker than can determine if a request needs to be deescalated from Urgent to Routine.

F. Concurrent Review
   1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a care plan has been agreed upon by the treating provider which is appropriate for the medical needs of that patient.

PROCEDURE

A. AAH time frames for processing UM request per attachment grid A:

   1. Performs medical review of authorization requests for covered benefits and Medical Necessity.

   2. Makes utilization decisions within required decision timeframes, but also within a timely manner in order to expedite care to Members.

3. Sends notifications to the Member and Provider about UM decisions according to the applicable current regulatory timeliness standards while using the correct decision template per line of business

(1) D-SNP: Integrated ~~Organizational Determination~~Coverage Decision Letter
(2) Group Care: Notice of Action
~~3.~~(3) MediCal: Notice of Action~~s.~~

B. The time of receipt of a request for authorization is when the request is made to AAH in accordance with its reasonable filing procedures, regardless of whether AAH has all the information necessary to make the decision at the time of the request.

1. For requests received during normal business hours, the date of receipt is logged as the same day the telephone call, fax, or portal submission is received.

2. For requests received outside of normal business hours via the UM on-call phone line ~~by~~ 510-326-5271 ~~line~~, the date of receipt is logged as the same day the telephone call is received.

3. For requests received by fax or portal that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.

C. Determining whether a Pre-Service Review marked as Urgent (Expedited) meets the definition of Pre-Service Review, Expedited (Urgent)

1. If the Medical Director makes the determination that the request does not meet expedited criteria, then the Medical Director may ask the Nurse reviewer to obtain additional information from the requesting provider to support the decision and /or will attempt to contact the requesting provider via a physician-to-physician phone call.
    a. For those non-supported expedited request then the Medical Director will change the status to routine and the UM Clinical Reviewer will follow notification policy

2. The UM Clinical Reviewer gives the name of the Medical Director and phone number to the requesting physician.

3. When a pre-service request is marked as Urgent (expedited) on the request form, the UM Clinical Reviewer will review for urgency and then refers to Medical Director for final determination in those cases perceived not to be urgent.

4. In those instances where the medical director disagrees with the requesting physician on urgency, a physician-to-physician phone call will be attempted.

D. When a pre-service request for pharmaceuticals (including injectables) and Part B Medication is received by FAX or portal in the UM Department, the UM staff Member receiving the submission notifies the Pharmacy staff via the pharmacy group email to enable Pharmacy to complete the pharmaceutical review.

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Commented [MF3]: @Lim, Luke this process refers to an e-mail from UM to Pharmacy- I want to verify that is the process we should continue vs utilizing the task feature within Tru Care.

Commented [LL4R3]: I see those emails and we should continue using this.
We'll need to design a different notification process in case of expedited that arrives over weekend or holiday, starting in 2026.

1. Physician Administered Drug reviews follow Pharmacy timeliness requirements (see RX-011 Decision and Notification Requirements)

2. Therapeutic enteral formula reviews follow the medical UM timeliness requirements, (Pre-Service Urgent, Routine, Routine Current, Urgent Concurrent, Delay, Retrospective, etc.), per MMCD Policy letter 12-005 Enteral Feeding.

E. MONITORING

1. The Utilization Management Department, on a routine basis, reviews the results from the monthly authorization audit ~~to ensure that all elements of timeliness are met. conducted by the Alliance Compliance Department~~. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

Commented [WM5]: @Findlater, Michelle I was looking for something monitoring related and just happened to notice this is saying the Compliance Department. I remember seeing a comment somewhere from Allison saying Compliance did not do the audits. I was not sure if this was the same case here or not.

Commented [MF6R5]: Thanks- I will Modify this.

DEFINITIONS / ACRONYMS

A. ~~**Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider~~**Centers for Medicare and Medicaid (CMS)** a federal agency within the U.S. Department of Health and Human Services that administers the nation's major healthcare programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health insurance marketplace.

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B. **Department of Health Care Services (DHCS)** is the State agency responsible for administration of the Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP). Child Health and Disabilities Prevention (CHDP) and other health related programs.

C. **Department of Mental Health Care (DMHC)** is the state agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community base public mental health services statewide.

D. **Integrated Coverage ~~Determination~~Decision Letter** is a standardized notification issues by D-SNP plans when they make adverse integrated organizational determinations under 42 CFR § 422.631.

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~~D.~~E. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

F. Notice of action (NOA) is a formal written notification issued by a Managed Care plan to inform members and providers that an adverse benefit determination has occurred.

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~~E.~~G. **Member** means any eligible beneficiary who has enrolled in Alameda Alliance for Health or Group Care.

~~F.~~H. **Post Stabilization Care** means Medically Necessary care following stabilization of an Emergency Medical Condition.

I. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

~~G.~~J. **Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider

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~~H.~~K. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

~~I.~~L. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. It is a formal review of the coverage, Medical Necessity, efficiency, or appropriateness of health care services, which can be performed on a preservice, concurrent, or post service basis.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management Department (UM/ LTSS)
Compliance Department
Pharmacy Department

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RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
RX-011 Decision and Notification Requirements
UM-001 UM Authorization Processes
UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal, ~~and~~ Group Care and D-SNP

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REVISION HISTORY

11/10/2016, 4/12/2018, 4/16/2019, 5/21/2020, 3/18/2021, 3/22/2022, 02/21/2023, 12/18/2024, 8/1/2025

REFERENCES

1. 2025 UM Standards; UM 5, Element A: Notification of Nonbehavioral Healthcare Decisions

2. 42 CFR § 422.631, 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), 422.590 (e), 422.631(a) and 422.633(f))

~~1. Attachment 13 – Member Services, Item 8 (A) through (E)~~

~~2.~~3. CA Health and Safety Code sections 1367.01(h)(1) through (5)

4. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care

5. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)

~~3.~~6. EAE SMAC (2025 Boilerplate, AIP D-SNP Model Materials)

~~4.~~7. MMCD Policy Letter 12-005 Enteral Feedings

~~5.~~8. Title 22 CCR Section 53855 (a) or any future amendments thereto.

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POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/10/2016
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~11/15/2024~~
Administrative Oversight Committee Approval Date	TBD~~12/18/2024~~

POLICY STATEMENT

Alameda Alliance will meet all applicable state and federal timely decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.

POLICY

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2. The attached, "UM Timeliness Standards for Medi-Cal/ Group Care/D-SNP" document shows the timeliness standards specific to Medi-Cal, ~~and~~ Group Care and D-SNP and is based on DHCS, DMHC, 42 CFR, Health and Safety Code §1367.01, & NCQA Standard UM 5.

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   a. Day of admission is counted as day one
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   1. The day of receipt of a request for authorization is when the request is made to Alameda Alliance in accordance with its reasonable filing procedures, regardless of whether Alameda Alliance has all the information necessary to make the decision at the time of the request.

D. Receiving Authorizations During Business Hours and After Business Hours

   1. For requests received during normal business hours by UM phone line, fax, or portal the date/time received is logged as the same the telephone call, fax, or portal submission is received.

   2. Alameda Alliance informs providers, via the provider manual and website that Acute Inpatient, Post Stabilization or Urgent Discharge ~~urgent~~ requests submitted after normal business hours should be made by calling UM On-call line 510-326-5271.
      a. For requests received by fax or portal submissions that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.

E. Alameda Alliance has a process for determining urgency (expedited request status)
   1. When a pre-service request is marked as urgent (expedited) on the request form and the UM Clinical Reviewer questions the urgency, the UM Clinical Reviewer will forward the request to a Medical Director reviewer to determine whether the request is urgent (expedited) or routine, based on the presenting referral information.
      a. The Physician Reviewer is the only decision maker than can determine if a request needs to be deescalated from Urgent to Routine.

F. Concurrent Review
   1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a care plan has been agreed upon by the treating provider which is appropriate for the medical needs of that patient.

PROCEDURE

A. AAH time frames for processing UM request per attachment grid A:

   1. Performs medical review of authorization requests for covered benefits and Medical Necessity.

   2. Makes utilization decisions within required decision timeframes, but also within a timely manner in order to expedite care to Members.

3. Sends notifications to the Member and Provider about UM decisions according to the applicable current regulatory timeliness standards while using the correct decision template per line of business

(1) D-SNP: Integrated ~~Organizational Determination~~Coverage Decision Letter
(2) Group Care: Notice of Action
~~3.~~(3) MediCal: Notice of Action~~s.~~

B. The time of receipt of a request for authorization is when the request is made to AAH in accordance with its reasonable filing procedures, regardless of whether AAH has all the information necessary to make the decision at the time of the request.

1. For requests received during normal business hours, the date of receipt is logged as the same day the telephone call, fax, or portal submission is received.

2. For requests received outside of normal business hours via the UM on-call phone line ~~by~~ 510-326-5271 ~~line~~, the date of receipt is logged as the same day the telephone call is received.

3. For requests received by fax or portal that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.

C. Determining whether a Pre-Service Review marked as Urgent (Expedited) meets the definition of Pre-Service Review, Expedited (Urgent)

1. If the Medical Director makes the determination that the request does not meet expedited criteria, then the Medical Director may ask the Nurse reviewer to obtain additional information from the requesting provider to support the decision and /or will attempt to contact the requesting provider via a physician-to-physician phone call.
    a. For those non-supported expedited request then the Medical Director will change the status to routine and the UM Clinical Reviewer will follow notification policy

2. The UM Clinical Reviewer gives the name of the Medical Director and phone number to the requesting physician.

3. When a pre-service request is marked as Urgent (expedited) on the request form, the UM Clinical Reviewer will review for urgency and then refers to Medical Director for final determination in those cases perceived not to be urgent.

4. In those instances where the medical director disagrees with the requesting physician on urgency, a physician-to-physician phone call will be attempted.

D. When a pre-service request for pharmaceuticals (including injectables) and Part B Medication is received by FAX or portal in the UM Department, the UM staff Member receiving the submission notifies the Pharmacy staff via the pharmacy group email to enable Pharmacy to complete the pharmaceutical review.

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Commented [MF3]: @Lim, Luke this process refers to an e-mail from UM to Pharmacy- I want to verify that is the process we should continue vs utilizing the task feature within Tru Care.

Commented [LL4R3]: I see those emails and we should continue using this.
We'll need to design a different notification process in case of expedited that arrives over weekend or holiday, starting in 2026.

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1. Physician Administered Drug reviews follow Pharmacy timeliness requirements (see RX-011 Decision and Notification Requirements)

2. Therapeutic enteral formula reviews follow the medical UM timeliness requirements, (Pre-Service Urgent, Routine, Routine Current, Urgent Concurrent, Delay, Retrospective, etc.), per MMCD Policy letter 12-005 Enteral Feeding.

E. MONITORING

1. The Utilization Management Department, on a routine basis, reviews the results from the monthly authorization audit ~~to ensure that all elements of timeliness are met. conducted by the Alliance Compliance Department~~. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

Commented [WM5]: @Findlater, Michelle I was looking for something monitoring related and just happened to notice this is saying the Compliance Department. I remember seeing a comment somewhere from Allison saying Compliance did not do the audits. I was not sure if this was the same case here or not.

Commented [MF6R5]: Thanks- I will Modify this.

DEFINITIONS / ACRONYMS

A. ~~**Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider~~**Centers for Medicare and Medicaid (CMS)** a federal agency within the U.S. Department of Health and Human Services that administers the nation's major healthcare programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health insurance marketplace.

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B. **Department of Health Care Services (DHCS)** is the State agency responsible for administration of the Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP). Child Health and Disabilities Prevention (CHDP) and other health related programs.

C. **Department of Mental Health Care (DMHC)** is the state agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community base public mental health services statewide.

D. **Integrated Coverage ~~Determination~~Decision Letter** is a standardized notification issues by D-SNP plans when they make adverse integrated organizational determinations under 42 CFR § 422.631.

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~~D.~~E. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

F. Notice of action (NOA) is a formal written notification issued by a Managed Care plan to inform members and providers that an adverse benefit determination has occurred.

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~~E.~~G. **Member** means any eligible beneficiary who has enrolled in Alameda Alliance for Health or Group Care.

~~F.~~H. **Post Stabilization Care** means Medically Necessary care following stabilization of an Emergency Medical Condition.

I. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

~~G.~~J. **Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider

~~H.~~K. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

~~I.~~L. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. It is a formal review of the coverage, Medical Necessity, efficiency, or appropriateness of health care services, which can be performed on a preservice, concurrent, or post service basis.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management Department (UM/ LTSS)
Compliance Department
Pharmacy Department

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
RX-011 Decision and Notification Requirements
UM-001 UM Authorization Processes
UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal, ~~and~~ Group Care and D-SNP

REVISION HISTORY

11/10/2016, 4/12/2018, 4/16/2019, 5/21/2020, 3/18/2021, 3/22/2022, 02/21/2023, 12/18/2024, 8/1/2025

REFERENCES

1. 2025 UM Standards; UM 5, Element A: Notification of Nonbehavioral Healthcare Decisions

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2. 42 CFR § 422.631, 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), 422.590 (e), 422.631(a) and 422.633(f))

~~1. Attachment 13 – Member Services, Item 8 (A) through (E)~~

~~2.~~3. CA Health and Safety Code sections 1367.01(h)(1) through (5)

4. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care

5. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)

~~3.~~6. EAE SMAC (2025 Boilerplate, AIP D-SNP Model Materials)

~~4.~~7. MMCD Policy Letter 12-005 Enteral Feedings

~~5.~~8. Title 22 CCR Section 53855 (a) or any future amendments thereto.

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POLICY AND PROCEDURE

Policy Number	UM-054
Policy Name	Notice of Action
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	10/12/2017
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~11/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~12/18/2024~~TBD

OVERVIEW

Alameda Alliance maintains processes and mechanisms to notify members and providers of Utilization Management (UM) determinations, (medical/surgical and behavioral health,) in a timely manner according to State and Federal regulations as well as NCQA standards.

A. POLICY

1. Members and requesting practitioners are provided with written notifications of UM decisions. These include notice of action (NOA) letters for denials, modifications, and deferrals/delays, which clearly and concisely document and communicate the reasons for the decision so that members and practitioners receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.

    a. The NOA informs the member of an adverse benefit determination. An adverse benefit determination is defined to mean any of the following actions taken by the Alliance as listed below:

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i. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
ii. The reduction, suspension, or termination of a previously authorized service.
iii. The denial, in whole or in part, of payment for a service.
    a) The failure to provide services in a timely manner.
    b) The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
    c) For a resident of a rural area with only one health plan, the denial of the beneficiary's request to obtain services outside the network.
    d) The denial of a beneficiary's request to dispute financial liability.

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2. Notification documents
    a. Alameda Alliance utilizes the template NOAs approved by the California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).
        i. The Member is informed of Alameda Alliance's decision by a written NOA. The NOA templates are approved by DHCS prior to use. Any changes to the templates are subject to DHCS review and approval prior to use. The NOA includes the "Your Rights under Managed Care" attachment explaining the member's right to the Alliance's appeal process, the State Fair Hearing, and the Independent Medical Review (IMR) process. The member must exhaust their appeal right with the Plan prior to requesting a State Fair Hearing or IMR case.
            1. Deemed exhaustion of appeals processes:
            2. If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing.
            3. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

        ii. Notice of Action (NOA) Requirements
            1. The written NOA shall include the following:
                a) A statement of the action the Alliance intends to take.
                b) A clear and concise explanation of the reasons for the decision. The specific reasons for the denial shall be in easily understandable language and include the clinical reasons for a decision regarding medical necessity.
                c) A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.

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d) The clinical reasons for the decision. Alliance shall explicitly state how the member's condition does not meet the criteria or guidelines.
    i. Medical Necessity Denials: Documentation within its system the reason for the denial and the specific evidenced based criterion used to make the denial.
    ii. Benefit Denials: For each benefit/non-medical necessity denial, Document within its system the reason for the denial, including the specific benefit provision, administrative procedure or regulatory limitation used to make the denial.
e) Documentation shall include this information in the denial notice sent to the member or the member's authorized representative.
f) For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.
g) Statement included that the member can request copies of all documents and records relevant to the NOA free of charge, including the criteria and guidelines used. Any requests received by the Plan for the criteria or guidelines will include the specific procedures/conditions that were requested. The following disclosure notice will also be included with all copies of criteria requests "the materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefit covered under your contract."
h) The written NOA must have the current DHCS standardized "NOA Your Rights" Template, non-discrimination notice, and language taglines attachments enclosed. The written Your Rights Attachment includes the following:
    i. Member's or provider's right to request an internal Appeal to the Plan within 60 calendar days from the date on the NOA.
    ii. Member's right to request a state hearing only after filing an internal appeal with the Plan and receiving notice that the adverse benefit determination has been upheld.
    iii. Member's right to request a state hearing if the Plan fails to send a resolution notice in response to the

Appeal within the required timeframe (Deemed Exhaustion).

1. Deemed exhaustion of appeals process: If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing

iv. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

v. Procedures for exercising the Member's rights to request an Appeal.

vi. Circumstances under which an expedited review is available and how to request it.

vii. Member's right to have benefits continue pending resolution of the Appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.

1. The member's rights to Aid Paid Pending and instructions on how to timely file for an appeal (i.e. within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate.

2. Translation
   a) NOA templates must be translated into the required threshold languages.
   b) NOA mailed to the member must be in the preferred threshold language using the translated template. The rationale for the adverse decision will also be translated into the preferred threshold language of the member.
   c) If member's preferred language is non-threshold, the member may request the letter to be translated into their preferred language. AAH will provide the full translation within 21 calendar days.

iii. Member Identifier in Approval and NOA letters:

1. Member social security numbers or member Medicare HIC numbers can never be used in UM approval or NOA letters. Use of these numbers constitutes a protected health information (PHI) breach.
2. If there is a legitimate business need to include the member Client Identification Number (CIN) on approval and NOA UM letters, then using the CIN number would be permissible.

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iv. NOA Letters to Members and Providers sShall aAlso iInclude:
1. Member Appeal Rights according to the member's product line.
2. A reference to the evidence-based criteria, benefit provision as described in the member's EOC, guideline, protocol.
3. Medi-Cal NOA letters shall also include a citation to the specific regulations or Alameda Alliance authorization procedures supporting the action on which the deferral, modification, denial, or termination decision is based.
4. Information about how the member can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the deferral, modification, denial, or termination decision is based.
5. Information on accessing interpretive in services in Threshold Languages and information regarding accessing Teletype/Tele Typewriter (TTY) service
6. Provider right to discuss the UM decision of denial, deferral, modification, or termination with the peer reviewer.
7. The NOA must include a phone number for the requesting practitioner to call the peer reviewer to discuss the decision.

b. Timeliness of notifications communication
   i. Refer to UM-051 Attachment A for Timeliness Standards for notifications to both provider and member
c. Oversight and monitoring of the notification process
   i. Refer to UM-051

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3. PROCEDURE

a. Production of NOA letters:
   i. Approvals
      1. Automatically generated by the system after approval entered.
      2. NOA approval letters mailed the next business day.
      3. Copy of the letter stored in system.

   ii. Denials
      1. Potential denials forwarded to UM Physician.
      2. Medical review of potential denials completed.
      3. Denial determination made and documented in system.
      4. Forwarded to UM coordinator.
      5. Coordinator produces NOA letter.
      6. NOA mailed the NOA the same day or next business day, and no later than the required two business days for routine authorization decisions, and within 72 hours for urgent authorizations.

b. Reports are generated from data from various sources:
   i. Authorization data systems

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ii. Claims and payments.
iii. Encounter data
iv. Medical records

c. The data is compared to available sources of comparable data and benchmarks:
   i. Internally developed performance measures
   ii. DHCS-established Minimum Performance Levels (MPLs) and High Performance Levels (HPLs).
   iii. National Medicaid HEDIS results for the 25th and 75th percentiles
   iv. Previous year's network performance
   v. CMS benchmarks when applicable
   vi. NCQA 75th percentile for industry standards
   vii. MCG criteria when applicable

d. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.

e. Out of Network Behavioral Health Data is collected by AAH on at least a quarterly basis
   i. These data are reviewed by the Utilization Management Committee, to monitor the process for appropriate utilization of services.
   ii. Findings are reported at both the Utilization Management and the Quality Improvement Committee meetings because both quality and utilization components are included.
   iii. Detailed analysis may be conducted to determine the root cause of an identified trend.
   iv. Interventions are developed and approved by the Utilization Management and Quality Improvement Committees and carried out by departments.

f. Aggregation of all NOA data including Alameda Alliance, and delegates is done for performance monitoring of NOA compliance

g. Alameda Alliance generates monthly reports to monitor the network performance with the established measures.
   i. A statistical report is generated for outlier practitioners.
      1. A Practitioner Corrective Action Plan is developed as appropriate for outlier providers.
   ii. A statistical report of network adequacy is generated.
      1. A referral to Provider Services is made when network adequacy problems are identified.

h. Data from the monthly analysis is submitted as part of the UM Work Plan to the UM Subcommittee for discussion and recommendations for addressing outlier results.

i. The UM Subcommittee recommendations are reported to the Quality Improvement Health Equity Committee (QIHEC).

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DEFINITIONS

Notice of Action (NOA) is defined as a formal letter from an MCP informing a member of an "adverse benefit determination."

Notice of Appeal Resolution (NAR) is a formal letter from an MCP informing a member of the outcome of an appeal of an adverse benefit determination.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Authorization Processes
UM-051 Timeliness of UM Decisions
CMP-019 Delegation Oversight
BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/15/18, 11/21/19, 1/21/2021, 03/22/2022, 02/21/2023, 6/20/2023, 12/18/2024, 10/31/2025

REFERENCES

DHCS Contract, Exhibit A, Attachment 5 – Utilization Management
DHCS All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights' Attachments—Superseded by APL 21-011
DHCS All Plan Letter 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Templates

MONITORING

The Utilization Management Department, on a routine basis, reviews the results from the authorization audits conducted by the Alliance Compliance Department to ensure compliance with adverse benefit determinations and notice of action requirements.

This policy is reviewed annually to ensure compliance with regulatory and contractual requirements.

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POLICY AND PROCEDURE

Policy Number	UM-056
Policy Name	Standing Referrals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	3/01/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversite Committee Approval Date	TBD

Policy Number	UM-056
Policy Name	Standing Referrals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, DSNP
Effective Date	3 10 11201s
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024, TBD
Administrative Oversight Committee Approval Date	7/17/2024, TBD

Purpose:
This policy establishes guidelines for issuing standing referrals to specialists for DSNP enrollees with chronic or disabling conditions that require ongoing specialty care to ensure continuity of treatment, reduce administrative burden and improve health outcomes.

Scope:
This policy applies to all enrollees who require ongoing specialty care due to chronic, complex, or disabling conditions. It outlines the processes to be followed by all healthcare providers, care managers and administrative staff.

POLICY STATEMENT

The Alliance provides standing referrals to specialists for enrollees who require continuing specialized medical care over a prolonged period of time as part of ongoing ambulatory care or due to a life-threatening, degenerative, or disabling condition. Services shall be authorized as a medically necessary proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and

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consistent with benefit coverage ~~.~~ to enhance care coordination. Requests can be made by a member, Primary Care Physician (PCP) or specialist. The enrollee may receive a standing referral to a specialist or Specialty Care Center (SCC), in accordance with applicable rules and regulations in accordance with H&S Code section 1374.16. This policy supports our Model of Care for DSNP enrollees by

- Facilitating care coordination for vulnerable populations
- Supporting appropriate utilization of healthcare services
- Enhancing continuity of care/treatment
- Reducing barriers to specialty care for enrollees with complex needs
- Promoting an interdisciplinary approach to care

POLICY

1. The Alliance shall maintain a referral management process and may delegate the referral management process to delegated entities.

~~1.~~

a) Delegated Entities shall maintain policies and procedures for referral management that includes reviews of requests for standing referrals for enrollees who require continuing specialty care or treatment for a medical condition or disease that is life threatening, degenerative, ~~or disabling~~or disabling.

2. The Alliance shall establish and implement a procedure to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the Primary care Physician (PCP), in consultation with both the specialist, if any, and The Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or SCC.

a) The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director.

~~b)~~ If a treatment plan is necessary during care and is approved by The

b) Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.

c) A treatment plan may be deemed unnecessary if The Alliance approves a current standing referral to a specialist.

d) The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

3. The Alliance shall establish and implement guidelines for standing referral requests for enrollees that required specialized medical care over a period of time and who have a life- threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for the purpose of having specialist coordinate he enrollee's health care.

~~3.~~

a) The referral shall be made if the PCP, in consultation with the specialist or SCC, and Medical Director, determines that the continued specialized medical care is medically necessary for the enrollee.

b) The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral for the enrollee, as determined by the Medical Director.

c) If a treatment plan is deemed necessary in the course of the care and isapproved by The Alliance, in consultation with the PCP, specialist. SCC and the enrollee, a referral will be made accordance with the treatment plan.

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d) A treatment plan may be deemed unnecessary if The Alliance approves the applicable referral to a specialist or SCC.

4. Qualifying conditions for standing referrals that require ongoing specialist involvement

~~4.~~

a) ~~1.~~ Chronic conditions include but are not limited to:

- ~~a)~~i. Diabetes
- ~~b)~~ii. Chronic heart failure
- ~~c)~~iii. Cardiovascular disorders
- ~~d)~~iv. Chronic lung disorders
- ~~e)~~v. HIV/Aids
- ~~f)~~vi. End-stand renal disease
- ~~g)~~vii. Cancer with active treatment
- ~~h)~~viii. Severe hematologic disorders
- ~~i)~~ix. Neurological disorders
- ~~j)~~x. Chronic/disabling mental health disorders

b) ~~2.~~ Frequent specialty visits defined as four or more visits in a six-month period

c) ~~3.~~ Enrollees in case/care management programs for chronic conditions

d) ~~4.~~ Enrollees with disabilities requiring specialized healthcare services

e) ~~5.~~ Enrollees requiring ongoing care from a specialist functioning as a principal care provider for complex, chronic or disabling conditions

5. Standing referral to a specialist or SCC are provided within The Alliance's network to participating providers, unless there is no specialist or SCC within The Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

6. Authorization and Referral Processes for Standing Referrals

a) Required documentation for Standing Referrals

- i. Diagnosis of a qualifying chronic/disabling condition
- ii. Clinical rationale supporting the need for ongoing specialty care
- iii. Anticipated frequency and duration of specialist visits needed
- iv. Specific services to be provided by the specialist
- v. Treatment goals and expected outcomes
- vi. Coordination plan between PCP and specialist

b) Authorization determinations for specialty services shall be processed accordance with Alliance's and/or its delegated entity's policies and procedures for referral management and within required time frames for standing referrals, as described in this policy, as described in AAH policy UM-057 Authorization Service Requests, and according to applicable regulations.

~~i.~~ Standing Referral authorization requests will be processed as a prospective review (a prior authorization ~~request,)~~request) to approve, deny, modify or delay based on medical necessity. (HSC 1367.01)

i.

~~ii. 11.~~ Services shall be authorized as medically necessary for proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage.

ii.

~~iii. 111.~~ Determinations (authorized, denied, or modified) for a standing referral shall be

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made within three (3) business days from the date the request is made by the enrollee or the enrollee's PCP and all appropriate medical records and other information necessary to make the determination are received by The Alliance or delegated entity, as applicable.

iii.

~~iv. 1v.~~ Once the determination is made, the request for the standing referral shall be processed within four (4) business days of the date of the proposed treatment plan (if any), is submitted to a physician reviewer.

iv.

v. ~~v.~~ The duration of an initially approved standing referral authorization shall be determined by the Medical Director, as medically appropriate, but shall not exceed one year. Standing referrals for mental health conditions up to 6 months with reassessment. Extensions beyond the initial authorization period requires clinical reassessment and documentation of ongoing need.

~~v1. Upon expiration of the approved standing referral authorization, the PCP or enrollee may submit a new request to renew the standing referral authorization which shall be evaluated with this policy.~~

7. Timeliness – Standards:

a) Determ~~an~~inations within:

~~1~~i. Three (3) business days from receipt of request for standing referral.

b) Processed Within four (4) business days of the date of the proposed treatment plan, if any, is submitted to the Medical Director.

c) Notification - UM staff will generate ~~the~~a letter of notification of the decision to the Member, PCP and Specialist within:

~~1~~i. Two (2) calendar days of the final determination of ~~for routine~~ request

8. Specialist Responsibilities

a) Provide regular updates to the PCP regarding condition, treatment plan and progress of the enrollee
b) Procedures, diagnostics or treatments not included in the standing referral require separate authorization
c) Notify the Health plan and PCP of any significant changes in the enrollee's condition
d) Participate in care coordination activities (medication reconciliation, coordination of services across settings, education regarding condition/treatment

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PROCEDURE

1. Standing Referral Requests managed by delegates will be processed using the Delegated Entities UM Policy for Authorizations. Staff procedures may differ from The Alliance UM processes but Delegates will administer to the regulatory requirements.

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2. Requests for a standing referral are initiated by the PCP/Specialist/Member after the Specialist and PCP agree on the Treatment Plan.

3. Referral requests are received via fax, online or phone through the UM designated mode of communication and processed by the Alliance's Utilization Management (UM) department.

4. UM department will process the referral request using guidelines from UM Authorization policy and procedure. The case will be routed to UM Nurse for review.

5. Upon receipt of a request for Standing Referral/Extended Specialty Referral, after the initial consultation has been completed, the UM Nurse will review the request and assures that the pertinent information is included in the referral:
   a) Member diagnosis
   b) Required treatment
   c) Requested frequency and time period
   d) Relevant medical records
   e) Other referrals, evaluation, or procedures, if any
      i. If additional information is needed the UM Nurse will request and allow the PCP/Specialist sufficient time to submit for determination per UM Policy - Timeliness of UM Decision Making.

6. UM Nurse will confirm the Treatment Plan includes review and signature of the PCP or Specialist validating the requested services. The UM Nurse forwards the completed request to the Medical Director for final determination.

7. Medical Director will review each request to ensure the Treatment Plan is appropriate and supported by the PCP and Specialist.

8. Medical Director will forward the case with the final determination to the coordinator of record for appropriate notifications to PCP/Specialist and Member.

9. Annual Renewals

   a) Standing referrals are valid for up to one calendar year unless indicated otherwise, from the date of the latest determination. ~~.~~
   b) Review of standing referral will be at least 30 days prior to expiration of the current authorization or when there is a significant change in their condition.
   c) The renewal request must include:
      - Updated clinical information
      - Treatment progress and outcomes
      - Rational for continued specialty care
      - Revised treatment plan goals if applicable
   d) UM Staff will process authorizations with the approved number of visits based on the approved Treatment Plan.
   ~~e) Requests for renewals to Standing Referrals are reviewed using the guidelines of this policy and the latest clinical information with a new Treatment Plan from PCP and Specialist.~~

10. Monitoring/Oversight
    - The health plan will monitor utilization patterns related to standing referrals to ensure appropriate use and identify opportunities for improved care coordination
    - Number/types of referrals authorized

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- Denials/appeals related to standing referrals
- Provider compliance with reporting requirements
- Annual evaluation of the standing referral process as part of all over quality improvement
-

11. Preventive Care:

a) The specialty care provider is responsible for addressing the member's preventive health while the member is under his/her care for primary and specialty care services. Preventive services such as comprehensive history and physical exam, immunization, preventive screenings, and counseling, etc. must be addressed and be provided according to the periodicity guideline for preventive care for both adults and children, per recommendation by the US Preventive Services Task Force (USPSTF).

12. Monitoring

a) The Utilization Management Department, on a routine basis, reviews the results from the monthly authorization audit to ensure that all elements are met. Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

~~a)~~

DEFINITIONS/ ACRONYMS

Benefits Determination: A denial of a requested service that is specifica11y excluded from a ~~Member's~~member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

Criteria means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes.

Medical Necessity: Determinations on decisions that are (or which could be considered to be) covered benefits, ~~including determinations~~including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

Medically Necessary (Group Care Program): Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. (Group Care Program Evidence of Coverage)

Medically Necessary (Medi-Cal Program): means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that

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a medical -Practitioner, exercising prudent clinical judgment, would provide to a ~~Member~~member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

- Consistent with nationally accepted standards of medical practice:
  - "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas ~~and any~~and any other relevant factors.
  - For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
  - For purposes of covered services for Medi-Cal Members, the te~~nn~~rm "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    - When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable -to Early -and Periodic Screening, Diagnosis,- and Treatment -(EPSDT) -Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

Medical Necessity Determination means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services; and care or service that could be considered either covered or non-covered, depending on the circumstances.

Member means any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan

Non-Contracted Provider is a provider of health care services who is not contractually affiliated with AAH

Prior Authorization or Prospective Review-: A type of Organization Determination that occurs prior to services being rendered.

Provider means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

- NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care ~~services, but~~services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

Specialty Care Center means a center that -is accredited -or ~~designated by~~designated by an agency ~~of the~~of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for

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which it is accredited or designated.

Standing Referral means a referral to see a specialist for a specified period of time without requiring new referrals for each ~~visits~~visit up to one year

Utilization Management (UM) means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources

DSNP (Dual eligible special needs plan): A mediocre advantage plan that exclusively enrolls individuals who are entitled to both Medicare (Title XVIII) and Medicaid (title XIX)

AFFECTED DEPARTMENTS/PARTIES

Utilization Management

RELATED POLICIES AND PROCEDURES

1. UM-001 - Utilization Management
2. UM-051 -UM Timeliness Standards
3. UM-057 -Authorization Request Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

3/01/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, ~~8~~7/17/2024

REFERENCES

1. California Health and Safety Code -HSC § 1374.16
2. DHCS Contract Exhibit A, Attachment 9, Access and Availability, Section 7
3. California Welfare and Institutions Code Section 14450.5
4. California Health and Safety Code - HSC § 1367.01
5. Title 42 CFR 422.2, 101(f), ~~-~~107, 631

~~MONITORING~~

~~Delegated Medical Groups~~

- ~~The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.~~
- ~~The Alliance reviews reports from delegated groups of all authorized~~

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~~specialty and inpatient services that are the Alliance's financial responsibility.~~

- ~~Internal Monitoring~~
  - ~~The Utilization Management Department, on a routine basis, reviews:~~
    - ~~Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the~~

~~quality of the denial language.~~

- ~~Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.~~
- ~~Quarterly reports of authorizations and claims for non-network specialty referrals and standing referrals~~

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POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD~~11/15/2024~~
Administrative Oversight Committee Approval Date	TBD~~12/18/2024~~

OVERVIEW

Alameda Alliance for Health (Alliance) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K.**

POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity specific to each Line of Business (LOB).

B. The Alliance shall communicate to all contracted health care practitioners the procedures,

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treatments, and services that require authorization and the procedures and timeframes necessary to obtain such authorizations.

1. Communication shall include the data and information the Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) that guide the UM decision-making process.
2. The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
    i. alamedaalliance.org/providers/provider-resources
    ii. alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
3. The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

~~3.~~ **PROCEDURE**

~~C. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as Prior Authorization (PA) timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Coverage (EOC). If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service. If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, the Alliance will do the following:~~

~~1. Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.~~
~~2. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.~~
~~3. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.~~
~~4. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.~~

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A. UM Parity

~~D.~~1. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria, disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH)~~, Counsel of Autism Services Providers~~, American Psychiatric Association, and the American Psychological Association.~~.~~

~~E.~~2. The ~~below services~~services below are exempt from prior authorization, based on regulatory requirements:

a. Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
b. Urgent care, whether in or out of network
c. Primary Care Visits
d. Preventative Services
e. Immunizations/Vaccines
    i. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, the Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.
    ~~e.~~
f. Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare.
g. Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
h. Basic perinatal care – a woman can go directly to any network provider for basic perinatal care
i. Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
j. Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
k. HIV testing and counseling
l. Minors do not need authorization for:
    i. Sexual or physical abuse
    ii. Suicidal ideations
    iii. Pregnancy care

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iv. Sexual assault
v. Drug and alcohol abuse treatment

~~m.~~ Biomarker Ttesting ~~which is FDA approved~~

m.

i. ~~For all lines of business (LOB) prior authorization is exempt for members with advanced or metastatic cancer stage 3 or 4, or for cancer progression or reoccurrence in members with advanced or metastatic cancer stage 3 or 4 **(Health & Safety Code §1367.665).**~~ Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.

ii. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6.

iii. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

a) Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the Alliance coding list will be updated at least annually. Any updates are configured in the Alliance UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.

iv. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:

a) A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
b) A national coverage determination made by the Centers for Medicare and Medicaid Services
c) A local coverage determination made by a Medicare Administrative Contractor for California
d) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff

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e) Standards set by the National Academy of Medicine

~~i.~~

~~F. The below services provided by the Alliance's direct network do not require prior authorization:~~

~~1. Specialty visits (initial and follow-up visits)~~

~~2. Mental Health and Substance Use Disorder outpatient visits~~

~~Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements~~

3. The below services provided by the Alliance's direct network do not require prior authorization:
   a. Specialty visits (initial and follow-up visits)
   b. Mental Health and Substance Use Disorder outpatient visits
   c. Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements

4. Services Requiring Prior Authorization
   a. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:
      i. Contracted providers are informed in the service agreements by accessing the Provider Manual, the Prior Authorization Grid information located on the Alliance website and are available upon request.
      ii. Non-contracted providers are informed via the Alliance website/Section – Authorization.

5. Services for which authorization is required include, but are not limited to:
   a. Out-of-network providers/ services/ facilities.
   b. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
   c. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA) for Medi-Cal, and all inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT).).
   d. Selected major diagnostic tests.
   e. Home Health Care/ Private Duty Nursing care.
   f. Selected durable medical equipment.
   g. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.). See UM-007 New and Experimental Technology Review Process policy.
   h. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
   i. CBAS services.
   j. Inpatient admissions (non-emergency).
   k. Inpatient hospice care.
   l. Inpatient abortions.

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m. Skilled nursing facilities admissions.
n. Long-term care (LTC) Custodial Nursing Facility admissions.
o. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions.
p. Subacute Admissions.
q. LTC Skilled nursing facilities Bed Hold/ Leave of Absence.
r. Major Organ Transplant Services.
s. Out of Network Second opinion.
t. Podiatry services.
u. Acupuncture, greater than four (4) visits per month for Adults. Limits do not apply for children under the age of 21.
v. Chiropractic.
w. Treatment and services related to gender dysphoria.
x. Enhanced Care Management (ECM)

6. Out of Network/Non-Contracted Providers
   a. The Alliance requires services to be provided within the contracted network. Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which the Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long- Term Care nursing facility capacity:
   b. At the time of the initial processing of the authorization request, the Authorization Coordinator (AC) will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and document the out of network reason for the request.
   c. If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdrawing in the case notes and closes the case.
   d. If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer / or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.
      i. The UM Nurse / BH Reviewer / Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.
         a) If determined services are medically necessary but not available within the Alliance network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer / or Pharmacist determines if the non-contracted provider is the most appropriate and approve for initiation of one-time Letter of Agreement (LOA) through Provider Contracting.
            - The Alliance maintains a list of non-contracted providers which may be ~~directly~~ authorized due to lack of availability within the provider network, as long as medical necessity criteria for the requested service(s) are met.~~.~~
      ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM

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Nurse / BH Reviewer will call the provider to obtain additional information that will either support or disprove the need for the utilization of an out of network provider.

a) This call will be documented in the medical record

iii. If the provider continues to ~~request for the~~request the OON authorization, the UM Nurse / BH Reviewer will ~~escalate~~refer the case to the Medical Director / Doctoral BH Reviewer / or Pharmacist to ~~possible~~review for re-direction -into the network.

a) If determination is to re-direct, the UM Nurse / BH Reviewer / Pharmacist will confirm with the newly identified in-network provider that the services can be provided,- and provided within the applicable time and distance and timely access standards.

b) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

e. For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

7. Enhanced Care Management Authorizations

a. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:

i. Routine requests not to exceed five (5) days.

ii. Expedited requests not to exceed 72 hours.

b. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:

i. Provider notification not to exceed 24 hours, (oral or written) after decision.

ii. Written notification to provider and member not to exceed two (2) working days after decision.

c. The Alliance will authorize ECM for a minimum of six (6) months for each request.

d. Delegated ECM Providers and/ or their subcontractors must follow Alliance authorization requirements, including adjudication standards and referral documentation.

e. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.

f. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.

g. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

8. Authorization of Community Supports (CS) Services

a. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:

i. Routine requests not to exceed five (5) business days.

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ii. Expedited requests not to exceed 72 hours.
iii. Retrospective requests not to exceed 30 calendar days.

b. ~~2.~~ Notification time frames for authorization request ~~determination decisions~~ for CS will follow regulatory UM timelines, for example:
   i. Provider notification not to exceed 24 hours, (oral or written) after decision.
   ii. Written notification to provider and member not to exceed two (2) working days after decision.

9. The Alliance Medical Management Referrals for Autism Services
   a. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
   b. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.
   c. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
      i. The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
      ii. UM Staff will process referral requests as defined in Sections 3.1
   d. UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

10. Standard Fertility Services
   a. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment). See Policy UM-029 Sensitive Services for further guidance on covered benefits.
   b. For Medi-Cal members, the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

11. Indian Health Service Programs
   a. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

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12. Telehealth

1. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as Prior Authorization (PA) timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Coverage (EOC) specific to that LOB. If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service. If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, the Alliance will do the following:
   i. Notify the Member of their right to access their medical records pursuant to, and consistent with, Health and Safety Code Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
   ii. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.
   iii. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
   iv. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

13. Non- Benefit and Unlisted Codes

a. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician / Medical Director/~~,~~ doctoral BH Reviewer / Pharmacy does not have the clinical expertise in treating the requested service~~d~~ to render the UM determination, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.
   i. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will utilize the recommendation in rendering the final UM determination.

b. Non-Benefit Codes
   i. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.
   ii. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

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iii. The Alliance UM Nurse Reviewer will use UM criteria (DHCS, LCD, NCD and/ or MCG), patient records to guide the UM decision-making process
iv. All potential denials of these services will go to the MD for review and final determination

c. Unlisted Codes
i. The Alliance may cover an unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.
ii. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
iii. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
iv. All potential denials of these services will go to the MD for review and final determination

B. UM Review Process

1. Pre-Service Review
a. Authorization requests are submitted by phone, fax, in writing, or via secure portal.
b. Upon receipt of the authorization request, the UM Coordinator will review the request for:
i. Member eligibility
ii. Completeness of the request
iii. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
iv. Presence of medical records.
c. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

2. Appropriate Classification of Determination
a. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
b. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.
c. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

3. The Alliance service types are processed as:
a. Prior Authorization
b. Concurrent
c. Post-Service/Retrospective Review

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4. The Alliance authorization determinations are documented as:
   a. Approved
   b. Modified (Partial approval)
   c. Denied
   d. Delayed
   e. Reduce
   f. Stop
   g. Suspend
   h. Deny
   i. Change
   j. Withdraw~~l~~
   k. Dismiss

5. Auto-authorization is an authorization approval process for contracted providers that utilizes system–generated approvals that do not require a ~~manual~~ clinical review. The Alliance considers the following factors in determining services to be on auto-authorization:
   a. Regulatory/Contractual guidelines
   b. Member access to services
   c. Utilization patterns:
      i. Volume of authorizations
      ii. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
   d. Patient safety
   e. Provider consistency in scope of utilization requests

~~3.~~

~~G. The Alliance considers the following factors in determining services that do or do not require prior authorization, concurrent review, or retrospective review:~~
~~1. Regulatory/Contractual guidelines~~
~~2. Member access to services~~
~~3. Utilization patterns:~~
~~a. Volume of authorizations~~
~~b. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews~~
~~4. Patient safety~~
~~5. Provider consistency in scope of utilization requests~~

6. For Authorization requests ~~s~~not determined ~~using~~by system-generated auto-authorization, the UM Coordinator reviews the pre-service authorization request ~~the~~ for services that can be ~~,~~approved within the scope of a UM coordinator ~~auto-authorization criteria~~. The pre-service request workflow:
   a. For requests ~~meeting~~that can be approved within a UM coordinator's scope ~~authorization criteria~~, the UM Coordinator approves the request following UM guidelines.
      i. Services that can be approved within the scope of a UM Coordinator ~~Scope~~

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~~authorization is an authorization approval process that~~ does not require licensed clinical review ~~and can be completed by a non-clinical UM staff~~. The Alliance considers the following factors in determining services that can be approved ~~to be on auto-authorization~~within the scope of a UM Coordinator:

a) Regulatory/Contractual guidelines
b) Member access to services
c) Utilization patterns:
   - Benefit limitations
   - Volume of authorizations
   - Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
d) Patient safety
e) Provider consistency in scope of utilization requests

ii. For requests ~~not~~that are beyond the scope of a UM coordinator, or do not meet the parameters that ~~meeting~~ a UM Coordinator can approve ~~Scope Criteria~~, the UM Coordinator routes the request to the UM Nurse/~~-~~doctoral BH Reviewer/~~-~~or Pharmacy technician for clinical review.~~:~~

~~H. Auto-authorization is an authorization approval process that does not require clinical review and can be completed by a non-clinical UM staff. The Alliance considers the following factors in determining services to be on auto-authorization:~~

~~1. Regulatory/Contractual guidelines~~
~~2. Member access to services~~
~~3. Utilization patterns:~~
~~a. Volume of authorizations~~
~~b. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews~~
~~4. Patient safety~~
~~5. Provider consistency in scope of utilization requests~~

~~5.~~ The list of services on auto-authorization and within UM coordinator scope ~~is~~are reviewed and approved at least annually at UMC and QIHEC. UM staff will process requests in accordance with the auto-authorization and coordinator scope guidelines after approval by UMC and QIHEC (see attachment section of the policy).

b.

~~Services for which authorization is required include, but are not limited to:~~

~~1. C. Out-of-network providers/ services/ facilities.~~
~~2. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).~~

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3. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA), inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT).
4. Selected major diagnostic tests.
5. Home Health Care/ Private Duty Nursing care.
6. Selected durable medical equipment.
7. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
8. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
9. CBAS services.
10. Inpatient admissions (non-emergency).
11. Inpatient hospice care.
12. Inpatient abortions.
13. Skilled nursing facilities admissions.
14. Long-term care (LTC) Custodial Nursing Facility admissions.
15. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions.
16. Subacute Admissions.
17. LTC Skilled nursing facilities Bed Hold/ Leave of Absence.
18. Major Organ Transplant Services.
19. Out of Network Second opinion.
20. Podiatry services.
21. Acupuncture, greater than four (4) visits per month for Adults. Limits do not apply for children under the age of 21.
22. Chiropractic.
23. Treatment and services related to gender dysphoria.

I. Immunization/Vaccination

1. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, the Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.

J. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.

1. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA) approved therapy for advanced or metastatic stage 3 or 4 cancer.

a) Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As

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new coding updates are released by CMS, the Alliance coding list will be updated at least annually. Any updates are configured in the Alliance UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.

2. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:

a) A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug

b) A national coverage determination made by the Centers for Medicare and Medicaid Services

c) A local coverage determination made by a Medicare Administrative Contractor for California

d) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff

e) Standards set by the National Academy of Medicine

Biomarker testing is provided to Group Care members in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples. Any restricted or denied use of biomarker testing for the medically necessary reasons noted above are subject to grievance and appeal processes.

K. Non-Benefit Codes

1. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.

a. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process

c. All potential denials of these services will go to the MD for review and final determination

L. Unlisted Codes

1. The Alliance may cover an unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.

a. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process

c. All potential denials of these services will go to the MD for review and final determination

M. Standard Fertility Services

a. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for

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~~Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).~~

~~b. For Medi-Cal members, the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.~~

~~N. Indian Health Service Programs~~

~~1. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).~~

~~O. Appropriate Classification of Determination~~

~~1. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.~~

~~2. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.~~

~~3. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.~~

~~P. The Alliance service types are processed as:~~

~~1. Prior Authorization~~

~~2. Concurrent, inpatient~~

~~3. Concurrent, Outpatient (care currently underway)~~

~~4. Post-Service/Retrospective Review~~

~~Q. The Alliance authorization determinations are documented as:~~

~~1. Approved~~

~~2. Modified~~

~~3. Denied~~

~~4. Delayed~~

UM Decision Making

~~R.~~

1. The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
    a. Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.

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b. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

i. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

~~b.~~c. A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.

~~c.~~d. UM Reviewers make UM authorization approval decisions based on UM Committee approved auto authorization criteria, coordinator scope and other UM Committee approved UM criteria UM-001, and auto authorization criteria.

i. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria and Policy RX 002

~~d.~~e. Qualified Behavioral Health (BH) Reviewer~~s~~ staff make BH authorization approval decisions based on QIHEC- and UM Committee approved BH UM criteria.

i. See UM-012 Care Coordination policy regarding approved BH UM criteria.

~~e.~~f. A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.

~~f. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria.~~

~~g.~~ Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility and Retro Authorization submission greater than 90 days.

~~g.~~

~~i.~~h. Retro Authorizations >90 days will still be reviewed for Medical Necessity

i. Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002

2. Minimum Clinical Information for Review of UM Requests for Authorization

a. When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.

b. Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:

i. Office and hospital records

ii. A history of the present problem

iii. A clinical exam

iv. Diagnostic testing results

v. Treatment plans and progress notes

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vi. Patient psychosocial history
vii. Information on consultations with the treating practitioner
viii. Evaluations from the other health care practitioners and providers
ix. Photographs
x. Operative and pathological reports
xi. Rehabilitation evaluations
xii. A printed copy of criteria related to the request.
xiii. Information regarding benefits for services of procedures
xiv. Information regarding the local delivery system
xv. Patient characteristics and information
xvi. Information from responsible family members
xvii. Minimum Data Set (MDS)
xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

~~h.~~

~~S. In instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the Alliance shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if the Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.~~

~~T. The Alliance shall make all UM decisions and notifications within the required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, the Alliance shall adhere to the strictest standard.~~

~~U.~~3. The Alliance shall process the assessment of appropriateness of medical services on a case-by- case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:

~~1.~~a. Determining and ensuring response appropriate to urgency of request.
~~2.~~b. Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.
~~3.~~c. Ensuring that correct UM criteria are selected for review of request.
~~4.~~d. Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
e. Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member using the strictest standard.

~~5.~~

4. For authorization requests not consistent with the request (i.e., conflicting CPT codes to diagnosis, conflicting HCPCS to documentation, etc.), not meeting UM / BH/ or

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Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer/ Pharmacy Technician forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review

~~When determining medical necessity, the Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, the Alliance works with the requesting providers to obtain the information in a timely manner.~~

5. Missing Clinical Information:
    a. Formal requests for missing information can be made either by phone or in writing.
        i. Missing information includes:
            a) Incomplete name, ID number, contact information.
            b) Diagnosis or Service codes
            c) Incomplete Attachments
            d) Required Title XXII forms
    b. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician / Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
        i. Call attempts should be documented in the authorization request case. Up to three (3) attempts will be made:
            a) One (1) Fax and two (2) phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician / doctoral BH / Pharmacist Reviewer for a Peer-to-Peer request.

6. Request for additional information
    a. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.

7. For the Medi-Cal and Group Care lines of business instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the Alliance shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe.
    a. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.

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A deferral notice is warranted if the Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.

8.

9. For the D-SNP Line of business, the plan may extend the timeframe for a standard or expedites integrated organization determination by up to 14 days in instances where the Alliance cannot make a decision to Approve, Reduce, Stop, Suspend, Deny or Change the request within the required timeframe for a standard or expedited requests because it is not in receipt of information reasonably necessary or requested the Alliance will send out the Coverage Decision Letter template to the provider and beneficiary within the required time frame or as soon as the Alliance becomes aware that it will not meet the timeframe. All requests for extensions must meet the following requirements:
    a. The enrollee or provider requests the extension; or
    b. The applicable integrated plan can show that—
        i. The extension is in the enrollee's interest; and
        ii. There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.
    c. Upon receipt of all information reasonably necessary and requested, UM Nurse/ Physician/ Medical Director / BH Reviewer / or Pharmacist may approve the request for authorization following the strictest timeframe guidance dependent upon line of business.
10. For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider notification using the appropriate template dependent on the Line of business

~~V.~~

~~W.~~11. Rescission
    a. No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when the Alliance did not make an accurate determination of the member's eligibility.
    b. D-SNP Dismissing a request: The applicable integrated plan dismisses a standard or expedited integrated organization determination request, either entirely or as to any stated issue, under any of the following circumstances:
        i. The individual or entity making the request is not permitted to request an integrated organization determination under § 422.629(l).
        ii. The applicable integrated plan determines the party failed to make out a valid request for an integrated organization determination
    c. D-SNP Withdrawal of a request: A request that is made by the enrollee or the enrollees Authorized Representative (AOR) to voluntarily withdrawal their request for a service.

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12. An enrollee or the enrollee's representative files a request for an integrated organization determination, but the enrollee dies while the request is pending, and both of the following apply:
    a. The enrollee's surviving spouse or estate has no remaining financial interest in the case.
    b. No other individual or entity with a financial interest in the case wishes to pursue the integrated organization determination.
    c. A party filing the integrated organization determination request submits a timely request for withdrawal of their request for an integrated organization determination with the applicable integrated plan.

13. Notice of dismissal. The applicable integrated plan must mail or otherwise transmit a written notice of the dismissal of the integrated organization determination request to the parties. The notice must state all of the following:
    a. The reason for the dismissal.
    b. The right to request that the applicable integrated plan vacate the dismissal action.
    c. The right to request reconsideration of the dismissal.

14. Continuation of benefits
    a. Within 10 calendar days of the applicable integrated plan sending the notice of adverse integrated organization determination the plan must continue the enrollees benefits under parts A and V of title XVIII and title XIX if all of the following occur:
        i. The enrollee files the request for an integrated appeal timely in accordance with § 422.633(d);
        ii. The integrated appeal involves the termination, suspension, or reduction of previously authorized services;
        iii. The services were ordered by an authorized provider;
        iv. The period covered by the original authorization has not expired; and
        v. The enrollee timely files for continuation of benefits.

15. Duration of continued or reinstated benefits. If, at the enrollee's request, the applicable integrated plan continues or reinstates the enrollee's benefits, as while the integrated reconsideration is pending, the benefits must be continued until—
    a. The enrollee withdraws the request for an integrated reconsideration;
    b. The applicable integrated plan issues an integrated reconsideration that is unfavorable to the enrollee related to the benefit that has been continued;
    c. For an appeal involving Medicaid benefits—
        i. The enrollee fails to file a request for a State fair hearing and continuation of benefits, within 10 calendar days after the applicable integrated plan sends the notice of the integrated reconsideration;
        ii. The enrollee withdraws the appeal or request for a State fair hearing; or
A State fair hearing office issues a hearing decision adverse to the enrollee.
        i.

16. Medical Director / Physician Reviewer Review
    a. The Medical Director / Physician / doctoral BH Reviewer reviews pre-service

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authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director / Physician Reviewer / doctoral BH reviews the information summary provided by the UM Nurse / BH Reviewer, the clinical information, and the appropriate UM Criteria.

i. The Medical Director / Physician/ doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.

ii. To evidence appropriate professional review, each UM case must include one of the following:

1. The reviewer's written signature or initials
2. The reviewer's unique electronic signature or identifier on the denial notation
3. A signed or initialed note from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.
4. The direct Peer to Peer phone number specific to the MD who made the decision.

b. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or Pharmacy technician for processing:

iii. Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.

iv. Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

D. Peer to Peer Discussions

1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the Alliance decision maker. Providers are notified of this process in the UM determination notifications.

a. When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the Alliance UM decision maker.

i. Oral request includes reading the standard statement for availability of the discussion exactly as identified in the NOA letter/ Integrated Denial Notice.

ii. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director / Behavioral Health / Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit."

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v. The Alliance provides easy access for Providers and utilizes direct Peer to Peer telephone number to serve as the entry point of contact.

2. UM Medical Directors will answer the UM calls and obtain the key information to have the UM decision maker return the call:
   a. Member name and ID#
   b. Referral #
   c. Name of the Physician requesting the return call.
   d. Contact number for the requesting Physician.
   e. Best time to reach the requesting Physician.

3. If the Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.
4. Every attempt is made to return calls on the same day.
   a. Two (2) attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
   b. The Alliance Physician / Medical Director / doctoral BH Reviewer / Pharmacist will document all outreach attempts in TruCare.
5. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
   a. In the denial notification, or
   b. By telephone, or
   c. In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
6. The organization includes the following information in the denial file:
   a. The denial notification, if the treating practitioner was notified in the denial notification.
   b. The time and date of the notification, if the treating practitioner was notified by telephone.
   c. Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

~~X.~~7. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

~~Y. Authorization of Enhanced Care Management (ECM)~~
~~a. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:~~
   ~~i. Routine requests not to exceed five (5) days.~~
   ~~ii. Expedited requests not to exceed 72 hours.~~
~~b. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:~~
   ~~i. Provider notification not to exceed 24 hours, (oral or written) after decision.~~

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ii. Written notification to provider and member not to exceed two (2) working days after decision.

c. The Alliance will authorize ECM for a minimum of six (6) months for each request.

i. Delegated ECM Providers and/ or their subcontractors must follow Alliance authorization requirements, including adjudication standards and referral documentation.

d. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.

e. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.

f. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

Y. Authorization of Community Supports (CS) Services

1. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:

a. Routine requests not to exceed five (5) business days.

2. Expedited requests not to exceed 72 hours.2. Notification time frames for authorization request determination decisions for CS will follow regulatory UM timelines, for example:

a. Provider notification not to exceed 24 hours, (oral or written) after decision.

b. Written notification to provider and member not to exceed two (2) working days after decision.

Z.8. Post Service/Retrospective Review Process

1.a. The Alliance does not accept post-service or retrospective authorization requests for non- emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:

i.

a. Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at time of service, incorrect eligibility information at time of service.b. In-patient services where the facility is unable to confirm enrollment with the Alliance.

9. 2. If the Alliance receives a request for services >90 days from the Date of Service the request will be reviewed for Medical Necessity and then processed as an administrative denial.

a. Medical Necessity review will follow the typical UM process

b. b. All potential Medical Necessity denials will be sent to the Medical Directors for review.

10. Decision Notification

a. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or

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Pharmacy technician for processing:

i. Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.

1. Delays, Denials, Modifications, Terminations, Reduce, Stop, Suspend, Withdraw~~l~~, Dismiss, -Deny or Change

a. The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Single Plan Model Transition Requirements

~~AA.~~1. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous MCP to Alameda Alliance for Health (Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance adhered to the requirements of All Plan Letter (APL) 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members who transitioned into the Alliance adhered to the requirements of the 2024 Managed Care Plan Transition Policy Guide and APL 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

~~1.~~2. The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

~~2. Particular attention and resources were focused on members in Special Populations:~~
~~a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services~~
~~b. Adults and children with authorizations to receive Community Supports (CS)~~
~~c. Adults and children receiving Complex Care Management (CCM)~~
~~d. Enrolled in 1915(c) waiver programs~~
~~e. Receiving in-home supportive services (IHSS)~~
~~f. Children and youth enrolled in California Children's Services (CCS)~~
~~g. Children and youth receiving foster care, and former foster youth through age 25~~
~~h. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C~~
~~i. Taking immunosuppressive medications, immunomodulators, and biologics~~
~~j. Receiving treatment for end-stage renal disease (ESRD)~~
~~k. Living with an intellectual or developmental disability (I/DD) diagnosis~~
~~l. Living with a dementia diagnosis~~
~~m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)~~

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n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
o. Receiving specialty mental health services (adults, youth, and children)
p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
q. Receiving hospice care
r. Receiving home health
s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care
v. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services (CBAS)

3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

BB. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

1.Contracted providers are informed in the service agreements, by accessing the Provider Manual, the Prior Authorization Grid information located on the Alliance website and are available upon request.

2.Non-contracted providers are informed via the Alliance website/Section — Authorization.

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PROCEDURE

A. **Pre-Service Review**

1. **Authorization requests are submitted by phone, fax, in writing, or via secure portal.**
2. **Upon receipt of the authorization request, the UM Coordinator will review the request for:**

a) **Member eligibility**
b) **Completeness of the request**

i. **Presence of medical codes, e.g., ICD-10, CPT, HCPCS**
ii. **Presence of medical records.**

3. **Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.**

4. **Upon selecting the authorization request from the queue, the assigned UM Coordinator reviews the pre-service authorization request against benefit grid, approved auto-authorization criteria. The pre-service request workflow:**

a) **For requests meeting auto-authorization criteria, the UM Coordinator approves the request**

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following UM guidelines via Auto-Authorization.

b) For requests not meeting Auto-Authorization Criteria, the UM Coordinator routes the request to the UM Nurse/ doctoral BH Reviewer/ or Pharmacy technician.

5. The UM Nurse/ BH Reviewer/ or Pharmacy technician performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, as noted in UM-001 Utilization Management Policy and the UM Program Description.

a) The UM Nurse / BH Reviewer/ or Pharmacy technician documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.

b) The UM Nurse /BH Reviewer/ or Pharmacy technician workflow includes:

c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider approval notification.

d) For authorization requests not consistent with the request (i.e., conflicting CPT codes to diagnosis, conflicting HCPCS to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization

a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.

b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.

c) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:

i. Office and hospital records
ii. A history of the present problem
iii. A clinical exam
iv. Diagnostic testing results
v. Treatment plans and progress notes
vi. Patient psychosocial history
vii. Information on consultations with the treating practitioner
viii. Evaluations from the other health care practitioners and providers
ix. Photographs
x. Operative and pathological reports
xi. Rehabilitation evaluations
xii. A printed copy of criteria related to the request.
xiii. Information regarding benefits for services of procedures
xiv. Information regarding the local delivery system
xv. Patient characteristics and information
xvi. Information from responsible family members

xvii. Minimum Data Set (MDS)
xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

B. Missing Clinical Information:
1. Formal requests for missing information can be made either by phone or in writing.
a) Missing information includes:
i. Incomplete name, ID number, contact information.
ii. Diagnosis or Service codes
iii. Incomplete Attachments
iv. Required Title XXII forms
2. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician / Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
a) Call attempts should be documented in the authorization request case. Up to three (3) attempts will be made:
i. One (1) Fax and two (2) phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician / doctoral BH / Pharmacist Reviewer for a Peer-to-Peer request.

C. Request for additional information
1. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.
2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the UM Physician / Medical Director BH Reviewer / or Pharmacist will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.
3. Formal requests for additional information must be made in writing to the provider and the Member using the most recent DHCS or Alliance templates.
4. For routine or expedited requests, an extension of up to 14 calendar days from the day of receipt may be granted if either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interest of the beneficiary.
5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
6. Upon receipt of all information reasonably necessary and requested, UM Nurse / Physician/ Medical Director / BH Reviewer / or Pharmacist may approve the request for authorization within five (5) business days or 72 hours for standard and expedited requests, respectively.
a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
7. A full description of the Member and Provider Notice of Action communication is found in UM – 054 Policy Notice of Action.

D. Medical Director / Physician Reviewer Review

1. The Medical Director / Physician / doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director / Physician Reviewer / doctoral BH reviews the information summary provided by the UM Nurse / BH Reviewer, the clinical information, and the appropriate UM Criteria.

a) The Medical Director / Physician/ doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.

b) To evidence appropriate professional review, each UM case must include one of the following:

i. The reviewer's written signature or initials

ii. The reviewer's unique electronic signature or identifier on the denial notation

iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

2. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or Pharmacy technician for processing:

a) Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.

b) Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM 054 Notice of Action.

E. Peer to Peer Discussions

1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the Alliance decision maker. Providers are notified of this process in the UM determination notifications.

a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the Alliance UM decision maker.

b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the NOA letter.

i. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director / Behavioral Health / Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit."

2. The Alliance provides easy access for Providers and utilizes the Alliance UM telephone number to serve as the entry point of contact.

3. UM / BH Staff / Pharmacy will answer the UM calls and obtain the key information to have the UM decision maker return the call:

a) Member name and ID#

b) Referral #

c) Name of the Physician requesting the return call.

d) Contact number for the requesting Physician.

e) Best time to reach the requesting Physician.

4. UM / BH/ or Pharmacy Staff will note the request for the discussion in the TruCare case and

notify the appropriate UM decision maker.

a) If the Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision maker for the day.

5. Every attempt is made to return calls on the same day.

a) Two (2) attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.

b) The Alliance Physician / Medical Director / doctoral BH Reviewer / Pharmacist will document all outreach attempts in TruCare.

6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:

- In the denial notification, or
- By telephone, or
- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

7. The organization includes the following information in the denial file:

- The denial notification, if the treating practitioner was notified in the denial notification.
- The time and date of the notification, if the treating practitioner was notified by telephone.
- Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician / Medical Director/ / doctoral BH Reviewer / Pharmacy does not have the clinical expertise in treating the requested serviced to render the UM determination, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist may consult with a Board Certified Consultant to assist inmaking the medical necessity determination.

1. When using a Board Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers

1. The Alliance requires services to be provided within the contracted network.

a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which the Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long Term Care nursing facility capacity:

2. When services are not available within the network:

a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and documents the out of network reason for the request.

b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes thecase.

c) If the decision is to continue using a non-contracted provider, the AC routes the request to

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~~the UM Nurse / BH Reviewer / or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.~~

~~d) The UM Nurse / BH Reviewer / Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.~~

~~i. If determined services are medically necessary but not available within the Alliance network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer / or Pharmacist reviews with the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time Letter of Agreement (LOA) through Provider Contracting.~~

~~ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer reviews case with the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist to possible re-direct into the network.~~

~~(i) If determination is to re-direct, the UM Nurse / BH Reviewer / Pharmacist will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.~~

~~(ii) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.~~

~~e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))~~

~~**H. Services that require prior authorization, but no prior authorization obtained**~~

~~1. Post-Service requests that meet the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH / Pharmacy Department using medical necessity review criteria.~~

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~~a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Physician / Medical Director / doctoral BH Reviewer / or Pharmacist and changed to a routine urgency status.~~

~~2. Post-Service requests that do not meet the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.~~

~~a) UM Coordinator will review post-service request to ensure:~~

~~i. Member was eligible at the time of services.~~

~~ii. Services required prior authorization.~~

~~iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.~~

~~b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Physician / Medical Director / doctoral BH Reviewer / or Pharmacist for potential denial.~~

~~c) If documentation is found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer / or Pharmacist to confirm the services authorized match~~

~~the services requested.~~

~~i. UM Nurse / BH Reviewer / or Pharmacist will assess the documentation and confirm the prior authorization was related to the requested service.~~

~~(i) If the services match, the case will be completed as approved and closed according to policy.~~

~~3. Post Service/Retrospective requests that meet the exception criteria and are submitted greater than 90 calendar days from the date of service.~~

~~a) Services are reviewed for medical necessity and if there is an exception to prior authorization based on UM Policy.~~

~~4. Post Service/Retrospective requests that do not meet the exception criteria and are submitted greater than 90 calendar days from the date of service:~~

~~a) Services will be denied as "no authorization obtained for service that required prior authorization."~~

~~i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.~~

~~b) UM Coordinator will route request to the Medical Director / doctoral BH Reviewer / or Pharmacist for potential denial.~~

~~c) The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.~~

~~i. If documentation supports prior authorization was required and not obtained, Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will document findings and deny case as "no prior authorization obtained."~~

~~ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will document findings for approval along with the reasons.~~

~~d) Case is routed back to the UM Coordinator to complete the member and provider notifications.~~

~~e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.~~

~~I.~~F. ~~P~~Potential Quality Indicator (PQI)

1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH / Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance with QI-104 Potential Quality of Care Issues.

~~J.~~G. Referrals to Care Management

1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service needs, then the UM staff will complete the Care Management / CCS / BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management / BH Policies.

~~K.~~ H. Reporting and Tracking

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~~1.~~ 1. All pre-service requests are entered into the Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.

~~2.~~ 2. The HealthCare Analytics department has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.

~~i.~~ Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

b.

~~I. The Alliance Medical Management Referrals for Autism Services~~

~~1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.~~

~~2. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.~~

~~3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.~~

~~a) The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.~~

~~b) UM Staff will process referral requests as defined in Sections 3.1~~

~~• UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.~~

~~M.~~c. The Alliance UM / BH / Pharmacy departments provide oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but are not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations:** Pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

C. **Behavioral Healthcare Practitioner (BHP):** A physician or other health professional who has advanced education and training in the behavioral healthcare field and /or BH/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical area~~r~~ of practice.

~~C.~~

D. **Benefits Determination:** A denial of a requested service that is specifically excluded from a

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Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

~~D.~~

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

F. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer:** A licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

I. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

J. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

K. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. ((iii) Not

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primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

L. **Medically Necessary (Medi-Cal Program):** Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

i) Consistent with nationally accepted standards of medical practice:

(1) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

(2) For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

(3) For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through ~~the~~ diagnosis or treatment of disease, illness, or injury and

(4) When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to

(a) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT

(b) Supplemental Services as defined in Title 22, 51340 and 51340.1.

M. **Medical Necessity Determination:** UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

N. **Member:** Any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan.

O. **National Committee for Quality Assurance (NCQA**): A non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

P. **Non-Contracted Provider:** A provider of health care services who is not contractually affiliated with the Alliance.

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Q. **Post Service or Retrospective:** Utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

R. **Prior Authorization:** A type of Organization Determination that occurs prior to services being rendered.

S. **Provider:** Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services~~,~~ but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

T. **Qualified Health Care Professional:** A primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

U. **Utilization Management (UM):** The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

V. **UM / BH Reviewer:** A Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. Board Certified Behavioral Analysts and licensed qualified autism providers are qualified by scope of practice, license or credential and experience in the use of criteria set to clinically autism services. They apply QIHEC and UM Committee approved criteria to authorize care for members meeting the criteria within their scope of practice.

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AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on The Alliance website, Provider Section,
2. BH-001 Behavioral Health Services
3. BH-002 Behavioral Health Services
4. BH-005 Care Coordination-Behavioral Health
5. BH-006 Care Coordination-Substance Abuse
6. CM-002 Coordination of Care
7. CM-009 ECM Program Infrastructure
8. QI-104 Potential Quality of Care Issues

9. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making
10. RX-002 PA Review Process
11. UM-054 Policy Notice of Action
12. UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, 7/17/2024, 12/18/2024, 09/17/2025,

REFERENCES

- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- 28 CCR, §1300.51 (d)(I-6)
- 42 CFR 422.631
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- APL 22-010 Cancer Biomarking Testing
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- CMS-10146 Notice of Denial of Medicare Part D Prescription Drug Coverage
- DHCS Contract, Exhibit A, Attachments 5, 9, 13
- DHCS Provider Manual, Family Planning, June 2022, page 1.
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- D-SNPs: Integration & Unified Appeals & Grievance Requirements | CMS
- Medicare parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance eff. 11/18/2024
- Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Effective January 1, 2025

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- NCQA Standards, Utilization Management
- SB 600, Section 1374.551. (a)
- Title 22, Section 51159
- WIC Section 14197

- ~~SB 600, Section 1374.551. (a)~~
- ~~"May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.~~
- ~~Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).~~
- ~~DHCS Provider Manual, Family Planning, June 2022, page 1.~~
- ~~DHCS Contract, Exhibit A, Attachments 5, 9, 13~~
- ~~Title 22, Section 51159~~
- ~~28 CCR, §1300.51 (d)(I-6)~~
- ~~Health & Safety Code, Section 1367.01, 1367.665; 1370.6~~
- ~~2024 Medi-Cal Managed Care Plan Transition Policy Guide~~
- ~~42 CFR 438.900(d)~~
- ~~42 CFR Subpart K~~
- ~~NCQA Standards, Utilization Management~~
- ~~WIC Section 14197~~
- ~~APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates~~
- ~~APL 22-010 Cancer Biomarking Testing~~
- ~~APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care~~
- ~~APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21~~
- ~~APL 23-018 Managed Care Health Plan Transition Policy Guide~~
- ~~APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.~~
- ~~APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care~~
- ~~APL 23-027 Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care~~

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MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance

Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.

iii. Quarterly reports of authorizations and claims for non-network specialty referrals.

3. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provides for the remediation of poor interrater reliability. The Alliance also ensures interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional details about the Inter-Rater Reliability Process.

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POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD~~11/15/2024~~
Administrative Oversight Committee Approval Date	TBD~~12/18/2024~~

OVERVIEW

Alameda Alliance for Health (Alliance) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K.**

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POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity specific to each Line of Business (LOB).

B. The Alliance shall communicate to all contracted health care practitioners the procedures,

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treatments, and services that require authorization and the procedures and timeframes necessary to obtain such authorizations.

1. Communication shall include the data and information the Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) that guide the UM decision-making process.
2. The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
    i. alamedaalliance.org/providers/provider-resources
    ii. alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
3. The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

~~3.~~ **PROCEDURE**

~~C. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as Prior Authorization (PA) timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Coverage (EOC). If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service. If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, the Alliance will do the following:~~

~~1. Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.~~
~~2. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.~~
~~3. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.~~
~~4. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.~~

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A. UM Parity

~~D.~~1. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria, disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH)~~, Counsel of Autism Services Providers~~, American Psychiatric Association, and the American Psychological Association.~~.~~

~~E.~~2. The ~~below services~~services below are exempt from prior authorization, based on regulatory requirements:

a. Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
b. Urgent care, whether in or out of network
c. Primary Care Visits
d. Preventative Services
e. Immunizations/Vaccines
    i. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, the Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.
    ~~e.~~
f. Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare.
g. Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
h. Basic perinatal care – a woman can go directly to any network provider for basic perinatal care
i. Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
j. Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
k. HIV testing and counseling
l. Minors do not need authorization for:
    i. Sexual or physical abuse
    ii. Suicidal ideations
    iii. Pregnancy care

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Preview

iv. Sexual assault
v. Drug and alcohol abuse treatment

~~m.~~ Biomarker Ttesting ~~which is FDA approved~~

m.

i. ~~For all lines of business (LOB) prior authorization is exempt for members with advanced or metastatic cancer stage 3 or 4, or for cancer progression or reoccurrence in members with advanced or metastatic cancer stage 3 or 4 **(Health & Safety Code §1367.665).**~~ Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.

ii. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6.

iii. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

a) Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the Alliance coding list will be updated at least annually. Any updates are configured in the Alliance UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.

iv. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:

a) A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
b) A national coverage determination made by the Centers for Medicare and Medicaid Services
c) A local coverage determination made by a Medicare Administrative Contractor for California
d) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff

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e) Standards set by the National Academy of Medicine

~~i.~~

~~F. The below services provided by the Alliance's direct network do not require prior authorization:~~

~~1. Specialty visits (initial and follow-up visits)~~

~~2. Mental Health and Substance Use Disorder outpatient visits~~

~~Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements~~

3. The below services provided by the Alliance's direct network do not require prior authorization:
   a. Specialty visits (initial and follow-up visits)
   b. Mental Health and Substance Use Disorder outpatient visits
   c. Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements

4. Services Requiring Prior Authorization
   a. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:
      i. Contracted providers are informed in the service agreements by accessing the Provider Manual, the Prior Authorization Grid information located on the Alliance website and are available upon request.
      ii. Non-contracted providers are informed via the Alliance website/Section – Authorization.

5. Services for which authorization is required include, but are not limited to:
   a. Out-of-network providers/ services/ facilities.
   b. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
   c. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA) for Medi-Cal, and all inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT)).
   d. Selected major diagnostic tests.
   e. Home Health Care/ Private Duty Nursing care.
   f. Selected Durable Medical Equipment (DME)
      i. The Alliance's DME Provider California Home Medical Equipment (CHME) follows specific guidance provided by The Alliance which allows CHME to approve some new and replacement DME per agreed upon parameters. These may include equipment such as:
         a) Knee Mobility Scooters (non-motorized)
         b) Cubby Beds
         c) Manual Wheelchairs
         d) Walkers
         e) Incontinence Supplies

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f) Respiratory Products such a CPAPs and Nebulizers

g. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.). See UM-007 New and Experimental Technology Review Process policy.

h. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.

i. CBAS services.

j. Inpatient admissions (non-emergency).

k. Inpatient hospice care.

l. Inpatient abortions.

m. Skilled nursing facilities admissions.

n. Long-term care (LTC) Custodial Nursing Facility admissions.

o. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions.

p. Subacute Admissions.

q. LTC Skilled nursing facilities Bed Hold/ Leave of Absence.

r. Major Organ Transplant Services.

s. Out of Network Second opinion.

t. Podiatry services.

u. Acupuncture, greater than four (4) visits per month for Adults. Limits do not apply for children under the age of 21.

v. Chiropractic.

w. Treatment and services related to gender dysphoria.

x. Enhanced Care Management (ECM)

6. Out of Network/Non-Contracted Providers

a. The Alliance requires services to be provided within the contracted network. Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which the Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long- Term Care nursing facility capacity:

b. At the time of the initial processing of the authorization request, the Authorization Coordinator (AC) will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and document the out of network reason for the request.

c. If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdrawing in the case notes and closes the case.

d. If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer / or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.

i. The UM Nurse / BH Reviewer / Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.

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a) If determined services are medically necessary but not available within the Alliance network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer / or Pharmacist determines if the non-contracted provider is the most appropriate and approve for initiation of one-time Letter of Agreement (LOA) through Provider Contracting.

- The Alliance maintains a list of non-contracted providers which may be ~~directly~~ authorized due to lack of availability within the provider network, as long as medical necessity criteria for the requested service(s) are met.~~.~~

ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer will call the provider to obtain additional information that will either support or disprove the need for the utilization of an out of network provider.

a) This call will be documented in the medical record

iii. If the provider continues to ~~request for the~~request the OON authorization, the UM Nurse / BH Reviewer will ~~escalate~~refer the case to the Medical Director / Doctoral BH Reviewer / or Pharmacist to ~~possible~~review for re-direction -into the network.

a) If determination is to re-direct, the UM Nurse / BH Reviewer / Pharmacist will confirm with the newly identified in-network provider that the services can be provided,- and provided within the applicable time and distance and timely access standards.

b) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

e. For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

7. Enhanced Care Management Authorizations

a. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:

i. Routine requests not to exceed five 7 calendar days.

ii. Expedited requests not to exceed 72 hours.

b. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:

i. Provider notification not to exceed 24 hours, (oral or written) after decision.

ii. Written notification to provider and member not to exceed two (2) working days after decision.

c. The Alliance will authorize ECM for a minimum of six (6) months for each request.

d. Delegated ECM Providers and/ or their subcontractors must follow Alliance authorization requirements, including adjudication standards and referral

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documentation.

e. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.

f. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.

g. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

8. Authorization of Community Supports (CS) Services

a. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:

i. Routine requests not to exceed seven (7) calendar days.

ii. Expedited requests not to exceed 72 hours.

iii. Retrospective requests not to exceed 30 calendar days.

b. ~~2.~~ Notification time frames for authorization request ~~determination decisions~~ for CS will follow regulatory UM timelines, for example:

i. Provider notification not to exceed 24 hours, (oral or written) after decision.

ii. Written notification to provider and member not to exceed two (2) working days after decision.

c. Recuperative Care and Medically Tailored Meals, when offered post an acute care admission, are inherently time-sensitive and subject to expedited authorization timeframes.

9. The Alliance Medical Management Referrals for Autism Services

a. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.

b. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.

c. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.

i. The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.

ii. UM Staff will process referral requests as defined above

d. UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

10. Standard Fertility Services

a. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment). See Policy UM-029 Sensitive Services for further

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guidance on covered benefits.

b. For Medi-Cal members, the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

11. Indian Health Service Programs

a. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

12. Telehealth

1. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as Prior Authorization (PA) timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Coverage (EOC) specific to that LOB. If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service. If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, the Alliance will do the following:
   i. Notify the Member of their right to access their medical records pursuant to, and consistent with, Health and Safety Code Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
   ii. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.
   iii. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
   iv. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

13. Non- Benefit and Unlisted Codes

a. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician / Medical Director/~~,~~ doctoral BH Reviewer / Pharmacy does not have the clinical expertise in treating the requested service~~d~~ to render the UM determination, the Physician / Medical Director / doctoral BH

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Reviewer / or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.

i. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will utilize the recommendation in rendering the final UM determination.

b. Non-Benefit Codes

i. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.

ii. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

iii. The Alliance UM Nurse Reviewer will use UM criteria (DHCS, LCD, NCD and/ or MCG), patient records to guide the UM decision-making process

iv. All potential denials of these services will go to the MD for review and final determination

c. Unlisted Codes

i. The Alliance may cover an unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.

ii. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

iii. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process

iv. All potential denials of these services will go to the MD for review and final determination

B. UM Review Process

1. Pre-Service Review

a. Authorization requests are submitted by phone, fax, in writing, or via secure portal.

b. Upon receipt of the authorization request, the UM Coordinator will review the request for:

i. Member eligibility

ii. Completeness of the request

iii. Presence of medical codes, e.g., ICD-10, CPT, HCPCS

iv. Presence of medical records.

c. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

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2. Appropriate Classification of Determination
   a. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
   b. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render them covered then a medical necessity decision is needed.
   c. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

3. The Alliance service types are processed as:
   a. Prior Authorization
   b. Concurrent
   c. Post-Service/Retrospective Review

4. The Alliance authorization determinations are documented as:
   a. Approved
   b. Modified (Partial approval)
   c. Denied
   d. Delayed
   e. Reduce
   f. Stop
   g. Suspend
   h. Deny
   i. Change
   j. Withdraw~~l~~
   k. Dismiss

5. Auto-authorization is an authorization approval process for contracted providers that utilizes system–generated approvals that do not require a ~~manual~~ clinical review. The Alliance considers the following factors in determining services to be on auto-authorization:
   a. Regulatory/Contractual guidelines
   b. Member access to services
   c. Utilization patterns:
      i. Volume of authorizations
      ii. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
   d. Patient safety
   e. Provider consistency in scope of utilization requests

~~3.~~

~~G. The Alliance considers the following factors in determining services that do or do not require prior authorization, concurrent review, or retrospective review:~~
~~1. Regulatory/Contractual guidelines~~
~~2. Member access to services~~

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~~3. Utilization patterns:~~
~~a. Volume of authorizations~~
~~b. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews~~
~~4. Patient safety~~
~~5. Provider consistency in scope of utilization requests~~

6. For Authorization requests ~~s~~ not determined ~~using~~by system-generated auto-authorization, the UM Coordinator reviews the pre-service authorization request ~~the~~ for services that can be ~~,~~approved within the scope of a UM coordinator ~~auto-authorization criteria~~. The pre-service request workflow:
    a. For requests ~~meeting~~that can be approved within a UM coordinator's scope ~~authorization criteria~~, the UM Coordinator approves the request following UM guidelines.
        i. Services that can be approved within the scope of a UM Coordinator ~~Scope authorization is an authorization approval process that~~ does not require licensed clinical review ~~and can be completed by a non-clinical UM staff~~. The Alliance considers the following factors in determining services that can be approved ~~to be on auto-authorization~~within the scope of a UM Coordinator:
            a) Regulatory/Contractual guidelines
            b) Member access to services
            c) Utilization patterns:
                - Benefit limitations
                - Volume of authorizations
                - Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
            d) Patient safety
            e) Provider consistency in scope of utilization requests
        ii. For requests ~~not~~that are beyond the scope of a UM coordinator, or do not meet the parameters that ~~meeting~~ a UM Coordinator can approve ~~Scope Criteria~~, the UM Coordinator routes the request to the UM Nurse/-doctoral BH Reviewer/-or Pharmacy technician for clinical review.~~:~~

~~H. Auto-authorization is an authorization approval process that does not require clinical review and can be completed by a non-clinical UM staff. The Alliance considers the following factors in determining services to be on auto-authorization:~~
~~1. Regulatory/Contractual guidelines~~
~~2. Member access to services~~
~~3. Utilization patterns:~~
~~a. Volume of authorizations~~
~~b. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews~~
~~4. Patient safety~~
~~5. Provider consistency in scope of utilization requests~~

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5. The list of services on auto-authorization and within UM coordinator scope ~~is~~are reviewed and approved at least annually at UMC and QIHEC. UM staff will process requests in accordance with the auto-authorization and coordinator scope guidelines after approval by UMC and QIHEC (see attachment section of the policy).

b.

~~Services for which authorization is required include, but are not limited to:~~

~~1. C. Out-of-network providers/ services/ facilities.~~
~~2. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).~~
~~3. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA), inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT).~~
~~4. Selected major diagnostic tests.~~
~~5. Home Health Care/ Private Duty Nursing care.~~
~~6. Selected durable medical equipment.~~
~~7. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).~~
~~8. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.~~
~~9. CBAS services.~~
~~10. Inpatient admissions (non-emergency).~~
~~11. Inpatient hospice care.~~
~~12. Inpatient abortions.~~
~~13. Skilled nursing facilities admissions.~~
~~14. Long-term care (LTC) Custodial Nursing Facility admissions.~~
~~15. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions.~~
~~16. Subacute Admissions.~~
~~17. LTC Skilled nursing facilities Bed Hold/ Leave of Absence.~~
~~18. Major Organ Transplant Services.~~
~~19. Out of Network Second opinion.~~
~~20. Podiatry services.~~
~~21. Acupuncture, greater than four (4) visits per month for Adults. Limits do not apply for children under the age of 21.~~
~~22. Chiropractic.~~
~~23. Treatment and services related to gender dysphoria.~~

~~I. Immunization/Vaccination~~
~~1. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, the Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting~~

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~~immunization records.~~

~~J. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.~~

~~1. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA) approved therapy for advanced or metastatic stage 3 or 4 cancer.~~

~~a) Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the Alliance coding list will be updated at least annually. Any updates are configured in the Alliance UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.~~

~~2. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:~~

~~a) A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug~~

~~b) A national coverage determination made by the Centers for Medicare and Medicaid Services~~

~~c) A local coverage determination made by a Medicare Administrative Contractor for California~~

~~d) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff~~

~~e) Standards set by the National Academy of Medicine~~

~~Biomarker testing is provided to Group Care members in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples. Any restricted or denied use of biomarker testing for the medically necessary reasons noted above are subject to grievance and appeal processes.~~

~~K. Non-Benefit Codes~~

~~1. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.~~

~~a. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business~~

~~b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process~~

~~c. All potential denials of these services will go to the MD for review and final determination~~

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L. Unlisted Codes

1. The Alliance may cover an unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.

a. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process

c. All potential denials of these services will go to the MD for review and final determination

M. Standard Fertility Services

a. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

b. For Medi-Cal members, the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

N. Indian Health Service Programs

1. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

O. Appropriate Classification of Determination

1. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.

2. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.

3. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

P. The Alliance service types are processed as:

1. Prior Authorization
2. Concurrent, inpatient
3. Concurrent, Outpatient (care currently underway)
4. Post-Service/Retrospective Review

Q. The Alliance authorization determinations are documented as:

1. Approved
2. Modified
3. Denied

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~~4. Delayed~~

UM Decision Making

~~R.~~

1. The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
    a. Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
    b. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
        i. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
    ~~b.~~c. A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
    ~~c.~~d. UM Reviewers make UM authorization approval decisions based on UM Committee approved auto authorization criteria, coordinator scope and other UM Committee approved UM criteria UM-001, and auto authorization criteria.
        i. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria and Policy RX 002
    ~~d.~~e. Qualified Behavioral Health (BH) Reviewer~~s~~ staff make BH authorization approval decisions based on QIHEC- and UM Committee approved BH UM criteria.
        i. See UM-012 Care Coordination policy regarding approved BH UM criteria.
    ~~e.~~f. A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
    ~~f. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria.~~
    g. Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility and Retro Authorization submission greater than 90 days.
    ~~g.~~
    ~~i.~~h. Retro Authorizations >90 days will still be reviewed for Medical Necessity
    i. Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002

2. Minimum Clinical Information for Review of UM Requests for Authorization
    a. When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.

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b. Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:

i. Office and hospital records
ii. A history of the present problem
iii. A clinical exam
iv. Diagnostic testing results
v. Treatment plans and progress notes
vi. Patient psychosocial history
vii. Information on consultations with the treating practitioner
viii. Evaluations from the other health care practitioners and providers
ix. Photographs
x. Operative and pathological reports
xi. Rehabilitation evaluations
xii. A printed copy of criteria related to the request.
xiii. Information regarding benefits for services of procedures
xiv. Information regarding the local delivery system
xv. Patient characteristics and information
xvi. Information from responsible family members
xvii. Minimum Data Set (MDS)
xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

~~h.~~

~~S. In instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the Alliance shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if the Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.~~

~~T. The Alliance shall make all UM decisions and notifications within the required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, the Alliance shall adhere to the strictest standard.~~

~~U.~~3. The Alliance shall process the assessment of appropriateness of medical services on a case-by- case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:

~~1.~~a. Determining and ensuring response appropriate to urgency of request.
~~2.~~b. Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.

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~~3.~~c. Ensuring that correct UM criteria are selected for review of request.
~~4.~~d. Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
e. Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member using the strictest standard.

~~5.~~

4. For authorization requests not consistent with the request (i.e., conflicting CPT codes to diagnosis, conflicting HCPCS to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer/ Pharmacy Technician forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review

~~When determining medical necessity, the Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, the Alliance works with the requesting providers to obtain the information in a timely manner.~~

5. Missing Clinical Information:
    a. Formal requests for missing information can be made either by phone or in writing.
        i. Missing information includes:
            a) Incomplete name, ID number, contact information.
            b) Diagnosis or Service codes
            c) Incomplete Attachments
            d) Required Title XXII forms
    b. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician / Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
        i. Call attempts should be documented in the authorization request case. Up to three (3) attempts will be made:
            a) One (1) Fax and two (2) phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician / doctoral BH / Pharmacist Reviewer for a Peer-to-Peer request.

6. Request for additional information
    a. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.

7. For the Medi-Cal and Group Care lines of business instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of

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information reasonably necessary and requested, the Alliance shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe.

a. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.

A deferral notice is warranted if the Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.

8.

9. For the D-SNP Line of business, the plan may extend the timeframe for a standard or expedites integrated organization determination by up to 14 days in instances where the Alliance cannot make a decision to Approve, Reduce, Stop, Suspend, Deny or Change the request within the required timeframe for a standard or expedited requests because it is not in receipt of information reasonably necessary or requested the Alliance will send out the Coverage Decision Letter template to the provider and beneficiary within the required time frame or as soon as the Alliance becomes aware that it will not meet the timeframe. All requests for extensions must meet the following requirements:
   a. The enrollee or provider requests the extension; or
   b. The applicable integrated plan can show that—
      i. The extension is in the enrollee's interest; and
      ii. There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.
   c. Upon receipt of all information reasonably necessary and requested, UM Nurse/ Physician/ Medical Director / BH Reviewer / or Pharmacist may approve the request for authorization following the strictest timeframe guidance dependent upon line of business.

10. For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider notification using the appropriate template dependent on the Line of business

~~V.~~

~~W.~~11. Rescission

a. No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when the Alliance did not make an accurate determination of the member's eligibility.

b. D-SNP Dismissing a request: The applicable integrated plan dismisses a standard or expedited integrated organization determination request, either entirely or as to any stated issue, under any of the following circumstances:

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i. The individual or entity making the request is not permitted to request an integrated organization determination under § 422.629(l).

ii. The applicable integrated plan determines the party failed to make out a valid request for an integrated organization determination

c. D-SNP Withdrawal of a request: A request that is made by the enrollee or the enrollees Authorized Representative (AOR) to voluntarily withdrawal their request for a service.

12. An enrollee or the enrollee's representative files a request for an integrated organization determination, but the enrollee dies while the request is pending, and both of the following apply:

a. The enrollee's surviving spouse or estate has no remaining financial interest in the case.

b. No other individual or entity with a financial interest in the case wishes to pursue the integrated organization determination.

c. A party filing the integrated organization determination request submits a timely request for withdrawal of their request for an integrated organization determination with the applicable integrated plan.

13. Notice of dismissal. The applicable integrated plan must mail or otherwise transmit a written notice of the dismissal of the integrated organization determination request to the parties. The notice must state all of the following:

a. The reason for the dismissal.

b. The right to request that the applicable integrated plan vacate the dismissal action.

c. The right to request reconsideration of the dismissal.

14. Continuation of benefits

a. Within 10 calendar days of the applicable integrated plan sending the notice of adverse integrated organization determination the plan must continue the enrollees benefits under parts A and V of title XVIII and title XIX if all of the following occur:

i. The enrollee files the request for an integrated appeal timely in accordance with § 422.633(d);

ii. The integrated appeal involves the termination, suspension, or reduction of previously authorized services;

iii. The services were ordered by an authorized provider;

iv. The period covered by the original authorization has not expired; and

v. The enrollee timely files for continuation of benefits.

15. Duration of continued or reinstated benefits. If, at the enrollee's request, the applicable integrated plan continues or reinstates the enrollee's benefits, as while the integrated reconsideration is pending, the benefits must be continued until—

a. The enrollee withdraws the request for an integrated reconsideration;

b. The applicable integrated plan issues an integrated reconsideration that is unfavorable to the enrollee related to the benefit that has been continued;

c. For an appeal involving Medicaid benefits—

i. The enrollee fails to file a request for a State fair hearing and continuation

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of benefits, within 10 calendar days after the applicable integrated plan sends the notice of the integrated reconsideration;

ii. The enrollee withdraws the appeal or request for a State fair hearing; or

A State fair hearing office issues a hearing decision adverse to the enrollee.

i.

16. Medical Director / Physician Reviewer Review

a. The Medical Director / Physician / doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director / Physician Reviewer / doctoral BH reviews the information summary provided by the UM Nurse / BH Reviewer, the clinical information, and the appropriate UM Criteria.

i. The Medical Director / Physician/ doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.

ii. To evidence appropriate professional review, each UM case must include one of the following:

1. The reviewer's written signature or initials
2. The reviewer's unique electronic signature or identifier on the denial notation
3. A signed or initialed note from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.
4. The direct Peer to Peer phone number specific to the MD who made the decision.

b. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or Pharmacy technician for processing:

iii. Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.

iv. Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

D. Peer to Peer Discussions

1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the Alliance decision maker. Providers are notified of this process in the UM determination notifications.

a. When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the Alliance UM decision maker.

i. Oral request includes reading the standard statement for availability of

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the discussion exactly as identified in the NOA letter/ Integrated Denial Notice.

ii. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director / Behavioral Health / Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit."

v. The Alliance provides easy access for Providers and utilizes direct Peer to Peer telephone number to serve as the entry point of contact.

2. UM Medical Directors will answer the UM calls and obtain the key information to have the UM decision maker return the call:
   a. Member name and ID#
   b. Referral #
   c. Name of the Physician requesting the return call.
   d. Contact number for the requesting Physician.
   e. Best time to reach the requesting Physician.

3. If the Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.

4. Every attempt is made to return calls on the same day.
   a. Two (2) attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
   b. The Alliance Physician / Medical Director / doctoral BH Reviewer / Pharmacist will document all outreach attempts in TruCare.

5. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
   a. In the denial notification, or
   b. By telephone, or
   c. In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

6. The organization includes the following information in the denial file:
   a. The denial notification, if the treating practitioner was notified in the denial notification.
   b. The time and date of the notification, if the treating practitioner was notified by telephone.
   c. Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

~~X.~~7. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and

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within the UM timeliness standards.

~~Y. Authorization of Enhanced Care Management (ECM)~~

~~a. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:~~

~~i. Routine requests not to exceed five (5) days.~~

~~ii. Expedited requests not to exceed 72 hours.~~

~~b. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:~~

~~i. Provider notification not to exceed 24 hours, (oral or written) after decision.~~

~~ii. Written notification to provider and member not to exceed two (2) working days after decision.~~

~~c. The Alliance will authorize ECM for a minimum of six (6) months for each request.~~

~~i. Delegated ECM Providers and/ or their subcontractors must follow Alliance authorization requirements, including adjudication standards and referral documentation.~~

~~d. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.~~

~~e. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.~~

~~f. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.~~

~~Y. Authorization of Community Supports (CS) Services~~

~~1. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:~~

~~a. Routine requests not to exceed five (5) business days.~~

~~2. Expedited requests not to exceed 72 hours.2. Notification time frames for authorization request determination decisions for CS will follow regulatory UM timelines, for example:~~

~~a. Provider notification not to exceed 24 hours, (oral or written) after decision.~~

~~b. Written notification to provider and member not to exceed two (2) working days after decision.~~

~~Z.~~8. Post Service/Retrospective Review Process

~~1.~~a. The Alliance does not accept post-service or retrospective authorization requests for non- emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:

i.

~~a.~~ Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at time of service, incorrect eligibility information at time of service.b. In-patient services where the facility is unable to confirm enrollment with the Alliance.

9. ~~2.~~ If the Alliance receives a request for services >90 days from the Date of Service the

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request will be reviewed for Medical Necessity and then processed as an administrative denial.

a. Medical Necessity review will follow the typical UM process

b. ~~b.~~ All potential Medical Necessity denials will be sent to the Medical Directors for review.

10. Decision Notification

a. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or Pharmacy technician for processing:

i. Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.

1. Delays, Denials, Modifications, Terminations, Reduce, Stop, Suspend, Withdraw~~l~~, Dismiss, ~~-~~Deny or Change

a. The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Single Plan Model Transition Requirements

~~AA.~~1. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous MCP to Alameda Alliance for Health (Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance adhered to the requirements of All Plan Letter (APL) 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members who transitioned into the Alliance adhered to the requirements of the 2024 Managed Care Plan Transition Policy Guide and APL 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

~~1.~~2. The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

~~2. Particular attention and resources were focused on members in Special Populations:~~
~~a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services~~
~~b. Adults and children with authorizations to receive Community Supports (CS)~~
~~c. Adults and children receiving Complex Care Management (CCM)~~
~~d. Enrolled in 1915(c) waiver programs~~
~~e. Receiving in-home supportive services (IHSS)~~
~~f. Children and youth enrolled in California Children's Services (CCS)~~

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g. Children and youth receiving foster care, and former foster youth through age 25
h. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
i. Taking immunosuppressive medications, immunomodulators, and biologics
j. Receiving treatment for end-stage renal disease (ESRD)
k. Living with an intellectual or developmental disability (I/DD) diagnosis
l. Living with a dementia diagnosis
m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
o. Receiving specialty mental health services (adults, youth, and children)
p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
q. Receiving hospice care
r. Receiving home health
s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care
v. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services (CBAS)

3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

BB. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

1. Contracted providers are informed in the service agreements, by accessing the Provider Manual, the Prior Authorization Grid information located on the Alliance website and are available upon request.
2. Non-contracted providers are informed via the Alliance website/Section – Authorization.

PROCEDURE

A. **Pre-Service Review**

1. **Authorization requests are submitted by phone, fax, in writing, or via secure portal.**
2. **Upon receipt of the authorization request, the UM Coordinator will review the request for:**

a) **Member eligibility**
b) **Completeness of the request**

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i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
ii. Presence of medical records.

3. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned UM Coordinator reviews the pre- service authorization request against benefit grid, approved auto-authorization criteria. The pre-service request workflow:
a) For requests meeting auto authorization criteria, the UM Coordinator approves the request following UM guidelines via Auto-Authorization.
b) For requests not meeting Auto-Authorization Criteria, the UM Coordinator routes the request to the UM Nurse/ doctoral BH Reviewer/ or Pharmacy technician.

5. The UM Nurse/ BH Reviewer/ or Pharmacy technician performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, as noted in UM-001 Utilization Management Policy and the UM Program Description.
a) The UM Nurse / BH Reviewer/ or Pharmacy technician documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
b) The UM Nurse /BH Reviewer/ or Pharmacy technician workflow includes:
c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider approval notification.
d) For authorization requests not consistent with the request (i.e., conflicting CPT codes to diagnosis, conflicting HCPCS to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
c) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
i. Office and hospital records
ii. A history of the present problem
iii. A clinical exam
iv. Diagnostic testing results
v. Treatment plans and progress notes

vi. Patient psychosocial history
vii. Information on consultations with the treating practitioner
viii. Evaluations from the other health care practitioners and providers
ix. Photographs
x. Operative and pathological reports
xi. Rehabilitation evaluations
xii. A printed copy of criteria related to the request.
xiii. Information regarding benefits for services of procedures
xiv. Information regarding the local delivery system
xv. Patient characteristics and information
xvi. Information from responsible family members
xvii. Minimum Data Set (MDS)
xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

B. Missing Clinical Information:
1. Formal requests for missing information can be made either by phone or in writing.
a) Missing information includes:
i. Incomplete name, ID number, contact information.
ii. Diagnosis or Service codes
iii. Incomplete Attachments
iv. Required Title XXII forms
2. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician / Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
a) Call attempts should be documented in the authorization request case. Up to three (3) attempts will be made:
i. One (1) Fax and two (2) phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician / doctoral BH / Pharmacist Reviewer for a Peer-to-Peer request.

C. Request for additional information
1. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.
2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the UM Physician / Medical Director BH Reviewer / or Pharmacist will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.
3. Formal requests for additional information must be made in writing to the provider and the Member using the most recent DHCS or Alliance templates.
4. For routine or expedited requests, an extension of up to 14 calendar days from the day of receipt may be granted if either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best

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~~interest of the beneficiary.~~

5. ~~The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.~~
6. ~~Upon receipt of all information reasonably necessary and requested, UM Nurse / Physician/ Medical Director / BH Reviewer / or Pharmacist may approve the request for authorization within five (5) business days or 72 hours for standard and expedited requests, respectively.~~

a) ~~If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.~~

7. ~~A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.~~

D. ~~Medical Director / Physician Reviewer Review~~

1. ~~The Medical Director / Physician / doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director / Physician Reviewer / doctoral BH reviews the information summary provided by the UM Nurse / BH Reviewer, the clinical information, and the appropriate UM Criteria.~~

a) ~~The Medical Director / Physician/ doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.~~

b) ~~To evidence appropriate professional review, each UM case must include one of the following:~~

i. ~~The reviewer's written signature or initials~~
ii. ~~The reviewer's unique electronic signature or identifier on the denial notation~~
iii. ~~A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.~~

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2. ~~Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or Pharmacy technician for processing:~~

a) ~~Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.~~

b) ~~Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.~~

E. ~~Peer to Peer Discussions~~

1. ~~For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the Alliance decision maker. Providers are notified of this process in the UM determination notifications.~~

a) ~~When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the Alliance UM decision maker.~~

b) ~~Oral request includes reading the standard statement for availability of the discussion exactly as identified in the NOA letter.~~

i. ~~"The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the~~

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~~Medical Director / Behavioral Health / Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit."~~

2. ~~The Alliance provides easy access for Providers and utilizes the Alliance UM telephone number to serve as the entry point of contact.~~
3. ~~UM / BH Staff / Pharmacy will answer the UM calls and obtain the key information to have the UM decision maker return the call:~~

a) ~~Member name and ID#~~
b) ~~Referral #~~
c) ~~Name of the Physician requesting the return call.~~
d) ~~Contact number for the requesting Physician.~~
e) ~~Best time to reach the requesting Physician.~~

4. ~~UM / BH/ or Pharmacy Staff will note the request for the discussion in the TruCare case and notify the appropriate UM decision maker.~~

a) ~~If the Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision maker for the day.~~

5. ~~Every attempt is made to return calls on the same day.~~

a) ~~Two (2) attempts will be made within a 24 hour period. Each attempt will be documented in the TruCare case.~~
b) ~~The Alliance Physician / Medical Director / doctoral BH Reviewer / Pharmacist will document all outreach attempts in TruCare.~~

6. ~~The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:~~

- ~~In the denial notification, or~~
- ~~By telephone, or~~
- ~~In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.~~

7. ~~The organization includes the following information in the denial file:~~

- ~~The denial notification, if the treating practitioner was notified in the denial notification.~~
- ~~The time and date of the notification, if the treating practitioner was notified by telephone.~~
- ~~Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.~~

~~F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician / Medical Director/ / doctoral BH Reviewer / Pharmacy does not have the clinical expertise in treating the requested serviced to render the UM determination, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.~~

1. ~~When using a Board Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will utilize the recommendation in rendering the final UM determination.~~

~~G. Out of Network/Non-Contracted Providers~~

1. ~~The Alliance requires services to be provided within the contracted network.~~

a) ~~Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which the Alliance does not have a contracted~~

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provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long Term Care nursing facility capacity:

2. When services are not available within the network:

a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and documents the out of network reason for the request.

b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes the case.

c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer / or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.

d) The UM Nurse / BH Reviewer / Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.

i. If determined services are medically necessary but not available within the Alliance network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer / or Pharmacist reviews with the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time Letter of Agreement (LOA) through Provider Contracting.

ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer reviews case with the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist to possible re- direct into the network.

(i) If determination is to re-direct, the UM Nurse / BH Reviewer / Pharmacist will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.

(ii) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that meet the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH / Pharmacy Department using medical necessity review criteria.

a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Physician / Medical Director / doctoral BH Reviewer / or Pharmacist and changed to a routine urgency status.

2. Post-Service requests that do not meet the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as

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~~services required prior authorization and no prior authorization was obtained.~~

~~a) UM Coordinator will review post-service request to ensure:~~

~~i. Member was eligible at the time of services.~~

~~ii. Services required prior authorization.~~

~~iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.~~

~~b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Physician / Medical Director / doctoral BH Reviewer / or Pharmacist for potential denial.~~

~~c) If documentation is found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer / or Pharmacist to confirm the services authorized match the services requested.~~

~~i. UM Nurse / BH Reviewer / or Pharmacist will assess the documentation and confirm the prior authorization was related to the requested service.~~

~~(i) If the services match, the case will be completed as approved and closed according to policy.~~

~~3. Post Service/Retrospective requests that meet the exception criteria and are submitted greater than 90 calendar days from the date of service.~~

~~a) Services are reviewed for medical necessity and if there is an exception to prior authorization based on UM Policy.~~

~~4. Post Service/Retrospective requests that do not meet the exception criteria and are submitted greater than 90 calendar days from the date of service:~~

~~a) Services will be denied as "no authorization obtained for service that required prior authorization."~~

~~i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.~~

~~b) UM Coordinator will route request to the Medical Director / doctoral BH Reviewer / or Pharmacist for potential denial.~~

~~c) The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.~~

~~i. If documentation supports prior authorization was required and not obtained, Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will document findings and deny case as "no prior authorization obtained."~~

~~ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will document findings for approval along with the reasons.~~

~~d) Case is routed back to the UM Coordinator to complete the member and provider notifications.~~

~~e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.~~

~~I.~~**F. PPotential Quality Indicator (PQI)**

1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH / Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance with QI-104 Potential Quality of Care Issues.

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~~J.~~G. **Referrals to Care Management**

1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service needs, then the UM staff will complete the Care Management / CCS / BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management / BH Policies.

~~K.~~ H. **Reporting and Tracking**

~~1.~~ 1. All pre-service requests are entered into the Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.

~~2.~~ 2. The HealthCare Analytics department has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.

~~i.~~ Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

b.

~~L. The Alliance Medical Management Referrals for Autism Services~~

~~1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.~~

~~2. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.~~

~~3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.~~

~~a) The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.~~

~~b) UM Staff will process referral requests as defined in Sections 3.1~~

~~• UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.~~

~~M.~~c. The Alliance UM / BH / Pharmacy departments provide oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but are not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity

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denial decisions for non-eligibility.

B. **Auto Authorizations:** Pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

C. **Behavioral Healthcare Practitioner (BHP):** A physician or other health professional who has advanced education and training in the behavioral healthcare field and /or BH/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical area~~r~~ of practice.

~~C.~~

D. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

~~D.~~

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

F. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer:** A licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

I. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

J. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care

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Program EOC, page 90)

K. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. ((iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

L. **Medically Necessary (Medi-Cal Program):** Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

i) Consistent with nationally accepted standards of medical practice:

(1) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

(2) For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

(3) For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through ~~the~~ diagnosis or treatment of disease, illness, or injury and

(4) When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to

(a) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT

(b) Supplemental Services as defined in Title 22, 51340 and 51340.1.

M. **Medical Necessity Determination:** UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of

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Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

N. **Member:** Any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan.

O. **National Committee for Quality Assurance (NCQA**): A non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

P. **Non-Contracted Provider:** A provider of health care services who is not contractually affiliated with the Alliance.

Q. **Post Service or Retrospective:** Utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

R. **Prior Authorization:** A type of Organization Determination that occurs prior to services being rendered.

S. **Provider:** Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

   i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services~~,~~ but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

T. **Qualified Health Care Professional:** A primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

U. **Utilization Management (UM):** The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

V. **UM / BH Reviewer:** A Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. Board Certified Behavioral Analysts and licensed qualified autism providers are qualified by scope of practice, license or credential and experience in the use of criteria set to clinically autism services. They apply QIHEC and UM Committee approved criteria to authorize care for members meeting the criteria within their scope of practice.

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AFFECTED DEPARTMENTS/PARTIES

All departments

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RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on The Alliance website, Provider Section,
2. BH-001 Behavioral Health Services
3. BH-002 Behavioral Health Services
4. BH-005 Care Coordination-Behavioral Health
5. BH-006 Care Coordination-Substance Abuse
6. CM-002 Coordination of Care
7. CM-009 ECM Program Infrastructure
8. QI-104 Potential Quality of Care Issues
9. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making
10. RX-002 PA Review Process
11. UM-054 Policy Notice of Action
12. UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, 7/17/2024, 12/18/2024, 09/17/2025, 10/28/2025

REFERENCES

- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- 28 CCR, §1300.51 (d)(I-6)
- 42 CFR 422.631
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- APL 22-010 Cancer Biomarking Testing
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

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- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- CMS-10146 Notice of Denial of Medicare Part D Prescription Drug Coverage
- DHCS Contract, Exhibit A, Attachments 5, 9, 13
- DHCS Provider Manual, Family Planning, June 2022, page 1.
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- D-SNPs: Integration & Unified Appeals & Grievance Requirements | CMS
- Medicare parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance eff. 11/18/2024
- Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Effective January 1, 2025
- NCQA Standards, Utilization Management
- SB 600, Section 1374.551. (a)
- Title 22, Section 51159
- WIC Section 14197

- ~~SB 600, Section 1374.551. (a)~~
- ~~"May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.~~
- ~~Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).~~
- ~~DHCS Provider Manual, Family Planning, June 2022, page 1.~~
- ~~DHCS Contract, Exhibit A, Attachments 5, 9, 13~~
- ~~Title 22, Section 51159~~
- ~~28 CCR, §1300.51 (d)(I-6)~~
- ~~Health & Safety Code, Section 1367.01, 1367.665; 1370.6~~
- ~~2024 Medi-Cal Managed Care Plan Transition Policy Guide~~
- ~~42 CFR 438.900(d)~~
- ~~42 CFR Subpart K~~
- ~~NCQA Standards, Utilization Management~~
- ~~WIC Section 14197~~
- ~~APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates~~
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- ~~APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21~~
- ~~APL 23-018 Managed Care Health Plan Transition Policy Guide~~
- ~~APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.~~
- ~~APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care~~
- ~~APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and~~

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~~Transition of Members to Managed Care~~

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
3. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provides for the remediation of poor interrater reliability. The Alliance also ensures interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional details about the Inter-Rater Reliability Process.

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ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-067
Policy Name	Treatment of Varicose Veins (lower extremities)
Department Name	Utilization Management Division
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	MCAL, IHSS
Effective Date	5/21/2020
Subcommittee Name	QIHEC
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) covers medically necessary treatment for members with varicose veins when conservative treatment has been unsuccessful in resolving symptoms. Various procedures in the treatment of varicose veins will be reviewed using MCG® guidelines.

PROCEDURE

1. Treatment of symptomatic varicose veins (blood vessels of the lower extremities) that have failed conservative therapy will be reviewed for medical necessity using the DHCS Provider Manual for Medi-Cal Line of Business and MCG® guidelines for Group Care Line of Business.

2. Varicose vein ablation procedures can only be rendered by licensed MDs or DOs that have active board certification in the below specialties.

3. Surgical treatment of varicose veins will be limited to the following board certified specialties:
   3.1. Vascular surgery
   3.2. Interventional radiology [IR]
   3.3. Dermatology
   3.4. Cardiology
   3.5. General Surgery

4. Limitations:
   4.1. Multiple treatment sessions of the same procedure on the same extremity.

Repeat procedures are only indicated if clinical and anatomic failure unresponsive to conservative treatment is demonstrated after the 90-day post-operative period.

4.1.1. Cosmetic surgery

Treatment using sclerotherapy or various laser treatments of the telangiectatic dermal veins (i.e. reticular, capillary, venule), which may be described as "spider veins" or "broken blood vessels" is considered cosmetic and not medically necessary. Medi-Cal is not required to cover cosmetic surgery. Cosmetic surgery is “surgery that is performed to alter or reshape normal structures of the body in order to improve appearance” (Health and Safety Code § 1367.63(d)) or self-esteem. However, if the service request is reconstructive in nature to improve function, and/ or for the alleviation or treatment of pain then it would be medically necessary.

DEFINITIONS / ACRONYMS

Catheter ablation: A technique involving the application of either radiofrequency or laser energy through an endovenous catheter for the purpose of ablating varicose vein tissue of the GSV or SSV; this does not include the “closure” or ablation of a vein using the injection of a sclerosing agent through a hollow catheter.

Cosmetic: Cosmetic surgery is “surgery that is performed to alter or reshape normal structures of the body in order to improve appearance” (Health and Safety Code § 1367.63(d)) or self-esteem. However, if the service request is reconstructive in nature to improve function, and/ or for the alleviation or treatment of pain then it would be medically necessary.

Saphenofemoral reflux: A backflow of blood in the veins causing varicose vein symptoms and bulging.

Saphenous vein: A vein that serves as the principal blood vessel returning blood from the surface of the leg back to the trunk.

Sclerotherapy: A treatment for varicose veins in which a chemical is injected into the vein causing the vein to shrink and close.

Varicose vein or varicosity: Veins that are abnormally swollen or enlarged due to weakening in the vein's wall. Measured in an upright position they are 3 mm in diameter or greater.

AFFECTED DEPARTMENTS/PARTIES

- Claims
- Health Care Services (Case Management, Long Term Care, Utilization Management)
- Provider Relations
- Quality Improvement

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RELATED POLICIES AND PROCEDURES

- UM-001 Utilization Management

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

- UM 063 Gender Affirming Surgery and Services
- UM-064 11/15/2018; *retired 11/21/2019*

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REFERENCES

1. DHCS (Medi-Cal) Provider Manual: Part 2 – Surgery: Cardiovascular System September 2020, page 8-9.

2. Milliman Clinical Guidelines (MCG) 28th Edition:
   a. Saphenous Vein Ablation, radiofrequency [MCG ACG: A-0174 (AC)] 28th Edition

   b. Saphenous Vein Ablation, Laser [ACG: A-0425 (AC)] 28th Edition

   c. Sclerotherapy, Leg Veins [MCG: A-0170 Sclerotherapy, Leg Veins (AC)] 28th Edition]

   d. Stab Phlebectomy [MCG: Stab Phlebectomy ACG: A-735 (AC) 28th Edition

MONITORING

1. Annual audits based on CPT codes submitted

draft

POLICY AND PROCEDURE

Policy Number	UM – 068
Policy Name	Tertiary and Quaternary Review Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	01/21/2021
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~12/18/2024~~TBD

POLICY STATEMENT

Commented [MF1]: @Lam, Allison policy ready for next level review

Alameda Alliance for Health and Alameda Alliance Wellness ("The Alliance") ensures that members are redirected to a contracted facility that will be able to provide appropriate level of care, efficient, and expedient access to care. The Alliance makes UM decisions only on the appropriateness of care and service and existence of coverage.

PURPOSE

The purpose of this policy is to establish and implement the Tertiary and Quaternary Review Process. This policy is implemented to outline the standard process utilized in reviewing appropriateness of referrals and transitions to a tertiary and quaternary level of care. This will ensure consistency of all reviews both internally and externally. This will result in the timely transition of members to the right level of care at the right time and high-quality outcomes.

PROCEDURE

~~A.~~ The Alliance maintains a network of providers that is supported by written agreement and is sufficient to provide adequate access to care. The Alliance maintains networks that meet time/distance standards and cover dual-eligible needs including by not limited to advanced cardiac care, neurosurgery, specialized cancer treatment and burn treatment units. The Alliance also maintains networks that support multi-organ transplants. Tertiary and Quaternary care referrals are reviewed for the purpose of medical

Commented [WM2]: @Findlater, Michelle Per 42 CFR § 422.116 D-SNPs are required to maintain networks that meet "time/distance" standards and cover dual-eligible needs, including LTSS, CICM and behavioral health.- Consider adding this in for a level of specificity and staying consistent with CMS wording of time/distance.

Commented [MT3R2]: @Findlater, Michelle I added wording into the document.

overview, preventing overtreatment, and to avoid unnecessary treatment that may result in lack of patient benefit and bear potential cause of harm.

A.

B. Within the Alliance's network that delivers both tertiary and quaternary care includes the following National Cancer Institute (NCI) designated comprehensive Cancer Centers:

1. Alta Bates Summit Comprehensive Cancer Center, Adult Cellular Therapy Program (Bone Marrow Transplants only)
2. University of California, San Francisco Helen Diller Family Comprehensive Cancer Center
3. Stanford Cancer Institute, (includes Oncology and Bone Marrow Transplant (BMT) Services) and Major Organ Transplants (MOT)

C. Requests for specific tertiary and quaternary centers (either within or outside the network) may be subject to redirection to another tertiary or quaternary care center with regards to access that may be based on ~~the~~ several factors. The Alliance considers the following referrals to tertiary or quaternary care centers as medically necessary:

1. Referrals generated from specialists in the community who document a medical need for a higher level of care in the form of a specialized diagnostic approach, treatment, or procedure, or screening.
2. Referrals when a continuity of care issue is documented and meets regulatory requirements for continuity of care coverage.
    a. For example, if the Member is in the midst of an active course of treatment for a medical or behavioral need~~,~~ and
    b. the Member has seen the tertiary or quaternary care provider within the last 12 months, referral authorization for continuity of care or active course of treatment would be indicated and ~~.~~
    c. ~~-~~The Provider must be willing to accept rates with the health plan, be a registered Medi-Cal provider, and
    d. Does not have documented quality of care concerns.
    ~~2.~~e. For D-SNP Line of business, the member or member's representative can submit a request for Continuity of Care via telephone to the plan.
3. Referrals whose redirection may result in delay of necessary medical diagnostic services or treatment. Ancillary medical requests (e.g., radiology, laboratory studies) must be considered for adequate coverage in alternative settings or redirections that could result in potential delays in treatment decisions.
4. Referrals to secondary specialties related to the primary specialty at a tertiary or quaternary care center where ~~there~~ an active course of treatment exists.
    ~~4.~~a. For example, a Member with NYHA Class IV congestive heart failure may be followed by a tertiary or quaternary care center cardiologist. If the Member also has co-morbid pulmonary hypertension requiring pulmonary specialty consultation, approving the tertiary or quaternary pulmonary consultation would be appropriate to allow for multi-disciplinary collaboration in the Member's overall care plan.
5. Requests for consultation with specialties that have limited access in the community or that are not available in the community network setting.

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Commented [WM4]: @Findlater, Michelle Do we want to speak to what happens if D-SNP member loses medi-cal eligibility?

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Requests are reviewed and evaluated based upon individual medical or behavioral needs.

~~5.~~ a. The request may include, but are not limited to the following specialties; ~~y~~ ~~request but not limited to these examples. For example, the following specialties should be considered for tertiary or quaternary care level approval:~~ neuro-oncology, complex surgical-oncology and gynecologic-oncology, neurosurgery, infectious disease and perinatology.

D. The Alliance considers the following requests to tertiary or quaternary centers as appropriate for potential redirection to in-network community-based ~~specialists~~specialists, provided redirection does not compromise care:

1. Hematology/ Oncology consultation for cancers that, ~~-~~based on ~~by~~ available documentation, ~~-~~**do not** demonstrate:
   a. ~~-~~advanced stages or metastasis,
   b. have not failed (or are deemed not likely to fail) standard care available in the community,
   c. and/or are not rare or aggressive cancer types.
2. Specialty requests for consultations when specialists with appropriate access standards that can provide equivalent services are available in the community.
3. Requests for ancillary services (e.g., radiology or laboratory testing) that will not result in delay of treatment or coordination of care.
4. Specialty consultation requests that do not therapeutically relate to another specialty for which the Member is being followed in a tertiary or quaternary care center, and for which a community-based specialist has appropriate access and can provide equivalent services.
5. Requests for continuity of treatment of stable Members in the maintenance phase of their medical condition.

E. The Alliance considers the following requests to tertiary or quaternary centers as **not** appropriate for potential redirection to in-network community-based specialists:

1. A complex cancer diagnosis ~~on the other hand~~that would support a referral to a tertiary or quaternary center.

~~1.~~2.Members who have lost eligibility with the Alliance.

~~1. Specialty requests for consultations when specialists with appropriate access standards that can provide equivalent services are available in the community.~~

~~2. Tertiary or quaternary care center requests for ancillary services (e.g., radiology or laboratory testing) that will not result in delay of treatment or coordination of care.~~

~~3. Specialty consultation requests that do not therapeutically relate to another specialty for which the Member is being followed in a tertiary or quaternary care center, and for which a community-based specialist has appropriate access and can provide equivalent services.~~

~~4. Tertiary or quaternary care requests for continuity of treatment of stable Members in the maintenance phase of their medical condition.~~

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~~A community-based specialist of the same discipline with appropriate access and equivalent services may be considered for redirection of stable Members in the maintenance phase of their medical condition.~~

F. Process for when a member is redirected to a community-based specialist:

1. When requested services are denied, modified or deferred, a Notice of Action (NOA) or ~~Notice of Medical Non-Coverage~~Coverage Decision Letter (CDL) is sent to the member and requesting provider in accessible formats. The NOA/CDL is a written notification of the UM decision that includes a clear and concise denial reason, a reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based, and a statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
2. The NOA or ~~Notice of Medical Non-Coverage~~Coverage Decision Letter (CDL) also includes the members' right to file an appeal of the determination, for D-SNP this is a unified Medicare and Medicaid appeals process
3. ~~2.~~ The Alliance's appeal process is outlined in policy and procedure *G&A-008 Adverse Benefit Determination Appeal Process*.

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DEFINITIONS / ACRONYMS

1. **Complex Cancer Diagnosis:** an advanced stage (Stage IV) or metastatic cancer, members who have failed (or are deemed likely to fail) standard care available in the community, and/ or are rare or aggressive cancer types.
2. **Tertiary Care**: specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.
3. **Quaternary Care**: used as an extension of tertiary care in reference to advanced levels of medicine with are highly specialized and not widely accessed. This could include experimental medicine, screening modalities and some types of uncommon diagnostic or surgical procedures; these services are usually only offered in a limited number of health care centers.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department

RELATED POLICIES AND PROCEDURES

- 42 CFR 422.107
- DHCS APL 25-006 Timely Access Requirements
- Health and Safety Code (H&S) 1367.03
- Senate Bill (SB) 332 (Chapter 724, Statutes of 2021)
- Senate Bill (SB) 225 (Chapter 601, Statues of 2022)

- UM-001 Utilization Management Program
- UM-036 Continuity of Care
- UM-051 Timeliness of UM Decisions
- UM-054 Notice of Action
- UM-057 Authorization Request
- G&A-008 Adverse Benefit Determination Appeal Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- General Overview of the Prior Authorization Process Workflow

REVISION HISTORY

01/21/2021, 3/22/2022, 2/21/2023, 3/19/2024, 12/18/2024, 08/18/2025

REFERENCES

- CA Health & Safety Code § 1370.6 (2021)
- Department of Health Care Services All Plan Letter 18-008, Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care, December 7, 2018.
- SB 987, Portantino. California Cancer Care Equity Act.

MONITORING

1. Internal Monitoring
    a. Auditing is done on a quarterly basis by the Utilization Management Department. The audit findings are presented to the Utilization Management Sub-Committee. Routine audits include a review of clinical decision making including a review of the appropriateness of the approval or denial of services based on medical necessity.
    b. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.

2. Staff Training
    a. Staff training is conducted for new hires and on an ad-hoc basis by either the Manager of Outpatient Utilization Management or the Utilization Management Director or Medical Director. Training would consist of changes to any applicable state regulation, and implementation of new or updated policy and procedures.

POLICY AND PROCEDURE

Policy Number	UM-069
Policy Name	Continuous Glucose Monitoring Equipment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	~~UM Medical Director~~Director, Utilization Management
Line(s) of Business	MCAL, IHSS, DSNP
Effective Date	11/23/2021
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD~~2/16/2024~~
Compliance Committee Approval Date	TBD~~3/19/2024~~

POLICY STATEMENT

Alameda Alliance for Health (AAH) and Alameda Alliance Wellness ensures appropriate utilization of all healthcare services for members in compliance with all applicable State and Federal regulations. The Alliance ~~AAH~~ maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services requiring authorization.
This policy establishes guidance for clinical decision making related to Continuous Glucose Monitoring equipment (CGM)[1].

~~**For Managed Care**: DHCS provides medical coverage for therapeutic continuous glucose monitors with an approved prior authorization (PA) meeting the established criteria for CGM users. Starting 7/1/2023, DHCS will start managing prior authorizations for AAH MediCal~~

~~[1] As of March 1, 2020, there is only one Food and Drug Administration (FDA) approved implantable therapeutic continuous glucose monitoring system (CGM). The Eversense Continuous Glucose Monitoring System was approved by the FDA in June 2018, with expanded indications in June, 2019. This implantable CGM is a prescription device that provides real-time glucose monitoring every five minutes for up to 90 days at a time for people with diabetes. The system consists of an implantable fluorescence-based sensor, a smart transmitter, and a mobile application for displaying glucose values, trends and alerts on the patient's compatible mobile device. The system is intended to provide real-time glucose readings, provide glucose trend information, and provide alerts for the detection and prediction of episodes of low blood glucose (hypoglycemia) and high blood glucose (hyperglycemia). The FDA requires the specific training or experience practitioners need in order to use the device and insofar as the sale and distribution of the device are restricted to practitioners who are enrolled in, undergoing, or have completed the specific training identified in the labeling. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38743~~

CGM users with Type 1, Type 2, and gestational diabetes as pharmacy benefits through the Medi-Cal Rx vendor Magellan[2].

For Group Care members: Type 1, Type 2 and gestational diabetics who meet the UM-069 CGM criteria, will be reviewed for medical necessity following AAH's policy criteria. All AAH's PA requests for Group Care members for initial and continued CGM use, will be managed principally by the Alliance contracted vendor, California Home Medical Equipment (CHME). Services must be requested and rendered by contracted providers. Requests from the delegated provider network, excluding Kaiser, will be routed to CHME for UM review.

For Dual members with Medicare and AAH coverage: Medicare is the primary insurance for CGM prior authorizations[3]. AAH will follow the DHCS All Plan Letter 13-003 Coordination of Benefits: Medicare and MediCal. For Managed Care members who are not eligible for CGM under the Medicare criteria, they will need to send PAs to Medi-Cal Rx vendor Magellan. For Group Care members who are not eligible for CGM under the Medicare criteria, they will need to send PAs to the AAH CGM DME preferred vendor.

The Alliance shall make all UM decisions and notifications within required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards.

Decisions to modify or deny shall be made by a qualified Physician with appropriate clinical expertise in treating the condition and disease based on medical necessity.

AAH is responsible for the oversight of contracted and delegated providers to ensure compliance with regulatory and contractual requirements, accreditation standards and AAH medical policies. Delegates are required to implement activities to support the policies but may have variations in the procedure or implementation activities.

I. The Alliance CGM Criteria

For an initial CGM authorization, the PA must have sufficient documentation to support that member has been using the requested product within the past 90 days or meets ALL of the following criteria:

[2] Medi-Cal Rx Provider Manual, V11.0, October 1, 2023. Page 142. Accessed 10/27/2023. Medi-Cal Rx Provider Manual

[3] Medicare Coverage Database. LCD L33822 Glucose Monitors (I-CGM). CMS. Updated 4/16/2023. Accessed 10/27/2023. LCD - Glucose Monitors (L33822) (cms.gov)

~~1. Is under the immediate or ongoing care of, and the CGM is ordered by, an endocrinologist or health care practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy; AND~~
~~2. Is with the manufacturer's recommendation for appropriate age range; AND~~
~~3. Has a diagnosis of either diabetes or gestational diabetes:~~
~~a. Diabetes (Type 1 or 2) and one of the following other criteria:~~
~~i. Insulin dependent based on regular insulin claim history in the past year or other documentation of regular insulin use: OR~~
~~ii. History of problematic hypoglycemia with documentation demonstrating recurrent (more than one) level 2 hypoglycemia events (glucose < 54 mg/dL [3.0 mmol/]) that persists despite attempts to adjust medication(s) and/ or modify the diabetes treatment plan within the last year.~~
~~b. Gestational Diabetes:~~
~~i. Restricted to approval for the duration of the pregnancy up to a maximum of 9 months; AND~~
~~ii. Estimated date of delivery must be included in the request.~~
~~A HbA1c (A1C) value measured within eight (8) months must be documented on the PA request~~

~~II. **Reauthorization of CGM**~~
~~The prior authorization request must not exceed 12 months and must include the following documentation to support the following criteria[4]:~~

~~1. Has been seen and evaluated by the prescriber annually, either in person or virtually through video or telephone conferencing with documentation of:~~
~~a. The date of the most recent visit; AND[5]~~
~~b. The member is using the device as prescribed~~

~~**Life of the prior authorization approval calling**~~
~~**III.** CGM initial authorization and subsequent reauthorizations will be for initiate on the date of approval based supply.~~

PROCEDURE

A. The Alliance shall make all UM decisions and notifications within required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards.
1. Decisions to modify or deny shall be made by a qualified Physician with appropriate clinical expertise in treating the condition and disease based on medical necessity.
2. The Alliance ~~AAH~~ is responsible for the oversight of contracted and delegated providers to ensure compliance with regulatory and contractual requirements,

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accreditation standards and the Alliance ~~AAH~~ medical policies. Delegates are required to implement activities to support the policies but may have variations in the procedure or implementation activities.

B. The Alliance CGM Criteria

For an initial CGM authorization, the PA must have sufficient documentation to support that member has been using the requested product within the past 90 days or meets ALL of the following criteria:

1. Is under the immediate or ongoing care of, and the CGM is ordered by, an endocrinologist or health care practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy; AND
2. Is with the manufacturer's recommendation for appropriate age range; AND
3. Has a diagnosis of either diabetes or gestational diabetes:
    a. Diabetes (Type 1 or 2) and one of the following other criteria:
        i. Insulin dependent based on regular insulin claim history in the past year or other documentation of regular insulin use: OR
        ii. History of problematic hypoglycemia with documentation demonstrating recurrent (more than one) level 2 hypoglycemia events (glucose < 54 mg/dL [3.0 mmol/]) that persists despite attempts to adjust medication(s) and/ or modify the diabetes treatment plan within the last year.
    b. Gestational Diabetes:
        i. Restricted to approval for the duration of the pregnancy up to a maximum of 9 months; AND
        ii. Estimated date of delivery must be included in the request.
4. A HbA1c (A1C) value measured within eight (8) months must be documented on the PA request
5. All initial authorizations of CGM will be for initiate on the date of approval-based supply.

C. Reauthorization of CGM- The prior authorization request must not exceed 12 months for Medi Cal (6 months for D-SNP reauthorizations) and must include the following documentation to support the following criteria:

1. Has been seen and evaluated by the prescriber annually, either in person or virtually through video or telephone conferencing with documentation of:
    a. The date of the most recent visit; AND
    b. The member is using the device as prescribed
2. All reauthorizations of CGM will be for initiate on the date of approval-based supply.

D. Authorization Requests by Line of Business

1. **For MediCal**: Authorizations are managed through the Medi-Cal RX vendor
2. **For Group Care members:** All AAH's PA requests for Group Care members for initial and continued CGM use, will be managed principally by the Alliance contracted vendor, California Home Medical Equipment (CHME).
3. **For Dual members with Medicare and AAH coverage:** Medicare is the primary insurance for CGM prior authorizations. AAH will follow the DHCS All Plan Letter 13-003 Coordination of Benefits: Medicare and Medi Cal. For Managed

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Commented [WM1]: @Findlater, Michelle Hey, just wanted to call attention to LCD 33822. "Every six (6) months following the initial prescription of the CGM, the treating practitioner conducts an in-person or Medicare-approved telehealth visit with the beneficiary to document adherence to their CGM regimen and diabetes treatment plan."

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Care members who are not eligible for CGM under the Medicare criteria, they will need to send PAs to Medi-Cal Rx vendor Magellan. For Group Care members who are not eligible for CGM under the Medicare criteria, they will need to send PAs to the AAH CGM DME preferred vendor.

4. **For DSNP members**: Authorizations are managed through the Medi-Cal RX vendor

~~**For initial and continuous PA requests for CGM processed by CHME, the request will be processed in accordance with the AAH Utilization Management (UM) policies and CHME UM workflow effective 2/1/2024.**~~

TYPE OF SERVICE	LOB	BENEFIT CRITERIA	NCB	PA REQUIRED	NO PA REQUIRED	RESOURCE
Durable Medical Equipment (DME)/Continuous Glucose Monitors (CGM)	Medi-Cal Medi-Cal Group Care	CGM type 1 diabetic users. –Benefit cCarved out to Medi-Cal Rx. Submit PA request to Medi-Cal Rx. CGM type 2 diabetic users, gestational diabetics who are not type 1 diabetic users. – Submit requests to California Home Submit requests to California Home Medical Equipment (CHME).		√* √		* PA required by Medi-Cal Rx. CoverMyMeds **www.covermymeds.com** Medi-Cal Rx Secure Portal California Home Medical Equipment (CHME) Toll-Free: **1.800.906.0626** Email: **aaorders@chme.org**
	Group Care Medi-Cal	CGM users – All – Submit requests to California Home Medical Equipment (CHME). Covered for chronic pathologic conditions that cause incontinence. Submit requests to California Home Medical Equipment (CHME).		√ √		California Home Medical Equipment (CHME) Toll-Free: **1.800.906.0626** Email: **aaorders@chme.org** California Home Medical Equipment (CHME) Toll-Free: **1.800.906.0626** Email: **aaorders@chme.org**
Durable Medical Equipment (DME)/Incontinence						

E. ~~For~~ Prior Authorizations management by CHME

1. Initial Review
   a) If a case meets the criteria requirement, CHME will process the request.
   b) If the case does not meet criteria ~~requirement~~requirements or the requested service provider is a non-contracted provider then the request will be routed to ~~AAH~~the Alliance UM Department for review and dispensation.
      i. Case routed to the Alliance will include the entire PA request with clinical supporting documentation and the CHME UM review with the reason for potential denial.
      ~~i.~~

F. For PA requests routed to the Alliance:

1. UM Coordinator will retrieve PA from the mode of transmission, i.e. facsimile, portal, phone, or mail.

2. UM Coordinator will enter the PA using the receipt date as the date of the initial request received by CHME or other CGM vendor.

3. Upon receipt of the PA, the UM Coordinator will review the request for:
   ~~a.~~a) Member eligibility
   ~~b.~~b) Completeness of the request
   ~~i.~~c) Presence of the applicable medical codes, e.g. ICD-10, CPT, HCPC.
   ~~ii.~~d) Contract status for the requested vendor

4. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate processing queue for MD Advisor to begin the clinical review

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5. MD Advisor reviews PA request, and clinical records. If needed, the MD Advisor may contact the requesting provider for additional information to support medical necessity.

6. MD Advisor initiates the clinical decision-making process using CGM criteria, and other medical considerations which may evidence medical necessity:

~~6.~~

a) CGM workflow for other medical considerations for MD Advisor Reviews:

- i. The patient has poorly controlled diabetes (HgA1C > 10) despite standard diabetic medical interventions and health education; OR
- ii. Complex comorbidities (i.e. CKD IIIB-IV, CHF NYHA Class III-IV, chronic steroid use, high risk pregnancy (prior fetal loss, prior pre/eclampsia, heart disease, morbid obesity)); OR
- iii. The patient has significant glucose variability (BG results fluctuate widely from 70-300, or standard deviation of BG >50mg/dl)[6]; OR
- iv. The patient has medical record documentation of recurrent severe hypoglycemia (blood glucose measurements less than 70 mg/dl), hypoglycemic unawareness (ie. Patient does not have symptoms with hypoglycemia), nocturnal hypoglycemia (known or suspected), wide fluctuations in blood glucose before mealtime, dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/ dL (known or suspected), OR postprandial hyperglycemia[7], despite best practice management; OR
- v. Recent hospitalizations or frequent ED visits for significant hypoglycemia or DKA.

~~7.~~G. Final determination documentation

~~c)~~1. If a case meets medical necessity, MD Advisor will document the rationale, clinical decision making and the final determination.

~~d)~~2. If the case does not meet medical necessity, the MD Advisor will document the rationale, clinical decision making, cite the source/criteria utilized and the final determination (modification or denial). In addition, the MD Advisor will complete the appropriate Notice of Action template.

~~1.~~ If the case does not meet medical necessity and the MD Advisor does not have experience or appropriate clinical expertise in treating the condition and disease, the MD Advisor will request an internal secondary MD reviewer to make the final determination.

3.

~~2.~~ The MD Advisor will route the PA to the UM Coordinator for final processing.

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[6] ~~LCD L33822 Glucose Monitors, updated 2/28/2022. CMS Pub. 100-03, (Medicare National Coverage Determinations Manual), Chapter 1, Section 40.2~~

[7] ~~MCG 27th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)~~

4.

5. The UM Coordinator will complete the PA process as defined in UM policy UM-057 Authorization Service Requests and UM-054 Notice of Action.

~~8.~~

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DEFINITIONS / ACRONYMS

Therapeutic Continuous Glucose Monitoring equipment: Continuous glucose monitoring automatically tracks blood glucose levels, also called blood sugar, throughout the day and night. A CGM works through a tiny sensor inserted under the skin, usually on the belly or arm. The sensor measures interstitial glucose level, which is the glucose found in the fluid between the cells. The sensor tests glucose every few minutes. A transmitter wirelessly sends the information to a monitor. The monitor may be part of an insulin pump or a separate device. Some CGMs send information directly to a smartphone or tablet. DHCS states CGM devices not having FDA designation as a therapeutic CGM are considered "nontherapeutic" CGMs and are considered as an "adjunct use" to blood glucose monitor testing. Diabetic treatment decisions must still be made using a home blood glucose monitor test.

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Utilization Management
Claims
Grievance and Appeals

RELATED POLICIES AND PROCEDURES

UM-051 Timeliness of Decisions~~,~~
UM-054 Notice of Action~~,~~
UM-057 Authorization Service Requests

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CGM Workflow for Physicians and Medical Advisors

REVISION HISTORY

11/23/2021, 6/28/2022, 9/19/2023, 3/19/2024, 09/08/2025

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- Understanding the Social Factors That Contribute to Diabetes: A Means to Informing Health Care and Social Policies for the Chronically Ill, Perm J. 2013 Spring; 17(2): 67–72

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MONITORING

Annually

POLICY AND PROCEDURE

Policy Number	UM-070
Policy Name	UM ~~Denial~~ System Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	07/15/2021
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~12/18/2024~~TBD

Commented [AL1]: @Findlater, Michelle - this version isn't the one our NCQA consultants recently submitted. I will email you the correct version.

Commented [MF2R1]: Updates made on 10/27/25 include the NCQA consultant updates that were not previously sent through UMC.

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") has advanced UM system controls to protect data from being altered outside of prescribed protocols.

Scope of UM information, UM denial information integrity is defines as maintaining and safeguarding information used in UM denial decision process against inappropriate documentation updates.

Alameda Alliance for Health's information integrity policy protects the following type of information:

- UM Requests from members or their authorized representatives
- UM request receipt date
- Appropriate practitioner review
- Use of board-certified consultants
- Clinical information collected and reviewed
- UM decision
- UM decision notification date
- UM denial notice

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The Alliance has advanced system controls capabilities specific to UM denial notification dates that:

1. Defines the date of receipt consistent with NCQA requirements
    a. See UM-051 Timeliness of UM Decision Making and Notifications for detail on required timelines for determination and notification of decisions
    b. The date of receipt in the UM denial system is defined as the date when the authorization is requested via Provider Portal, ADT feed, fax, or mail at the Alliance, even if it is not received by the Utilization Management Department.
        i. Via Provider Portal. The time and date that the request was submitted and accepted through the Provider Portal.
        ii. Via ADT hospital data feed. The time and date the request was received via data feed by the Alliance.
        iii. Via Fax. The time and date that the fax was received by the Alliance.
        iv. Via Mail. The time and date that the request was date stamped by the Facilities Department.
    c. The Alliance counts the time from the date when the Alliance receives the request, whether or not it is during business hours.

2. Defines the date of written notification consistent with NCQA requirements
    a. AAH adheres to the NCQA UM timeliness requirements for written notifications.
        i. The date of written notification is when the Alliance gives written notification of decision to members and providers either via fax, dated with fax confirmation or mailed with a dated postmark. See UM-051 Timeliness of UM Decision Making and Notifications for detail on required timelines for determination and notification of decisions

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PROCEDURE

1. Recording dates in system:
    a. Date of Receipt. Receipt date is documented in the Request date field upon receipt of a request for authorization by the UM staff, who enters the request into system of record, TruCare, (TC). The TC system automatically records the date and time of the entry. If the request date is different than the entry date the staff manually enter the correct receipt date.
    b. Fax ADT feed and Portal System Requests auto generate an entry date and request date
    c. Date of Written Notification:

i. Once the decision is made, the staff enters it into TruCare. The TC system automatically records the date and time of the determination and the Notification. Notification date fields are locked and cannot be changed once a notification letter is generated.

ii. If a change in the content of the Notification letter is needed after the dated Notification letter is generated, the specific authorization line request is voided, and a note entered about the reason for the change. The case is redetermined and a new Notification letter is generated.

2. Staff roles

a. The following staff are responsible for documenting completion of UM activities:

i. UM Nurses, UM Coordinators, Behavioral Health Nurses, Long-Term Care Nurses, Long-Term Care Coordinators, Community Supports Nurses and Community Supports Coordinators.

ii. UM Supervisors, UM Managers

b. The following staff are authorized to modify (edit, update, [delete]) UM information:

i. UM Supervisors

ii. UM Managers

iii. UM/ LTSS Directors

iv. Senior Director Health Care Services

c. The following staff are responsible for oversight of UM information integrity functions, including auditing functions:

i. UM Director (or designee)

ii. UM Manager (or designee)

3. Process for documenting updates to UM Information:

a. Circumstances when UM information may be updated:

~~2. Staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate:~~

~~a. Circumstances when dates can be modified~~

i. UM Denial System Error. When there is a technical error in the system confirmed by the Information Technology Department. Example: Date in system incorrect.

ii. Administration Error. When any UM staff member entered the incorrect request/receipt date or time into the system. Example: When any UM staff entered incorrect UM information into the system. ~~Date is incorrectly typed into the system~~

~~b. Level of staff who are authorized to modify Request dates/Receipt date prior to Notification.~~

~~i. UM Supervisors~~

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~~ii. UM Managers~~

~~iii. UM/LTSS Directors~~

~~iv. Senior Director Health Care Services~~

~~c.~~b. Request dates/Receipt date:

i. Prior to Determination, any staff member cannot change request date (receipt date). Once a denial determination is made, the request/receipt date cannot be changed.

~~d.~~c. If a system failure occurs that affects the recording of the date and time, the Sr. Director of Health Care Services, Director of Utilization Management/Long~~-~~Term Services or Supports, or the Managers of Inpatient/Outpatient/Long~~-~~Term Care Utilization Management will work with IT to develop an ad hoc report to determine the scope of the error and remediation actions to be taken. Notification dates are automatically generated by the system when the notification date is entered and cannot be changed.

~~i.~~ After the Notification is dated in the system, if a change is needed, the staff member notes in the system when an auth is voided and the reason for the void. Voiding an auth is allowed for an administrative error, such as wrong member or other content error. Voiding authorizations to modify receipt dates or notification dates is not allowed~~.~~

d. Falsifying UM dates are not permitted, ad hoc reports (Weekly, Bi-Weekly and Monthly) will determine the score of the error. (e.g., receipt date, UM decision date, notification date).

i.

~~3.~~4. Tracking modified UM information~~dates~~:

a. The TC system tracks all changes and modifications to UM information, (including voided authorizations). ~~receipt dates, (including voided authorizations).~~ This tracking protects the information from being fraudulently altered, the TC system documentation includes who made the change~~includes who made the change~~, what was changed (request date or voided auth) and when the change was made. This is a system generated staff ID with the date and time of entries that cannot be changed. A note must be completed by the person making the change to explain why the date was modified.

b. If a system failure occurred that affected the recording of the date and time, the Sr. Manager~~Director~~ of Health Care Services, Director Utilization Management/ LTSS or the Manager of Inpatient/Sr. Manager of Outpatient Utilization Management will work with IT to develop an ad hoc report to determine the scope of the error and remediation actions to be taken.

5. Inappropriate documentation and updates:

a. The following documentation and updates to UM information are inappropriate:

i. Falsifying UM dates (e.g., receipt date, UM decision date, notification date).

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ii. Creating documents without performing the required activities

iii. Fraudulently altering existing documents (e.g., clinical information, board certified consultant review denial notices).

iv. Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review).

v. Updates to information by unauthorized individuals

6. Tracking Dismissals and Withdrawals for D-SNP Determination Requests

a. Withdrawal

i. A request for initial determination can be withdrawn at any time before a decision is issued~~s~~

ii. The request for a withdrawal must come from the party who requests the initial determination

b. Dismissal

i. Plans must dismiss a request for an initial determination under any of the following circumstances:

- The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.
- The plan determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). *A valid request, as contemplated in §§ 422.568(a) and 423.568(a), includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (e.g., address, telephone number, email).* In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.
- The enrollee dies while the request is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.

~~b.~~ • The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the plan.

~~4.~~7. All UM system data is secured in accordance with AAH IT policy and procedures.

a. Password-protecting electronic systems is outlined in IT-003 Password Management Policy, the policy includes requirements for:

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i. Using strong passwords
ii. Avoiding writing down passwords
iii. User IDs and passwords unique to each user
iv. Changing passwords periodically

b. Access to the electronic systems is outlined in IT-010 Access Authorization Policy, the policy includes requirements for:
    i. Limiting physical access to the system; therefore, preventing unauthorized access and changes to system data.

c. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security is outlined in IT-009 Access Termination Policy. When staff leave the organization or move to a new role and no longer need access to the TruCare UM system, Human Resources notifies IT to remove access.

DEFINITIONS / ACRONYMS

1. **TruCare**: The Alliance's UM Information System where authorization requests are processed.

2. **Advanced System Control Capabilities**: The Information System has the capability to both automatically record dates and to prevent changes that do not meet the organization's policies and procedures.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department

RELATED POLICIES AND PROCEDURES

- 42 CFR 422.107
- 42 CFR §§ 422.568(a)
- 423.568(a)
- CMP-019 Delegation Oversight
- CMP-020 Corrective Action Plan
- ~~UM-001 Utilization Management~~
- IT-003 Password Management Policy
- IT-009 Access Termination Policy
- IT-010 Access Authorization Policy
- UM-001 Utilization Management
- ~~CMP-019 Delegation Oversight~~
- ~~CMP-020 Corrective Action Plan~~

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

7/15/2021, 11/23/2021, 6/28/2022, 10/19/2023, 12/18/2024, 10/27/2025

REFERENCES

- NCQA UM 12: UM System Controls, Element A: Protecting the Integrity of UM Denial Information~~System Controls~~
- NCQA Policies and Procedures (Section 5) Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events

Commented [AL3]: @Findlater, Michelle – let's reference the current verbiage in 2025 NCQA HP standards

(UM 12: UM Information Integrity)

MONITORING

The Alliance conducts audits to identify and assess and ensure that this policy and procedure is followed.

1. External Delegates
    a. The Compliance Department has oversight of the Annual Delegation Review of UM delegates as outlined in CMP-019 Delegation Oversight.
    b. The Sr. Director of Health Care Services or the Manager of Inpatient/Outpatient Utilization Management reviews 30 UM denial files on an annual basis.
    c. The Compliance Department has oversight of the Corrective Action Plan as outlined in CMP-020 Corrective Action Plan, as needed.

2. Internal UM Denial Systems
    a. UM Denial Audit Review
        i. Internal audits ~~—~~are conducted quarterly to support operational monitoring.
        ii. An annual audit is completed and reported at the UM Committee, and then to the QIHEC
        iii. Audit Process: The UM Director, Manager or designee is responsible for oversight of the UM System Controls Audits. The UM System Control Audit is performed by the UM Director, Manager, or designee.
            1. Quarterly the UM Director, Manager, or Supervisor reviews the report from the TC Analytics Department of all receipt date modifications. The report is generated 10 days after the end of the quarter.
            2. The UM Director, Manager, or Supervisor makes a random selection of 5% or 50 charts, whichever is fewer, for review against the system control requirements.
            3. The cases are reviewed for documentation of a receipt date change, with date of change, change made by the appropriate staff and for an acceptable reason.
            4. If any date modifications does not meet the acceptable process as outlines in the Alliance policy, a qualitative analysis is conducted, and action will be taken to correct the issue.

5. The results of the audit and any and any identified inappropriate documentation and updates are reported to the UM Director. If any fraud or misconduct is identified (identification of systemic issues (e.g., falsifying UM request receipt dates) affecting 5% or more of UM files), the UM Director will make a report to NCQA's Reporting Hotline: English-speaking USA and Canada 844-440-0077 Spanish-speaking North America 800-216-1288 (from Mexico, user must dial 001-800-216-1288). Website: https://www.lighthouse-services.com/NCQA
6. Consequence for Inappropriate documentation and updates may include staff training conducted on an ad-hoc basis by the Manager of Inpatient/ Sr. Manager Outpatient Utilization Management. Training consists of changed to any applicable state regulation, and implementation of new or updated policy and procedure. Training is documented and require evidence of the participants involved. Individuals found making inappropriate documentation and updates may be subject to disciplinary actions up to and including termination.
7. AAH Continues to monitor using a follow up audit for three to six months after the annual audit to ensure information integrity.
8. If AAH identifies findings less than three quarters before the NCQA survey submission date. AAH submits all monitoring information it has available so much

iv. The Manager of UM is responsible for taking actions and ensuring the effectiveness of these actions are monitored in the quarterly reports.

~~4. AAH continues to monitor until it demonstrates improvement of at least one finding over three consecutive quarters.~~
~~5. If the results do not demonstrate improvement of at least one finding during the look-back period, the AAH UM Director submits all quarterly monitoring reports to the Sr. Director, Health Care Services to demonstrating ongoing monitoring.~~
~~6. If AAH identifies findings less than three quarters before the NCQA survey submission date, AAH submits all monitoring information it has available.~~

~~iv. If any date modification does not meet the acceptable process as outlined in the Alliance policy, action will be taken to correct the issue. Action may include staff training conducted on an ad-hoc basis by the Manager of Inpatient/Outpatient Utilization Management. Training consists of changes to any applicable state regulation, and implementation of new or updated policy and procedures. Training is documented and require evidence of the participants involved.~~
~~v. The Manager of UM is responsible for taking actions and ensuring the effectiveness of these actions are monitored in the quarterly reports.~~

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POLICY AND PROCEDURE

Policy Number	UM-071
Policy Name	Major Organ and Bone Marrow Transplants
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	11/11/2022
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Purpose:
This policy provides guidelines for organ transplantation services covered for DSNP, Medi-Ceal care members. It outlines the requirements, procedures and coordination processes for major organ transplants (MOT).

Scope:
All providers, staff involved in MOT services including but not limited to non-clinical, clinical staff, Medical Directors, Chief Medical Officer and network management staff.

POLICY STATEMENT

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Effective January 1, 2022, the Alameda Alliance for Health ~~(The Alliance~~ covers the Major Organ Transplant (MOT) benefit for adult and non-CCS covered pediatric transplant recipients and donors, including related services such as organ procurement and living donor care as required by Title 42 of the Code of Federal Regulations (CFR) ~~Section 482.94, 482.94(c)(ii) and DHCS APL 21-015.~~ The Alliance shall refer, coordinate, and authorize the delivery of the transplant benefit and all medically necessary services associated with transplants to approved transplant programs that meet Centers for Medicare and Medicaid (CMS)~~D~~ and Department of Healthcare Services (DHCS) criteria~~, (Centers of Excellence for major organs and Center for Medicare and Medicaid Serves for Kidney, corneal and autologous islet cell transplants,)~~, including, but not limited to, pre-transplantation assessments/evaluations and appointments, organ procurement costs, hospitalization~~-~~, ~~-~~(including living donor's hospitalization,) surgery, discharge planning, complications, (including readmissions from complications,) post-operative services, medications not otherwise covered by the Alliance, transportation, and care coordination for members and living donors.

The Alliance will also cover all medically necessary ~~-~~services ~~-~~for both living donors and cadaver organ transplant donors regardless of a living donor's~~-~~ Medi- Cal eligibility.

The Alliance is not required to pay for costs associated with MOT for medical conditions that qualify as a CCS eligible condition.

The Alliance shall only authorize transplants to be performed in approved transplant programs located within a hospital that meets ~~regulatory~~ the Department of Health Care Services' (DHCS) criteria.

I. Covered Benefits
   a. The Alliance will cover all medically necessary major organ transplants as outlined in the CMS and Medi-Cal Provider Manual, including all updates and amendments ~~to the Provider Manual~~. excluding transplant that are considered experimental or investigational.

   b. The Alliance will ensure members receive covered benefits at a facility designated as an ~~Medi-Cal~~ approved Center of Excellence (COE) by organ type ~~-~~fortransplants related to the following major organs:

      - Bone marrow
      - Heart
      - Heart-lung
      - Kidney
      - Kidney-pancreas (simultaneous)
      - Liver
      - Liver-small bowel (combined)
      - Lung
      - Pancreas
      - Small bowel
      - Pancreas

   c. Kidney, corneal, and autologous islet cell transplants are not required to be performed in a COE or Special Care Center (SCC). For these organs, The

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Alliance will refer members to a transplant program that is approved by Centers for Medicare and Medicaid Services (CMS) to perform transplants for the respective organ and is a current Organ Procurement and Transplantation Network (OPTN) member.

d. Most pediatric conditions requiring organ transplants qualify as a CCS-eligible condition. Transplants for pediatric members are required to be performed only at a CCS-approved specialty care center (SCC) that has been approved for the specific organ and age group being requested. If the CCS program determines that the member is not eligible for the CCS program, but the transplant is medically necessary, the Alliance will authorize the transplant, as appropriate.

e. Network management will maintain documentation confirming each facility's approval status with CMS. Annual verification of each transplant center's status shall be conducted and documented.

f. All transplant centers for D-SNP network must meet the requirements specified in 42 CFR 482.72 including being a member of and abiding by the rules of the OPTN. Facility monitoring shall be conducted using CMS reports on transplant center outcomes and quality metrics. Appropriate action shall take place if a contracted center fails to meet CMS requirements, including potential network adjustments.

g. D-SNP enrollees are allowed to be listed at more than one transplant center if medically appropriate.

h. For D-SNP enrollees the Alliance will provide integrated care coordination for transplant patients that includes:

- Coordination between Medicare and Medicaid benefits
  - Medicare services include: hospital/physician services, organ acquisition costs, Part B or Part D drugs as applicable and follow up care and monitoring
  - Medi-Cal wrap around services: transportation, long-term care services, any additional services covered under Medi-Cal
- Communication with transplant centers and other providers including regular case conferences via a secure communication system established for sharing information between the Plan and transplant center
- Management of pre, post and transplant services
- Assistance with transportation, medication management and other services as needed
- Coordination with multiple transplant centers when an enrollee is listed at more than one facility

i. The Alliance will authorize appropriate non-emergency medical transportation, (NEMT,), non-medical transportation (NMT,) services and related travel expenses for Medi-Cal members related to transplant for

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recipients and living donors to obtain medically necessary services as per APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services. Lodging and transportation services are available to CCS-eligible members under CCS Maintenance and Transportation (M&T) benefit and not the responsibility of the Alliance. Upon the request of the MOT donor or recipient, Physician Certification Statement (PCS) form are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.

~~f.~~j. The Alliance will ensure that all medically necessary prescriptions are covered. Medi-Cal Rx will pay pharmacy claims for medically necessary MOT-related prescription drugs unless a member has other primary insurance or Medicare. The Alliance or other primary insurer/Medicare will be responsible for the cost of medically necessary facility or physician-administrated drugs.

II. Current Enrollment and Care Coordination Requirements

a. Medi-Cal members approved for a MOT and disenrolled from The Alliance prior to January 1, 2022, will remain disenrolled from the Alliance and enrolled in Fee-For-Service (FFS) Medi-Cal. The Medical Exemption Request (MER) and Emergency Disenrollment Exemption Request (EDER) process allows members to be disenrolled from the Alliance. The enrollment process into a managed care plan for mandatory enrollees will begin after the expiration of their MER or EDER.

b. The Alliance provides MOT services for members in and out of network. The Alliance does not require qualifying members to disenroll for out of network providers, inside or outside of the service area. Members are notified of the availability of the MOT benefit, and procedures regarding the MOT benefits in the Member Handbook, (Evidence of Coverage.) If members have questions or require more information about MOT, they may also call Member Services for assistance and referral for care coordination as needed.

c. The Alliance will ensure discharge planning/Transitional Care Services and coordination of care between all providers, organ donation entities, and transplant programs to ensure the transplant is completed as expeditiously as possible. Care coordination will be provided to the transplant recipients as well as the living donors.

II. Transplant Program Requirements

a. The Alliance submitted its MOT Network Assessment Template to DHCS for approval. Alliance is responsible for overseeing and monitoring its MOT Network.

~~b.~~ The Alliance will ensure all transplant procedures are performed in an approved transplant program which operates within a hospital setting, is certified, and licensed through CMS, and meets Medi-Cal state and federal regulations consistent with 42 CFR and Section 1138 of the Social Security Act (SSA).

~~e.~~

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b.

c. The Alliance will ensure that all contracted hospitals within which transplant programs are located meet regulatory criteria and that the hospital is enrolled to participate in the Medi-Cal program.

~~e. The Alliance will ensure that all contracted hospitals within which transplant programs are located meet regulatory criteria and that the hospital is enrolled to participate in the Medi-Cal program.~~

d. The Alliance will monitor the status of contracted hospitals with approved transplant programs to ensure they do not refer members or authorize referrals to a transplant program that no longer meets regulatory requirements or is no longer approved by CMS for the appropriate transplant type. The Alliance requires the necessary documentation from contracted hospitals in which transplant programs are located to validate those requirements are met no less than annually.

~~d.~~ The Alliance will monitor the status of contracted hospitals with approved transplant programs to ensure they do not refer members or authorize referrals to a transplant program that no longer meets regulatory requirements or is no longer approved by CMS for the appropriate transplant type. The Alliance~~AHH~~ shall require the necessary documentation from contracted hospitals in which transplant programs are located to validate those requirements are met no less than annually.

e. ~~transplant programs are located to validate those requirements are met no less than annually.~~

- If the Alliance becomes aware that a contracted hospital is no longer active, has lost its Medi-Cal approved COE status, or is no longer on COE or SCC list, the Alliance will notify any member who has an active referral to the transplant program no later than 30 days prior to the planned inactivation date.

~~e.~~f. Required Membership & Accreditation for all transplant programs:

- Solid organ transplant programs must meet the CMS Conditions of Participation for the specific organ type and must maintain an active membership with OPTN administered by UNOS.
- Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
- Transplants for pediatric members (less than 21 years of age,) are required to be performed only in a CCS-approved SCC (Special Care Center.) SCCs are within CCS-approved hospitals that provide comprehensive, coordinated health care to CCS-eligible members. Transplants for CCS-eligible members must be performed in an SCC that has been approved for the specific organ and age group.

~~f.~~g. Out-of-Network:

When the transplant program cannot perform the transplant surgery ~~and~~ an organ is available, the Alliance ~~may~~ arrange ~~for~~ the surgery ~~to~~ be performed

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at a different transplant program outside of its network. The Alliance will ensure that the transplant program meets regulatory COE requirements that are based on the following criteria:

- CMS approval for the appropriate organ
- OPTN membership for solid organs transplants; or
- Accreditation by the Foundation for the Accreditation of Cellular Therapy for bone marrow transplants; or
- CCS-approved SCC within a tertiary hospital.

g.h. Out-Of-State:

The Alliance may authorize transplants to be performed in a transplant program located outside of California if:

- The reason for the transplant to be provided out-of-state is advantageous to the member (i.e., the facility is closer to where the member resides, or the member can obtain the transplant sooner than the in-state facility).
- The Alliance member must consent to receiving the transplant out of state.
- The Alliance will ensure that the process for directly referring, authorizing referrals, and coordinating transplants for members to out-of-state transplant programs is not more restrictive than for in-state transplant programs and the facility is designated by CMS to perform transplants for a specific type of organ and is a current member of the OPTN. DHCS provider enrollment requirements will be waived for single case agreements/letters of agreement with out-of-state transplant programs.
- Membership & Accreditation
- Solid organ transplant programs must meet the CMS Conditions of Participation for the specific organ type and must maintain an active membership with OPTN administered by UNOS.
- Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
- An out-of-state transplant program is enrolled as a Medi-Cal provider.

h.i. The transplant program is responsible for placing members on the National Waitlist maintained by OPTN, administered by HRSA, once it has determinedbeen determined that the member is a suitable transplant candidate. The Alliance will refer members or will authorize referrals to the appropriate transplant program for an evaluation if the member's primary care physician (PCP) or specialist identifies the member as a potential transplant candidate.

III. Referral and Authorization Process and Requirements

a. The Alliance will directly refer adult members or authorize referrals to a transplant program that meets regulatory criteria foran evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for the transplant.

a.

b. The Alliance will authorize the request for the transplant after the transplant

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program confirms the transplant candidacy of the member. The Alliance will only apply utilization management protocols that do not establish unreasonable or arbitrary barriers for accessing coverage. If an authorization request is denied, the Alliance Chief Medical Officer (CMO) reviews the request and determines the appropriateness of the denial.

~~b.~~

c. Once the transplant program confirms that the member is a suitable transplant candidate, the Alliance shall authorize the request for the transplant. Expedited authorizations will be given if the organ that the member will receive is at risk of being unusable due to any delay in obtaining prior authorization or if the transplant program can provide immediate transplant services that would benefit the member's condition. The expedited authorizations will be completed no later than 72 hours after the request is made.

~~c.~~

d. The Alliance will refer pediatric members to the County CCS program for CCS eligibility determination within 72 hours of the member's PCP or specialist identifying the member as potential candidate for the transplant.
   - The County CCS program will be responsible for referring the CCS- eligible member to the transplant SCC. An ~~Integrated Systems~~Integrated Systems of Care (ISCD) Medical Consultant or designee will be responsible for determination of medical necessity and adjudication of the request for the transplant upon the SCC's confirmation that the member is a suitable candidate for the transplant.

   - Once the transplant program confirms that the member is a suitable transplant candidate, the ISCD Medical Consultant or designee will be required to authorize the request for the transplant. ~~.~~e

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- ~~E~~xpedited authorizations are required to be completed no later than 72 hours when the organ that the member will receive is at risk of being unusable due to any delay in obtaining prior authorization, or if the transplant program can provide immediate transplant services that would benefit the member's condition.

e. The Alliance will refer the member to an appropriate transplant program that meets regulatory criteria and will authorize the transplant if the CCS program determines that the member is not eligible for the CCS program, but the transplant is medically necessary.

IV. Delegation Oversight

a. The Alliance is subject to medical audits conducted by appropriate regulatory entities in which all activities related to transplants will be audited, including, but not limited to, service authorizations, referral processes, and general oversight and monitoring of the transplant programs.

b. The Alliance's transplant programs will be subject to grievances and appeals reporting, as well as the quarterly monitoring process.

PROCEDURE

I. For Alliance Medi-Cal Members:

a. The PCP or referred specialist is responsible for the initial diagnostic work-up prior to a referral to a Medi-Cal designated transplant program/center. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second surgical opinions, or hospital admissions must follow the Alliance's prior authorization referral procedures.

b. The Alliance will follow the procedures listed below for all potential major organ transplant candidates:

a. Alliance Utilization Management (UM) will assist the PCP or specialist with all necessary diagnostic, therapeutic, or other specialty referrals for the Member being evaluated as a candidate for a possible organ transplant.

b. The Alliance Utilization Management (UM) in collaboration with The Alliance Case Management, (CM) will directly refer adult members or authorize referrals to a transplant program that meets DHCS criteria for an evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for the transplant.

1. Upon identification of Member who need transplant related prior auth, UM Coordinator will create a referral to Case Management for provision of complex case management services

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c. The Alliance UM will refer pediatric members to the County CCS program for CCS eligibility determination within 72-hours of the member's PCP or specialist identifying the member as potential candidate for the transplant.

- ~~1.~~ Upon identification of pediatric member who need transplant related prior auth, UM Coordinator will create a referral to Case Management for provision of complex case management services
- ~~11. UM Transplant Nurse or designee in UM~~ The CCS coordinator will follow up to ensure the referral has been accepted and deemed eligible for CCS criteria. For members accepted through the CCS program, CCS will be required to authorize the request for the transplant.

~~m.~~ In the event CCS programs determines that the member is not eligible for CCS program and:

1. Transplant is necessary, the CCS RN will work with the Transplant Nurse ~~will~~ to refer the member to an appropriate COE or SCC that is accredited and certified.
2. Transplant is not necessary, the CCS RN/coordinator will collaborate ~~Transplant Nurse in collaboration~~ with CM ~~will~~ and ~~coordinate with~~ the referring physician and or PCP about the status of the referral and the appropriate next steps.

d. The UM Nurse will review the request and direct diagnostic, therapeutic, and/or specialty referrals as indicated.

e. For any emergency, non-emergency medical transportation, non-medical transportation services and related travel expenses related to transplant for transplant recipients and living donors to obtain medically necessary services [see policy #UM O16 Transportation policy] will be covered by the Alliance. Lodging and transportation services are available to CCS-eligible members under CCS Maintenance and Transportation (M&T) benefit and not the responsibility of the Alliance.

f. Once the transplant program confirms that the member is a suitable transplant candidate, UM will authorize the request for the transplant. The expedited authorizations are completed no later than 72 hours. [See policy# UM-001 Utilization Management Program for prior authorization process and UM- 051 for Timeliness of UM Decision Making requirements]

- ~~1.~~ The transplant program is responsible for placing members on the National Waitlist maintained by OPTN, administered by HRSA, once it has determined that the member is a suitable transplant candidate.
- ~~11.~~ The Transplant program is responsible for notifying the Alliance that member has been placed on the wait list and the date of placement.
- ~~111.~~ On a monthly basis and as needed, the transplant program is responsible for sharing the information which includes but is not limited to transplant data, medical records, case notes, care plan to the Alliance for continued care coordination.

g. The Alliance may refer Members who appear to meet criteria for a specific organ transplant to an approved Medi-Cal/Medicare Transplant

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Center.

~~1.~~ The Alliance will ensure that the Transplant program and or the transplant center/hospital is compliant with accreditation and

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- membership as set forth by this policy by checking the contract, available certification, or through primary source verification (PSV)

- ~~11.~~ If the Alliance becomes aware that a contracted transplant program/hospital no longer meets requirements, the Alliance shall:
    1. Create new authorizations for all open services to the new accredited COE.
    2. Complete a letter of agreement for all ongoing services if the member moves to an Out of network (OON) COE
    3. Notify any member who has an active referral to the transplant program no later than 30 days prior to the planned inactivation date.

- ~~111.~~ For Out-of-Network, the Alliance will ensure that the transplant program meets regulatory COE requirements that are based on the following criteria:
    1. CMS approval for the appropriate organ
        a. OPTN membership for solid organs transplants; or
        b. Accreditation by the Foundation for the Accreditation of Cellular Therapy for bone marrow transplants; or
    2. CCS-approved SCC within a tertiary hospital.

- ~~1v.~~ For Out-Of-State, transplant nurse or UM designee will review to ensure transplant to be provided out of state is advantageous to the member. UM nurse will ensure the member is aware and consented for the out-of-state transplant. The Alliance will also ensure that the transplant program meets regulatory COE requirements that are based on the following criteria:
    1. CMS approval for the appropriate organ
        a. OPTN membership for solid organs transplants; or
        b. Accreditation by the Foundation for the Accreditation of Cellular Therapy for bone marrow transplants; or
    2. CCS-approved SCC within a tertiary hospital.

h. The Alliance CM in collaboration with the Transplant Nurse will ensure discharge planning/Transitional Care Services and coordination of care between all providers, organ donation entities, transplant programs, and internal UM to ensure the transplant is completed as expeditiously as possible. Care coordination must be provided to the transplant recipients as well as the living donors. Complex Case Management & Transplant Nurse will follow the member through the entire organ transplant continuum and address all necessary care coordination needs unrelated or related to major organ transplants as well as the care of the living donor.

1. If a member is not accepted into a transplant program, the Member's assigned PCP and referral specialists continue to provide

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all medically necessary care, including Case Management (CM) services, as needed.

J. On a monthly basis, internal IT and Analytics will provide a report designed by UM and CM to allow the department to monitor the needed transplant related activities.

II. CCS Benefits for Medi-Cal Members:

a. All Members under 21 years of age who are potential transplant candidates will be referred to the local CCS Program for evaluation and diagnostic work- up.

b. The local CCS Program completes the necessary referral process on all Members less than 21 years of age, following determination of eligibility for CCS services.

c. All requests by the Center are sent to the local CCS program for authorization.
The Alliance coordinates care with the local CCS Program for major transplant services [see Policy# UM-008 Care Coordination - CCS for details on coordination of care].

~~d.~~ The Alliance and its Providers remain responsible for the provision of primary
d. care services.

DEFINITIONS / ACRONYMS

I. Utilization Management (UM) - the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources
~~I.~~

II. California Children's Services (CCS) - a state-funded program which covers medically necessary care and complex case management services related to certain diagnoses for children aged O - 21 years of age. CCS services are delivered by paneled providers and approved tertiary care medical centers in local communities.

III. Complex Case Management - a program designed to assist in managing the care of medically complex members by coordinating services that will ensure the improvement of patient outcomes and overall member satisfaction.

IV. Center of Excellence (COE) - Centers of Excellence are medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates.

V. Special Care Center (SCC) - Special Care Centers (SCC) provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions. SCCs are organized around a specific condition or system. SCCs are comprised of multi- disciplinary, multi-specialty providers who evaluate the client's medical condition and develop a family-

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centered health care plan to facilitate the provision of timely, coordinated treatment.

~~VI. DSNP (dual special needs plan): A Medicare advantage plan for individuals entitled to both Medicare and Medi-Cal assistance~~

VI. DSNP (dual special needs plan): A Medicare advantage plan for individuals entitled to both Medicare and Medi-Cal assistance

VII. OPTN (organ procurement transplantation network): unified network operated by UNOS that links all professionals involved in the US donation and transplantation system

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AFFECTED DEPARTMENTS/PARTIES

- Utilization Management/ CCS team
- Case Management
- Population Health Services
- Analytics

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- IT
- Provider Services
- Compliance

RELATED POLICIES AND PROCEDURES

- CMP-027 Pre-Delegation Audit
- CMP-028 Delegate Annual Audit
- UM-001 Utilization Management
- UM-003 Concurrent Review and Discharge Planning Process
- UM-008 Coordination of Care - California Children's Services
- UM-016 Transportation Policy
- UM-051 Timeliness of UM Decisions
- UM-054 Notice of Action
- UM-068 Tertiary and Quaternary Review Process
- UM-057 Authorization Service Request
- UM-060 Delegation Management and Oversight
- ~~CMP-027 Pre-Delegation Audit~~
- ~~CMP-028 Delegate Annual Audit~~

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/23/2021, 6/28/2022, 6/20/2023, 9/19/2023, 12/18/2024, 06/21/2025

REFERENCES

1. APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative attachment 2
2. Section 1138 of the Social Security Act (SSA)
   ~~APL 21-015 Attachment 2 Major Organ Transplants~~
3. APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services
4. DHCS Provider Manual, Part 2 - Transplants
5. Section 1138 of the Social Security Act (SSA)

Title 42 of the Code of Federal Regulations (CFR) parts 405, 482, 482.94, 482.94(c)(ii), 488,

6. and 498.

MONITORING

The Compliance and Utilization Department will review this policy along with the evaluation of performance annually for compliance with regulatory and contractual requirements. All policies will be brought to Quality Improvement Health Equity Committee and Administrative Oversight Committee annually.

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POLICY AND PROCEDURE

Policy Number	QI-D-005
Policy Name	DSNP MOC Staff Training
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	D-SNP
Effective Date	
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

Alameda Alliance Wellness is committed to ensuring that all employees, consultants, independent contractors, network providers, and subcontractors are thoroughly trained in D-SNP population management requirements to deliver high-quality, culturally competent, and equitable services to D-SNP population members and potential members. This training policy ensures compliance with CMS standards, promotes effective care coordination, and supports the unique needs of the D-SNP population, including those requiring dementia care, long-term services and supports (LTSS), and palliative care. Training will be completed within 90 days of employment or contract initiation and will be ongoing to maintain competency and compliance.

This policy applies to all permanent and temporary employees (full-time and part-time), consultants and independent contractors and network providers delivering services to D-SNP members, and delegated entities responsible for D-SNP related functions, such as care management or health risk assessments.

This policy covers initial and annual refresher training, ensuring all personnel are equipped to perform their roles in compliance with CMS regulations and organizational standards, without discrimination based on race, ethnicity, gender, sexual orientation, disability, or other protected characteristics.

This policy ensures compliance with 42 CFR § 422.101(f) and the CMS-approved Model of Care (MOC) requirements established under Social Security Act § 1859(f)(7), as well as relevant DHCS D-SNP Program Guide provisions for Medicare-Medi-Cal integration.

Commented [AL2R1]: Reviewed - looks good from HCS perspective.

Commented [MS3R1]: @Goradia, Jaini @Williams, Kayla

Commented [MS4R1]: @Ayala, Linda

Commented [MS5R1]: @Gerena, Kisha

Commented [LA6R1]: Reviewed - please see comments below.

Commented [GJ7R1]: Reviewed from Stars. Kristen A provided feedback.

Commented [TM8]: @Olson-Lennon, Elizabeth please review and edit as needed

PROCEDURE

1. Training Requirements
   1.1. Mandatory Training: All employees, consultants, independent contractors, network providers, and subcontractors that are member facing must complete D-SNP MOC training within 90 days of hire, contact initiation, or engagement, and annually thereafter.
   1.2. Scope of Training:
      1.2.1. CMS Model of Care (MOC): Understanding MOC components, including care coordination, quality improvement, and member-centered care.
      1.2.2. Health Risk Assessment (HRA): Conducting and documenting health risk assessments to identify member needs.
      1.2.3. Interdisciplinary Care Plan (ICP): Developing and updating individualized care plans tailored to member needs.
      1.2.4. Interdisciplinary Care Team (ICT): Roles and responsibilities within interdisciplinary care teams for coordinated care.
      1.2.5. CM Documentation: Proper documentation of case management activities in compliance with CMS and organizational standards.
      1.2.6. Policies, WF, and SOPs: Adherence to organizational policies, workflows, and standard operating procedures for D-SNP operations.
      1.2.7. Dementia Care Training: Best practices for supporting members with dementia, including communication, safety, and core coordination (e.g., Understanding Alzheimer's and Related Dementias, Understanding and Managing Behaviors and Communication Problems, Caregiver Stress and Management, Community Resources for Members and Caregivers).
      1.2.8. LTSS Training: Understanding LTSS delivery, including home- and community-based services and facility-based care, to support members with functional limitations (e.g., home-based services, community-based services, long-term institutional care).
      1.2.9. Social Determinants of Health (SDOH): Identifying and addressing SDOH (e.g., housing instability, food insecurity, transportation barriers, social isolation) through screenings, referrals to community resources, and care plan integration to improve health and equity outcomes.
      1.2.10. Palliative Care Training: Principles of palliative care to enhance quality of life for members with serious illnesses (e.g., Advanced Care Planning, Palliative Care Assessment, Plan of Care, Care Coordination, Pain and Symptom Management, Mental Health and Medical Social Services).
      1.2.11. Cultural Competency: Training to ensure equitable service delivery, respecting diverse member characteristics and identities.
   1.3. Frequency:
      1.3.1. Initial Training within 90 days.
      1.3.2. Annual refresher training for all personnel. Annual training for contracted downstream partners.
      1.3.3. Ad-hoc training for regulatory updates or performance deficiencies.
2. Training Delivery Modalities
   2.1. Methods may include:
      2.1.1. In-Person Workshops: Facilitated by internal or external experts for interactive learning.

Commented [OE9]: We can't train all vendors like this. Please remove them from this section.

Commented [WM10R9]: @Olson-Lennon, Elizabeth updated to be specifically refer MOC training only and that only for member facing vendors.

Commented [LA11]: As I read this, the procedure implies that all employees will take all these trainings, is that correct? CM documentation will only be critical for CM staff, Dementia Care alone is multiple hours.

Commented [LA12R11]: Also is it required that we share a population description of our DSNP members? I don't see this listed within the scope.

Commented [TM13R11]: This is the outline of the scope of training. It must be included.

Commented [AK14]: Is it possible to include annual CMS Star Program Training to the Scope? Verbiage could include: CMS Star Program Training: Cover regulatory requirements of the CMS Stars Program with focus on health plan employee impact on key areas to increase member health and experience through ensuring preventive and chronic care is received, monitoring that medications are appropriate and taken as needed, and maintaining high standards for plan and provider administrative processes.

Commented [TM15R14]: Stars isn't included in the MOC.

Commented [LA16]: How is this the same or different from the DEI and Cultural Sensitivity trainings already required?

Commented [TM17R16]: Its part of the MOC - not DEI very different and very brief

2.1.2. E-Learning Modules: Online courses accessible via the Learning Management System (LMS) for self-paced learning.
2.1.3. Webinars: Live or recorded sessions for remote providers and subcontractors.
2.1.4. Job Shadowing: On-the-job training for practical application of skills.

2.2. Accessibility: Training materials may be available in multiple formats (e.g., written, audio, video) and languages to accommodate diverse needs.

3. Delegated Entities: MOC training will be provided to delegated entities
4. Attendance Tracking and Documentation

4.1. Tracking:

4.1.1. The LMS will record attendance, completion status, and quiz scores for all training sessions.
4.1.2. In-person training will require sign-in sheets, verified by the Compliance, Training, and HR departments.
4.1.3. Delegated entities must submit attendance records to the Alliance within 10 business days of training completion.

4.2. Documentation:

4.2.1. Training completion certificates will be issued and stored in the LMS and employee/contractor files.
4.2.2. Proof of attendance (e.g., sign-in sheets, LMS reports) will be maintained for at least 7 years for CMS audits.
4.2.3. Delegated entity training records will be reviewed during quarterly audits to ensure compliance.

5. Notification of Training Due

5.1. Initial Training:

5.1.1. HR will notify new hires, consultants, and contractors of training requirements during onboarding and within 90 days of employment. onboarding.
5.1.2. Notifications will be sent via email and LMS alerts, specifying the 90-day deadline.

5.2. Annual Refresher:

5.2.1. Communication will be sent for the staff to complete annual training within 90 days of assignment
5.2.2. Managers will receive reports on their team's training status to ensure compliance.

5.3. Delegated Entities:

5.3.1. Vendor Management will notify delegated entities of training requirements and deadlines via email and contract agreements.

6. Management of Delegated Entity Training

6.1. Training Provision:

6.1.1. Delegated entities are held responsible for ensuring that all staff are trained and are required to submit proof of training, including new hire training (within 90 days of employment).
6.1.2. The Alliance will provide MOC training materials and access to LMS for delegated entities.
6.1.3. Training will cover MOC elements relevant to their delegated functions (e.g., HRA, ICP, CM).

6.2. Oversight:

6.2.1. All training to delegated entities is managed in collaboration with the Compliance, Vendor Management, and Training Teams.
6.2.2. Delegated entities must submit training completion reports at least annually and upon request.

Commented [MW18]: Need to confirm what time frame LMS uses to send out reminders.

Commented [WM19R18]: Compliance training and education policy does not set time frame for reminders

Commented [TM20]: @Fiel, Melissa lets discuss during Quality WG

Commented [CK21]: I am not sure that this is how it is currently handled adding visibility for input: @Smythe, Stephen ; @Broadnax, Marie @Reamer-Robinson, Lisha

Commented [TM22R21]: @Olson-Lennon, Elizabeth do you notify vendors or delegated entities?

Commented [WM23R21]: @Olson-Lennon, Elizabeth just wanting to confirm this is accurate

6.2.3. The Alliance will conduct annual reviews of delegated entity training programs to ensure alignment with CMS MOC.

6.3. Non-Compliance:

6.3.1. Failure to complete training will result in corrective action plans, potential contract amendments, or termination of the delegation agreement.

7. Actions for Incomplete Training

7.1. Employees/Temporary Staff:

7.1.1. Notifications for Incomplete Training for employees:

~~7.1.1.1.~~ Training not completed within 90 days of employment or within 90 days of assignment or the*first two weeks of employment*, the Department training representative will notify the employee and their immediate supervisor.

7.1.1.2. Training not completed within 60 days of the assignment date, the Employee's Department training representative will notify the employee and their immediate supervisor or manager.

7.1.1.3. Training not completed within 65 days of the assignment date, the Employee's Department training representative will notify the Employee's Manager and the Employee's Department Director.

7.1.1.4. Training not completed within 70 days, the Employee's Department training representative will notify the Compliance Director.

7.1.1.5. Training not completed within 75 days, the employee's department training representative will notify the Director of Compliance , who will notify the Chief Compliance Officer and the Human Resources Department.

7.1.2. If the Required MOC training is not completed within the first 90 days after employment or annually thereafter, the employee will be subject to disciplinary action, at the discretion of Senior Leaders, up to and including termination of employment.

7.2. Consultants/Contractors:

7.2.1. Consultants and independent contractors who have access to member data are required to complete MOC training as outlined in the contractual agreements. As possible, this shall be completed within standard required timeframes.

7.2.2. Consultants and independent contractors who have a current Business Associate Agreement in place with the Alliance are not required to complete the Compliance trainings unless otherwise mandated by contract.

7.2.3. Escalation:

7.2.4. All instances of non-compliance will be reported to the Compliance Department and Quality Improvement Committee for review and resolution.

8. Continuous Improvement

8.1. Training materials will be revised annually or as needed to reflect CMS regulatory changes, NCQA feedback, or audit findings.

8.2. Training will be regularly evaluated to ensure it addresses diverse member needs and promotes equitable care delivery.

DEFINITIONS

- Consultant: A consultant is a type of vendor who provides professional expert advice to the Alliance. In addition to working for the Alliance, a consultant most often maintains several different clients.
- b

Commented [CK24]: Only the new hire training needs to be completed within the first two weeks. All other training is completed within 90 days.

Commented [CK25R24]: Also, not all follow-ups are handled by Compliance. HR training is handled by HR, IT training follow up is handled by IT. And department training which we believe this qualifies as, is handled by the relevant departments until escalation is required and then compliance becomes involved.

Commented [CK26R24]: @Smythe, Stephen

Commented [TM27R24]: @Fiel, Melissa need to edit MOC 2AF7 timelines are different. We need to start a running log of updates in the MOC for CY 2027

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- D-SNP: Dual Eligible Special Needs Plan, a Medicare Advantage plan designed for individuals eligible for both Medicare and Medicaid, focusing on coordinated care for complex needs.
- Model of Care (MOC): A CMS-required framework outlining how special needs plans meet enrollee needs through care management, coordination, and quality improvement processes.
- HRA: Health Risk Assessment, a tool to identify member health needs and risks.
- ICP: Individualized Care Plan, a personalized plan addressing a member's health needs.
- ICT: Interdisciplinary Care Team, a group of professionals coordinating member care.
- CM: Case Management, the process of coordinating care for D-SNP members.
- LTSS: Long Term Support Services, services to assist with daily living activities.
- SDOH: Social Determinants of Health, non-medical factors (e.g., housing, food insecurity, transportation, education, social support) that influence health outcomes.
- WF: Workflow, standardized processes for D-SNP operations.
- SOPs: Standard Operating Procedures, detailed instructions for organizational processes.

AFFECTED DEPARTMENTS/PARTIES

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

REFERENCES

- Centers for Medicare & Medicaid Services (CMS), Medicare Managed Care Manual, Chapter 5: Special Needs Plan Model of Care.
- Social Security Act, Section 1859(f)(7): Special Needs Plan Model of Care Requirements.
- National Committee for Quality Assurance (NCQA) MOC Scoring Guidelines.
- CMS Long-Term Services and Supports (LTSS) Guidelines.
- 42 CFR § 422.101(f) – Special Needs Plan Model of Care Training Requirement
- DHCS All Plan Letter 24-004 – Quality and Health Equity Improvement Requirements

MONITORING

- The Human Resources (HR) Department, in collaboration with Compliance and Training Departments, will oversee training implementation and compliance.
- Quarterly audits will verify training completion, attendance records, and documentation accuracy. Audits will include delegated entities to ensure compliance with MOC training requirements.

- The Quality Improvement Health Equity Committee (QIHEC) and Governing Body shall review D-SNP MOC training outcomes annually to verify completion rates, effectiveness, and alignment with CMS/NCQA requirements.
- Training completion metrics, evaluation results, and remediation actions will be incorporated into the Plan's annual Model of Care Evaluation and reported to CMS, DHCS, and NCQA as required. Non-compliance with training requirements will trigger corrective action plans, including retraining, performance reviews, or contract termination for subcontractors.
- Training programs will align with NCQA MOC scoring criteria.